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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

AGENCY FOR INTERNATIONAL DEVELOPMENT

WASHINGTON, D. C. 20523

INDONESIA

COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM PROJECT

(497-0325)

PROJECT PAPER

SEPTEMBER 1981

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: N/A — DOCUMENT CODE: 3

2. COUNTRY/ENTITY: INDONESIA/USAID

3. PROJECT NUMBER: 497-0325

4. BUREAU/OFFICE: ASIA 04

5. PROJECT TITLE (maximum 40 characters): Comprehensive Health Improvement Program

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 86

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4): A. Initial FY 81 B. Quarter 4 C. Final FY 81

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 82 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	500	1,225	1,725	3,000	6,000	9,000
(Grant)	( )	( )	( )	( )	( )	( )
(Loan)	(500)	(1,225)	(1,725)	(3,000)	(6,000)	(9,000)
Other U.S. 1.						
Other U.S. 2.						
Host Country	-	1,700	1,700	-	9,000	9,000
Other Donor(s)						
TOTALS	500	2,925	3,425	3,000	15,000	18,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) 104	530		510	-	-	-	9,000	-	9,000
(2)									
(3)									
(4)									
TOTALS							9,000		9,000

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 562 300 540 530 740 400

11. SECONDARY PURPOSE CODE: 660

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BR						
B. Amount	9,000						

13. PROJECT PURPOSE (maximum 480 characters)

To accelerate and intensify the upgrading of the health sector services delivery systems of 3 outer-island provinces.

14. SCHEDULED EVALUATIONS: Interim MM 06 YY 84 — Final MM 06 YY 84

15. SOURCE/ORIGIN OF GOODS AND SERVICES: ☐ 000 ☒ 941 ☒ Local ☐ Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

17. APPROVED BY — Signature: Robert C. Simpson — Title: Acting Director, USAID/Indonesia — Date Signed: MM 07 DD 31 YY 81

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (8-79)

COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM - PROVINCE SPECIFIC

TABLE OF CONTENTS

ABBREVIATIONS/ACRONYMS USED

BAPPEDA	Provincial Development Planning Board
BAPPENAS	National Development Planning Board
B.K.I.A.	Balai Kesejahteraan Ibu dan Anak: Maternal-Child Health Center (Simple Outpatient clinic usually staffed by an auxiliary nurse or midwife)
B.K.K.B.N.	Badan Koordinasi Keluarga Berencana Nasional: National Family Planning Coordinating Board
BULOG	National organization responsible for distribution and pricing foods
BUPATI	Head of the Kabupaten (Regency) Government
CAMAT	Head of the Sub-District Government
COME	Community Oriented Medical Education
DEPKES	Department Kesehatan: Department of Health
DESA	Village
DINAS KESEHATAN	Office of Provincial Health Service Implementation
DOKABU	Head of the Kabupaten Government Health Service
FK	Fakultas Kedokteran: Medical School
G.B.H.N.	General Guidelines of State Policy
Gotong Royong	Cooperative mutual aid as traditionally practiced in Indonesia village
I.F.Y.	Indonesian Fiscal Year (April 1 through March 30)
INPRES	Special Development Fund from Central Executive level directly to Kabupaten and Provinces
KABUPATEN	Regency or District
KAKANWIL	Head of Provincial Health Services

KANWIL KESEHATAN	Office of Representatives of Ministry of Health in each province
KECAMATAN	Sub-District
K.M.S.	Kartu Menuju Sehat: Health Card
KOTAMADYA	Municipality, an urban equipment of the kabupaten headed by a Walikota, or mayor
L.K.M.D.	Lembaga Ketahanan Masyarakat Desa: Village Committee
LURAH	Village Chief
OUTER ISLANDS	Indonesian islands other than Java, Bali and Madura
PK	Perawat Kesehatan: Primary Health Nurse
P.K.K.	Pendidikan Kesejahteraan Keluarga: The Family Welfare Movement through village women
P.K.M.D.	Pembangunan Kesehatan Masyarakat Desa: Primary Health Care Model for Indonesia
POLICLINIC	Small, simple, outpatient clinic
P2WPK	Peningkatan Peranan Wanita Dalam Pembangunan Kesehatan: The Role of Women in Health Development
P2WKSS	Peningkatan Peranan Wanita Keluarga Sehat Sejahtera: The Healthy & Propering Family Program
PROKESA	Promotor Kesehatan Desa: Health Promotor at village level
PUSKESMAS	Pusat Kesehatan Masyarakat: Community Health Center, generally at kecematan level
PUSAT	Central Government Level
(RE) PELITA III	Third 5 year Development, 1979-1984
SPK	Sekolah Perawat Kesehatan: Nursing School
SPPH	Rural Sanitarian School

TAMAN GIZI	Village level nutrition improvement activities, such as weighing, cooking demonstration, lectures, etc.
U.P.G.K.	Usaha Perbaikan Gizi Keluarga: The Family Nutrition Improvement Program

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

PROJECT AUTHORIZATION

INDONESIA

Comprehensive Health
Improvement Program-
Province Specific
Project No. 497-0325

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Comprehensive Health Improvement Program - Province Specific for Indonesia (the Cooperating Country) involving planned obligations of not to exceed $9 million in loan funds over a five-year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project objectives are to strengthen the capabilities of the Cooperating Country to deliver health services in three provinces by increasing the number of paramedical personnel serving in these provinces and by improving the capability of provincial health officials to target, manage and evaluate specific health and nutrition activities. The project will finance training, technical services, commodities, health sector studies and intervention trials.

3. The Project Agreement, which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. a. Interest Rate and Terms of Repayment

The Cooperating Country shall repay the Loan to A.I.D. in U.S. dollars within forty (40) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country shall pay to A.I.D. in U.S. dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Goods and Services

Goods and services financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or in countries in-

cluded in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing.

Signature

Jon D. Holstine
Assistant Administrator
Bureau for Asia

9/4/81
Date

Clearances:

Herbert E. Morris, GC/ASIA — Date 9/4/81
G. R. van Raalte, ASIA/PD — Date 9/4/81
Robert Halligan, ASIA/DP — Date 9/4/81
William R. Ford, ASIA/ISPA — Date 9/4/81

PART I. - SUMMARY AND RECOMMENDATIONS

B. Summary Description of the Project

The health status of much of the rural population of Indonesia is considerably below the standards desired by the Government. Strong efforts have been made by the Department of Health to improve the situation through expansion of preventive and curative health services. Those measures, combined with overall economic and social development, will make an impact over time. However, the Government wants to accelerate the pace of health improvement having set ambitious goals for itself by the year 2000.

Because the country is so large and so dispersed it is very difficult for central agencies in Jakarta to work intensively with each Province or to give special attention to a few. Responsibility for sector program execution is therefore delegated to the provinces to do the best they can with the resources received from Jakarta and those they can obtain locally. Given their limited manpower and financial resources most provinces, have been severely handicapped in dealing effectively with their priority health sector problems.

This Project was developed to accelerate and intensify the upgrading of the health sector services delivery systems of three provinces to enable them to increase the pace of health status improvement of their populations. Through a problem solving approach that will increase the capability of provincial health officials to improve the targetting, operation and evaluation of specific health/nutrition activities, it will be seen whether demonstrable change can be achieved by focusing on several key constraints and priority health problems such as maternal and child health and nutrition.

The Project will address essentially two major constraints confronting these three provinces: a) inadequate quantity of paramedical personnel serving in the rural health centers and interfacing with the communities (especially the primary health nurse) and b) poor quality of services delivered due to inadequate budgets, training, information, planning, implementation and motivation. Although there are considerable geographic, economic and ethnic differences between the three provinces, differences in their health problems are a matter of degree rather than of kind. Therefore, even though the Project content for each Province is Province-specific, having been developed through intensive discussion and analysis in each Province, the components are very similar in each (See Section IIB. 2 Project Outputs).

FINANCIAL SUMMARY
($ 000)

	LOAN	COUNTERPART	TOTAL
MANPOWER DEVELOPMENT	$ 2,135	$ 1,950	$ 4,085
OTHER TRAINING	750	750	1,500
FIELD STUDIES & TRIALS	3,000	3,990	6,990
TECHNICAL ASSISTANCE	2,200	390	2,590
COMMUNITY MEDICINE	220	420	640
VEHICLES	-	750	750
EVALUATION	300	300	600
CONTINGENCY	395	450	845
T O T A L	$ 9,000	$ 9,000	$ 18,000

C. Summary Findings

The provinces selected for this Project are D.I. Aceh, Nusa Tenggara Timur, and Sumatera Barat. Bappenas encouraged inclusion of D.I. Aceh and NTT, and the Ministry of Health requested inclusion of Sumatera Barat. USAID and provincial health officials have worked together to identity priority areas of needs that could be addressed by the Project. USAID/Indonesia has reviewed carefully the proposals of D.I. Aceh, West Sumatera and Nusa Tenggara Timur Provinces to expand and improve the delivery of health services to their rural populations with the guidance and assistance of the Department of Health and finds the overall Project technically, administratively, financially and environmentally sound.

This Project complements many other health, nutrition and family planning sector programs in these provinces including some supported by USAID. These include Expanded Program in Immunization, Timor Malaria, Vitamin A deficiency prevention in D.I. Aceh, Rural Sanitation Manpower Development and Village Family Planning. In general it is expected that the health sector absorptive capacity of these provinces will increase enabling them to take greater advantage of other national programs. USAID support to the agricultural sector of these 3 provinces should complement the nutrition components of the Project.

The Provincial Development Program (PDP) assisted by USAID supported advisors in D.I. Aceh and Nusa Tenggara Timur and by German supported advisors in Sumatera Barat should provide an important linkage within these provinces to the Bappeda, the Provincial Development Planning Board. PDP coordination with the Project should enhance the integration of health sector activities with other provincial development programs.

The technical analyses are all positive. BAPPENAS has assured USAID that the counterpart funds included in the Project budget will be made available as needed. Further indication of GOI commitment to this Project is its inclusion in the "blue book", the GOI's annual listing of development activities requiring foreign assistance. The Project meets all applicable statutory criteria.

D. Recommendation

That AID fund this project as follows:
Amount : $ 9,000,000 Loan
Terms : 40 Years, including 10 year grace period
2% p.a. interest during grace period
3% p.a. thereafter

E. Project Development Team

USAID:
David H. Calder, M.D. Health Officer
Molly Mayo Gi erich, Public Health Advisor
Robert G. Pratt, Chief, Health & Nutrition Office
Nicholas G. Studzinski, Public Health Advisor
Joseph F. Stepanek, Economist

Provinces:
Dr. J. Fernandez, Chief, Provincial Health Office, Nusa Tenggara Timur
Dr. Gatot, Planning Officer, Provincial Health Office, and Staff, NTT
Dr. Yuliddin Away, Chief, Provincial Health Office, Daerah Istimewa Aceh
Dr. Rafki Ismail, Chief, Provincial Health Office and Staff, Sumatera Barat
Dr. Hafid Ardi and Community Medicine Committee, Vice-Dean Andalas Medical School, Sumatera Barat

Central Department of Health Project Planning Coordination:
Dr. Hapsara M.P.H., Chief, Bureau of Planning
Dr. Freddie Rampen, Bureau of Planning

Department of Health Center for Education and Training:
Dr. Mohamad Isa, Director, Pusdiklat
Dr. Watimena, Chief of Program Management, Pusdiklat
Ms. Stein Wuntu, Chief of Sub-Section Methodology, Pusdiklat

Part II. -- BACKGROUND AND DETAILED PROJECT DESCRIPTION

A. Background

Despite great progress in Indonesia's development programs, especially in the fields of rice production, industry, public works, transportation and family planning, the health status of much of the population remains precarious and as yet below the standards that the Government desires for its people. Although health and nutrition statistics in Indonesia are not yet well developed, there is little doubt that the nationwide average infant mortality rate remains at least 100 per thousand live births; life expectancy at birth may just have reached 50 years; hundreds of thousands of children each year die from immunizable diseases; perhaps 40% or more of young children suffer chronic protein-calorie malnutrition; the yearly incidence of blindness from Vitamin A deficiency is perhaps 40,000 children; malaria still depresses the health and productivity of the population, predominantly in the outer islands; children's energy is depleted by recurrent diarrheal diseases and respiratory infections to a degree that is not yet quantitated; pregnant women do not eat enough protein, calories, vitamins or minerals; the majority of people are infected with various intestinal parasites; and cholera, typhoid, dengue hemmorhagic fever, TB, filariasis, yaws, and leprosy are all endemic or periodically epidemic in many parts of the country. Tremendous regional variations exaggerate these problems and others in different areas of the country.

The Government has succeeded in its goal to establish and maintain a high quality malaria control program protecting nearly 90 million people in Java-Bali-Madura, but malaria control activities in the other islands (outer islands) are still very limited. The enormous size and distribution of the population, the vastness of this nation of 3000 inhabited islands, and the major capital investment required have prevented at least 85% of the rural population from obtaining safe water supplies.

Total food production and per capita calorie consumption are clearly improving, but protein calorie malnutrition as well as specific nutrient deficiencies (vitamin A, iron, iodine) are still widespread due to poverty, imperfect distribution of food stuffs, seasonal fluctuations, ignorance, traditional food habits and beliefs, poor distribution of food within the family, increased metabolic demands and/or poor absorption due to concurrent illnesses, and other factors.

Responsibility for combatting these problems is shared by the Central and Provincial governments. Described briefly, under Indonesia's health system, the Deparment of Health (Depkes) in Jakarta sets goals, priorities and programs in the health/nutrition sector. The provincial health organization,

under each Governor, has responsibility for carrying out the day-to-day preventive and curative services in each province, with technical assistance from Depkes representatives living in each province and with major financial support from Jakarta. The provinces, then, to a large degree actually implement the programs, deliver services and gather data, within the relatively limited resources available from central and local sources and within the realities of the unique geographic, demographic, ethno-cultural and epidemiologic situation in each province.

The Department of Health has been increasing the quantity and quality of its public health oriented activities in recent years, but there is still a gap between these improved plans and their consistent implementation with direct and sustained effect on the health/nutrition status of the population. Even the best centrally conceived and planned programs often are as yet reaching only a small proportion of the public.

In the past 20 years, the Government has made giant strides in establishing the framework of a preventive/curative public health system that reaches all but the most remote sites. Hospitals exist in essentially every regency (Kabupaten) and more than 5000 public health centers (Puskesmas) have been built in nearly every sub-district (Kecamatan - approximately 30-80,000 inhabitants), even in some extremely remote areas. Though improving steadily, these Puskesmases are still poorly staffed, equipped and organized relative to their enormous public health responsibilities. Most Puskesmases are managed by a physician serving a post-graduation obligatory government service of 2-5 years. Many of these public health centers do not yet have adequate, realistic goals or adequate management, nor do they have appropriately trained staff to carry meaningful health/nutrition intervention and education services out into the communities where they are so vitally needed.

The provincial health/nutrition authorities face an enormously difficult task; they are responsible for improving the health/nutritional status of a relatively unhealthy and poorly educated population who have little experience interacting with organized government health services. It is estimated that nationwide perhaps only one-fifth of Indonesia's 147 million people have any contact with the government public health centers. The outer island provincial officials have the additional problems of remoteness from Jakarta, difficult communications even within their own provinces, tremendous ethno-cultural-linguistic variations, and a less developed social and public service infrastructure than Java/Bali. Their populations are increasing at a more rapid rate than Java/Bali. The personnel and material resources available to them to meet their health/nutrition needs are usually in shorter supply than the longer "established" systems in Java/Bali. The baseline data gathering and analysis mechanisms are inadequate, so much

so that no one is sure even what the infant mortality rate is. No viable system of collecting vital statistics on births or deaths is in place. Provincial officials by their own admission often have had insufficient training relative to their great responsibilities of providing services for millions of people scattered through their large provinces. More and more programs are "coming down" from the central level which they must attempt to implement and integrate into a health/nutrition system that is usually only patchwork at best. The provincial officials, often feel overwhelmed and recognize that they could benefit from further assistance. Undoubtedly, these provincial officials who are closest to the delivery end of services in rural communities, have relevant and innovative ideas for improving present programs or developing new ones. They understand the unique cultural, demographic, logistical and epidemiologic demands and expediencies in their provinces which vary so enormously throughout Indonesia. Their own provincial resources, although growing, are unlikely to allow them the opportunity for systematic development, trial and evaluation of their innovative program ideas. Foreign assistance, if carefully applied in conjunction with additional Indonesian resources, can help.

During the Government's first two 5-year development plans and the beginning of the current third plan (Pelita III), the stress has been laid on development of the basic infrastructure of the public health system (hospitals and health centers), communicable diseases control (especially malaria and smallpox), establishing a vital central planning bureau, and producing more physicians (there are now 13 government medical schools and also numerous private universities that produce small numbers of physicians). In addition, Pelita III is giving considerable emphasis to quantitative manpower development, the quality of services (especially in the areas of maternal-child health and nutrition), and, spurred on by the family planning program successes, community participation . As would be expected, progress has generally been faster in Java/Bali than in the outer islands.

The last couple of years have clearly shown the Government's increasing emphasis on improving provincial technical self-reliance, such as assigning more technically competent people at the provincial level and below; by the increasing reliance on the provincial and kabupaten development planning bodies (BAPPEDA); by the relatively large amount of "Presidential funds" (INPRES) channelled directly to the provinces and kabupatens; and by the increasing budgets provided to the provinces by the various sectoral ministries

The budget provided to the three provinces by Depkes during the first three years of Pelita III is shown in Annex G. Substantial increases are evident in several important categories related directly to the goals of the Project, including nutrition and health centers. This budget does not include INPRES funds provided to the Provinces for some salaries, medicines and health center construction.

The Ministry of Health is presently in the midst of a major effort to redefine primary health care in the Indonesian context and to explore new ways to develop a pervasive and effective system. They want an effective, low cost system that provides more people with the services they want and need. The Ministry is now placing great emphasis on manpower training, in recognition that large numbers of nurses/midwives, sanitarians and village outreach workers must be recruited, trained, deployed in the field, and provided meaningful career opportunities.

The Departments of Health and Education and Culture have made the commitment that the medical schools will develop effective "Community Medicine" components in their training program with the goal to produce physicians who understand better the communities they serve, who know better how to deliver services to them through the public health system and who are happier in rural service. Several schools in Java and Bali have significant and sometimes impressive Community Medicine programs (COME), but in the outer islands these have yet to mature.

CHIPPS represents an initiative on the part of the Department of Health to provide health officials in three provinces additional resources that will help the provinces respond to their specific and unique manpower and health service delivery needs. This intiative is supported by BAPPENAS who suggested Daerah Istimewa Aceh and Nusa Tenggara Timur as two provinces with special needs because of geographic, climatic, and social-economic factors. Sumatera Barat was suggested as a CHIPPS province because of the potential of its health department to work together with Andalas University to develop a community medicine program that functions effectively with the provincial health system. The Government has made a commitment to have community medicine programs in all the thirteen government medical schools in Indonesia. The medical school of Andalas University is prepared to begin its community medicine program in 1981-1982.

In March 1981 the Minister of Health announced at the annual national working meeting of all the Kakanwil Kesehatan (Heads of the Provincial Health Offices) that the Department of Health would increase its support for training more community-oriented health manpower to serve in rural areas. It was stated that special attention would be given to the training of more Perawat Kesehatan (PK) or primary health nurse and the retraining and upgrading to Perawat Kesehatan of nurse/midwives and auxiliary nurses trained under previous systems. The PK undergoes a three-year training program after junior high school graduation, oriented both on curative and preventive medicine, but with a heavy emphasis on community health. It is planned that the PK will staff village health centers and eventually become the backbone of the village health delivery

system. It was for this manpower training need that the Kakanwils for the three provinces were asked to identify the precise situation of the nursing schools' teachers and candidates for new training or retraining in their provinces and to determine how the process of training could be accelerated by CHIPPS. The high level central government commitment to training more and better qualified PKs (and doctors) who will have had a meaningful training experience in the community prior to being asked to serve in a Puskesmas augurs well for the succesful implementation of improved services in the three provinces. The high level administrative support for improved delivery of health services in the provinces is encouraging to provincial health officials who understand the obstacles they face in providing adequate services and who are not satisfied with the existing situation.

B. Detailed Project Description

1. Goal and Purpose

The Project will work intensively over five years with the government's non-hospital primary health care and public health system in three outer island provinces: Nusa Tenggara Timur, Sumatera Barat, and Daerah Istimewa Aceh. The Project will work toward the broadly defined goal of improving the general health and nutrition status of the rural population in these provinces. Because of the usefulness of quantitative measures in evaluating progress toward this goal, we will state that in quantitative terms the Project hopes to assist these three provinces reach the following standards by 1990: (a) decrease the infant mortality rate to 75 per 1000 live births*; and (b) double the number of rural women and children receiving effective health and nutrition services.

Of course any 5 year provincial health/nutrition sectoral program in Indonesia cannot alone accomplish this goal. Certainly there needs to be continued progress in Indonesia's multifarious non-health socio-economic development efforts that probably have as much effect on the public's health and nutrition status as do any health sector programs. Concurrently, there need to be continued improvements in the central Ministry of Health's performance in planning, guidance, support and evaluation for the actual service deliverers at the province level and below. It is reasonable, based on recent experience in Indonesia, to accept these assumptions of continued progress in these areas.

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* The Minister of Health announced in June 1981 that the goal for the year 2000 is to reduce infant mortality to 50 per 1000 live births.

Even within the health/nutrition sector alone, significant progress toward the goals will require a broad spectrum of project activities, specifically quantitative manpower development, qualitative manpower development and sectoral system development. Addressing these needs, the purpose of the Project, therefore, is to accelerate and intensify the upgrading of the health sector services delivery systems of D.I. Aceh, Sumatera Barat and Nusa Tenggara Timur.

The Ministry of Health and provinces correctly have identified the greatest quantitative manpower deficiency to be among the Perawat Kesehatan (PK), the primary health nurse stationed at the Puskesmas and their satellite clinics and responsible for much of the burden of delivering preventive and simple curative services. There is a shortage in each province of hundreds of these vital workers to meet even the minimum newly established government standards for adequate Puskesmas staffing. This Project will deal with this problem.

Qualitative manpower development itself has many facets. It will require improving technical, analytical and managerial skills of personnel at all levels in the system and should be directed toward better problem identificaton and analysis, problem quantification, planning and carrying out alternative intervention trials, and evaluation. A sounder information base obviously will be necessary as a tool for analysis and in making program decisions.

Qualitative manpower development is one of the justifications also for the project's efforts in organizing "Community Medicine" programs in the medical schools in Sumatera Barat and D.I Aceh. Inherent in this effort is the intent to foster a practical, workable cooperative effort among provincial health services, medical school faculty and the students. It is hoped to provide a training experience wherein new physicians graduate and enter their rural service with greater interest in and knowledge of the dynamics of rural and community health and ill-health, and with better skills and motivation to supervise and participate in successful intervention programs in the Puskesmas and villages. Realistically, Community Medicine training programs cannot be expected to "inspire" many young physicians to enter public health careers or dedicate themselves to serving rural areas; there are too many disincentives to that. Nevertheless, it is reasonable to seek that such programs cause many of these graduates to become more effective managers and deliverers of services in their inevitable role for several years as directors of the Puskesmases. This is vitally important since these services usually are the only services available to the majority of the rural poor.

Sectoral systems development here means analyzing interventions, ongoing and proposed, implemented by the

province's government health system and seeking ways they may operate with greater effectiveness, with greater public participation and with greater popularity. The mix of program/problem analyses will vary in each province according to their needs, desires and capabilities but will include investigations into management systems, improved data collection, two-way data flow, local and province-wide epidemiologic surveys, communicable disease control, protein-calorie and specific nutrient deficiency detection and correction, health education, school health, pharmaceutic logistics and utilization, and functional linkages with community groups and volunteers.

This last subject - functional linkages with community groups and volunteers - is of special importance in Indonesia with normally only one Puskesmas to serve more than 30,000 people, often in areas of poor communications. Attention will be given to defining and demonstrating the roles of community organizations, especially women's organizations, in cooperating with the formal health/nutrition system in order to maximize the effectiveness of each other's efforts. It is obvious that with a small staff and small resources the Puskesmas cannot regularly penetrate into all of the villages for close assessments, interventions and follow-up. On the other hand, village organizations can perform limited assessments, interventions and follow-up, but what they can accomplish is limited by technical personnel and resource constraints, some of which can be overcome by supplying these back-up resources from the Puskesmas.

In summary, then, this Project will assist 3 provinces address needs of quantitative and qualitative manpower development and sectoral systems development in order:

- that there will be a significantly increased number of professional rural health workers and that their training will be appropriate for the communities in which they will work;

- that the provincial public health system will be better able technically, analytically and managerially to carry out programs for which they are responsible.

- that the health/nutrition intervention programs will be better adapted to the often unique circumstances in these provinces; and

- that provincial initiative is demonstrated in planning, carrying out and evaluating trial interventions for operational service delivery problems with inputs from community organizations.

2. Project Outputs - Summarized for all Provinces

a. Manpower Development*

1) Primary Health Nurse (Perawat Kesehatan or PK)

All three provinces will place high priority on expanding the numbers and improving the capabilities of the primary health nurse (PK) working in their Puskesmases. Since many nurses and midwives currently working in the provinces were trained under previous systems and have not had the full PK curriculum, two types of in-service training will be provided in addition to enrollment of new students in the full three year curriculum.

- 3 year course - 290 graduates by March 1986
- 3 month retraining - 840 graduates by March 1986
- 12 month supplemental training - 450 graduates by March 1986

In addition, it is expected that the quality of performance of all PK participating in the program will be enhanced through a) on-the-job training received as part of their participation in studies, surveys and intervention trials, b) expanded community participation training and c) in some cases short-courses for upgrading technical, analytical or managerial skills.

2) Nursing Teachers

Many additional teachers will be required to staff adequately the nursing schools (Sekolah Perawat Kesehatan or SPK) where the nurses will be trained. Therefore, in each province nurses who apply to become teachers will receive one year training and some current teachers will receive a six week upgrading course at special nursing teacher schools in Java or South Sulawesi. These teachers will serve as classroom and fieldwork instructors for the full three year curriculum, three month retraining and twelve month upgrading courses. A total of approximately 125 teachers are expected to be trained in all provinces by the end of the project.

In addition, some of the new or existing teachers will receive additional qualitative improvement through short-courses, observation tours to innovative programs or even formal degree training in Indonesia.

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*See Annex H for a detailed explaination of the formal manpower training schools and course activities proposed for the three provinces.

3) Rural Sanitarians

D.I. Aceh and NTT provinces feel a great need to expand more rapidly the number of sanitarians assigned to Puskesmases to promote environmental sanitation measures. They will send new candidates, and some persons currently assigned as sanitarians but who were trained only in a short crash program, to the newly expanded sanitarian schools in Bali (from NTT) and either Medan or Lampung (from D.I. Aceh) for the full two-year curriculum. Approximately 85 new sanitarians will be trained from the 2 provinces.

4) Laboratory Technicians

In D.I. Aceh a maximum of eighty sanitarians or other Puskesmas paramedical staff will be given a three month course at the provincial laboratory technicians training school (Sekolah Analis) in basic laboratory techniques and return to their posts. Although newly trained sanitarians should have received thorough training in laboratory techniques many of those trained earlier are now lacking in those skills. The regular laboratory technician students will receive an improved education as a result of the training to be provided to their instructors.

5) Laboratory Technician Teachers

Faculty of the Aceh Sekolah Analis will receive some training to upgrade their technical, teaching and administrative skills.

6) Community Volunteers

Through a number of health services intervention trials in all three provinces, especially the Community Participation Program, many villagers (especially women) will be recruited and trained to become volunteer health/nutrition workers. They will receive training in community diagnosis, case finding, simple treatments, case follow-up, illness prevention and health/nutrition/family planning education. Supervisors will receive training in supervisory, motivational and managerial skills.

7) Medical School Faculty

Faculty involved with the community medicine programs of the medical school being developed in D.I. Aceh and the one operating in Sumatera Barat will receive training in community medicine approaches directly from consultants and through short courses, observational tours and perhaps degree training courses.

8) Medical Students

All students, many of whom will become Puskesmas doctors upon graduation, will receive instruction, including extensive field work, in community medicine. The graduates will have a better understanding of community dynamics, community-level diagnosis and the relationships between conditions of the village and condition of the villager (health/nutrition status). They will also receive technical and managerial training intended to help them design and manage health sector programs as Health Center doctors/managers following graduation.

9) Health Center Physicians and other staff

Those persons participating in surveys, special studies and intervention trials will receive on-the-job training in the required skills as necessary. Various staff members will take part in observation tours and short-courses. Puskesmas physicians will have opportunities to exchange technical information and program experiences with their colleagues at provincial-level conferences/workshops.

10) Provincial and Kabupaten Health/Nutrition Officials

Many of these officials, responsible for managing the provincial health delivery systems, will receive training and otherwise improve or update their skills through a variety of means, including direct participation in surveys, studies, intervention trials and evaluations, observational tours and short courses and even some long-term academic degree programs in public health and management, mostly in Indonesia.

b. Sectoral Systems Development

1) Epidemiological Survey

Various surveys will be carried out in each Province at different levels according to the problem and purpose, including village-level (by the villagers), regional and province-wide surveys. Among others, surveys will include protein-calorie malnutrition, nutritional anemia, goiter and cretinism, nightblindness, diarrheal diseases and tuberculosis. The surveys will have the objective of increasing the capacity of the provincial health staff to: a) identify and quantify the nature and extent of a particular problem, b) design and carry out the appropriate field trial and intervention, and c) decide on provincial policy and response to the problem. (All provinces)

2) Vital Statistics

A simple but reasonably accurate vital statistics gathering system will be initiated in pilot areas in one or two kabupatens per province. (All provinces)

3) Diarrheal Disease Control Program

In one kabupaten of D.I. Aceh the epidemiology and patterns of epidemic and endemic diarrheal diseases will be studied, alternative interventions analyzed and a kabupaten-wide control program undertaken. (D.I. Aceh)

4) Tuberculosis Control

Province-wide strategies for tuberculosis control will be developed (or revised) on the basis of surveys and intervention trials. (D.I. Aceh)

5) Nutrition Intervention Programs

Province-wide nutrition intervention programs will be developed (or revised) based on analyses of results of nutritional status surveys, food and consumption studies and intervention trials. These programs will include strategies and interventions to combat goiter and cretinism, iron deficiency anemia and Vitamin A deficiency, and protein-calorie malnutrition (PCM). (All provinces)

6) Role of Women

Opportunities to strengthen the role played by village women (and men) volunteers in health/nutrition/family planning improvement program will be studied. (All provinces)

7) Other Studies

Some other specialized studies to be carried out include the following:

a). strengthening the school health system (NTT, Sumbar)
b). upgrading the services of traditional birth attendants (All provinces)
c). maximizing coverage of pregnant women with tetanus immunization (All provinces)
d). improving cold chain maintenance for immunization program (Sumbar)
e). rabies control (D.I. Aceh)
f). drug management (NTT)

8) Information System

A viable two-way data and management information system will be developed to operate between province headquarters and the field in parts of at least one province (NTT).

9) Role of PKK in Health Sector Delivery System

The function of the PKK village welfare movement and its relationship to the Puskesmas will be analyzed in pilot project areas and findings incorporated in design of community-level programs supported by the Project in new PKK areas. Also the relationship between PKK supervisory networks and the Provincial Health services will be studied to adopt the most synergistic relationship possible. (NTT, possibly Sumbar and D.I. Aceh)

10) Community Medicine/Health Services Delivery

In Kabupaten Pasisir Selatan, Sumatera Barat the Medical School Community Medicine program (COME) and the Provincial and Kabupaten health services will collaborate to a) provide practical training to the medical students and b) provide intensified health services to the community as an example of what can be done through careful diagnosis and planning and dynamic organization and service delivery in collaboration with the community. (SUMBAR) The designers of the Community Medicine program for Universitas Syiah Kuala D.I. Aceh will receive some assistance in planning their program and training their instructors.

3. Project Inputs

a. Technical Assistance

1) Long-term Consultants - One long-term consultant will be assigned to each Province for a period of four years. The consultants will be physicians with experience in public health and clinical practice. They will provide technical and management assistance to the Provincial Health Chiefs (Kakanwils) in their role as Project Officers in their respective provinces. The consultants will work closely with all elements of the Provincial Project Implementation Units providing inputs as appropriate in planning, training, design, implementation and evaluation of studies, surveys and field trials. They will also advise their counterparts on the need for and selection of short-term consultants who will provide specialized expertise not readily available in the province. Loan funds will be used to pay the basic costs of the consultants with some local support costs provided by the counterpart budget.

2) Short-term Consultants - Approximately 120 person months of short-term consultants will be utilized in all three provinces as needed. Their services are expected to be especially helpful with regard to training, survey methodology, design and analysis of field studies, intervention trials, management information and evaluation. The consultants will be recruited from Indonesia and abroad as appropriate. Funds for these consultants will be provided equally by the loan and counterpart funds. The counterpart share will include the in-country support for all the consultants including office space, secretarial services and intra-province travel by vehicle or plane.

3) Fellowships - Various provincial health officials and faculty of the medical and nursing schools will be sent for long-term academic training in Indonesia or abroad. The costs of this training will be shared equally by both the loan and counterpart funds.

4) Observational Travel and Short-term Courses - Costs of these training activities will be supported by both loan and counterpart funds.

5) Community Medicine

Costs of consultants, fellowships and observation tours for both provinces (D.I. Aceh and Sumatera Barat) are included above. Operational costs for West Sumatera (D.I. Aceh will not be operational during the project period) will be included in both the loan and counterpart budgets. They will include such things as preparation of COME study modules, student and faculty transportation to and living costs in the field, field equipment, limited research funds, data analysis, vehicles, faculty salaries, etc.

6) Other Manpower Development

Additional inputs required to produce the desired manpower development outputs may be considered in three basic categories - infrastructure, teaching costs and students costs.

School buildings required for training the nurses, and other para-medical personnel are either already available or will be provided by the Government. In most cases existing facilities are adequate. In others, decisions to expand existing schools or build new ones will be made soon by the Government. Either alternative is satisfactory for the Project. All costs of building construction and utilities will be assumed by the Government.

Teaching costs will include basic salaries of faculties (provided by the Government), honoraria or incentives for additional teaching load and more field site instruction

resulting from the Project, transport and per diems for teachers during field training, and appropriate equipment and materials. Costs of these inputs and others required will be provided by both the Loan and Counterpart funds and apportioned as most convenient.

Students costs will be handled in the same way. These costs will include tuition and fees, books and materials, food and lodging, transportation, and field training costs.

7) Health Sector Studies and Intervention Trials

Inputs required for these activities will consist primarily of the time of professional and paramedical personnel and community volunteers in each province, funds for travel, per diems, and honoraria, vehicles and their operating costs, equipment and materials. These will be shared by the Loan and Counterpart funds as appropriate.

8) Vehicles

Each province will require a minimum of 15 vehicles to be able to carry out Project activity, specifically field implementation, supervision and follow-up. Counterpart funds will suport the acquisition of Project vehicles which will be essential to successful Project management.

9) Equipment

Purchase of simple audiovisual equipment, physical exam equipment, laboratory equipment and health/nutrition/family planning materials for classroom use will be supported by Loan funds. Counterpart funds will provide some other capital equipment as appropriate.

10) Evaluation

Costs of a mid-Project and final-Project evaluation will be supported by both Loan and Counterpart funds.

PART III -- PROJECT ANALYSES

A. Social Analysis

1. Socio-Cultural Feasibility

Motivation and organization

The central and provincial levels of the GOI recognize that the delivery of basic rural health services suffers a large disparity between expectation and actual performance. Although the network of a rural health system has been spread throughout Indonesia in the form of Kecamatan (sub-district) health centers (Puskesmas), Health Posts and Maternal-Child Clinics, the reality is that these facilities are being under-utilized. Recognizing that buildings and manpower alone are not going to provide "health for all by the year 2000", the GOI is seeking appropriate community participation in primary health care as a necessary informal accompaniment to the formal health services being provided by the government.

The activities in Primary Health Care and village development in Indonesia started to manifest themselves in various ways about one decade ago:

i) PKK (Pendidikan Kesejahteraan Keluarga) or the Family Welfare Promotion Movement began in Central Java in 1968. Started by the Governor's wife, the program set forth 10 points of community activity to be the focal points of special concern for village women. The movement has been institutionalized in Indonesia over the years with the Governor's wife in each province responsible for the intensification of PKK activities in her respective province. Assistance is provided in the province by each Kabupaten political leader's wife, the kecamatan leader's wife, and finally the village leader's wife who has ultimate responsibility at the village level for the activities to promote a healthy and prosperous family. While PKK activities are uneven throughout Indonesia at present, being dependent as they are on the motivation, knowledge, skills and leadership provided by the local officials' wives, the potential of the PKK to involve women in grassroot activities has been recognized by the central government. In March 1981 President Soeharto identified the PKK as the best way to organize women's activities to increase their role in national development. (The Indonesian Times, March 3, 1981).

ii) In 1979 the PKK movement was augmented by the P2WKSS program (Peningkatan Peranan Wanita Keluarga Sehat Sejahtera). This integrated "crash" program, coordinated by the office of the Associate Minister for the Role of Women, provided extra budgetary funds from

the Central Government for implementation of program activitity for low income families in two low-income villages in every kabupaten in Indonesia. The activities included baby weighing, supplementary feeding for those underweight, home gardening, basic sanitation, provision of safe water, and other inputs related to family health.

Throughout Indonesia it was felt that the "crash" program was useful and helped many of the families who participated. In some cases nutrition improved from the use of vegetables introduced in home gardening training. Some families had a modest increase in income from sale of surplus vegetables. In some villages the women were succesful in organizing clean-up campaigns along foot paths, roadsides and house yards and this had a beneficial impact on health and sanitation. The program further aroused the awareness of women to contribute to and participate in programs of general community benefit. It gave the people involved an intimate look at the difficulties with which they must deal if PKK activities are to be successfully intensified on a larger scale or longer term basis:

1. trying to work intensively with low-income, often isolated families;
2. trying to involve women in community activity;
3. trying to work in an integrated cooperative manner among several government departments, among community people and government officials, among men and women, etc.

Specific PKK activities in Indonesia are already government policy and are being directed toward the objective of including women more fully in community development. These activities can be grouped under five general headings:

1. Training activities at all levels of PKK organization with an emphasis on maintaining a participatory style of training; on integrated learning (men and women, civil servants with community people, different levels of government); and on appropriateness of training.

2. Activities designed to help village social infrastructure. Many villages still have undeveloped and inexperienced village councils. It is a goal of PKK activities to strengthen these village institutions so that communities will be able to deal with their own problem at the end of an intensive program.

3. Nutrition/health/family planning activities:

   a) Nutrition, including under-fives weighing, home gardening, supplementary feeding;
   b) Gotong Royong activities to improve home design, build latrines and provide safe water;
   c) Expanded immunization program for children;
   d) Family Planning education.

4. Non-formal education activities to expand literacy and income producing skills.

5. Socio-economic activities, including introduction of appropriate technology, improvement in production and marketing of local home industry products, and other similar activities.

iii) The UPGK (Usaha Perbaikan Gizi Keluarga) Family Nutrition Improvement Program is an integrated effort of three departments (Health, Agriculture, Religion) and BKKBN (the National Family Planning Coordinating Board) to achieve food and nutrition improvement, responding to the concern that "low quality of food not only causes the nation to become weak today but will create a weaker generation in the future" (President Soeharto). The GOI recognizes the problem of malnutrition as one of the handicapping factors in national development. In the 1978 General Guidelines of State Policy (GBHN) and TAP MR (Congress Stipulation) the present direction of development is stated to have two goals: 1) to improve the standard of living and welfare of the people; 2) to lay a strong foundation for the next stage of development. Improved nutrition is officially viewed as necessary to obtaining these goals.

The UPGK integrated package of activities is primarily aimed to overcome the problem of protein-calorie malnutrition, especially prevention of malnutrition among children under-five and pregnant/lactating women. The UPGK activities include: nutrition monitoring through monthly weighing of under-fives, including provision of a KMS (Growth Chart/Health Card) for each child; nutrition education; family food production through home gardening; supplementary feeding; Vitamin A capsule distribution; provision of Oralite; distribution of iron tablets to pregnant women; and the promotion of breastfeeding and good maternal-infant feeding practices.

The activities are implemented by village nutrition cadres who have been trained for this purpose by the Health Center (Puskesmas) or the BKKBN. In many

villages the PKK manages UPGK activities with the assistance of the government's health, family planning, agriculture, and religious officials. All these activities are based on the efforts of the community itself and are intended to encourage community responses to nutrition problems rather than dependence on outside resources.

The UPGK program has given provincial health officials an opportunity to implement a centrally designed program that addresses nationally defined needs. During Pelita III UNICEF has assisted the UPGK program through the Nutrition Directorate of the MOH. USAID, through the Village Family Planning/Mother-Child Welfare Project with BKKBN in East Java and Madura has supported the objectives of the UPGK program. Now that some experience has been obtained with UPGK and P2WKSS, provincial officials are aware of some adaptations that need to be made to fit the situation at the local level. The ability of village organizations to better manage and supplement their resources with a minimum of outside assistance, but with full support and cooperation of the Puskesmas, will be one target of this Project which has the advantage of learning from the evaluations of the UPGK experience.

iv) Primary Health Care in Indonesia is a major concern of the Department of Health. This program is handicapped by the preference of most physicians to live in cities where facilities and pay are more favorable. As a result, doctors' services are unevenly distributed with one doctor attempting to serve 40,000 to 100,000 persons in rural areas.

Recognizing that a special effort toward rural health care was necessary, the GOI created the Puskesmas (Rural Health Center) which was inspired by the previous acceptance by rural populations of the BKIA (Mother Child Health Clinic). The majority of the BKIA clinics were integrated into the Puskesmas as the latter became established. In addition to MCH activities, the Puskesmas is also intended to provide services in: communicable disease control, community health education, family planning, laboratory, outpatient clinic, school health, and in some cases a dental clinic. The goal of establishing a Puskesmas in every Kecamatan (3,500 kecamatans each with an average population of 43,000 in 1980) was achieved during the Second Five Year Plan (1974-1979); however the ideal of a well-staffed Puskesmas was far from attained and many of today's more than 5000 Puskesmases still have no doctors and lack other categories of health manpower. As evaluation of utilization and coverage of

the Puskesmas system revealed that the Centers were being used by only 20% of the target population, many of those being the more privileged and better-educated, an awareness developed that still more effort must be made to reach the village poor. Experimentation with village cadres in Banjarnegara in Central Java, and with integrated MCH/Family Planning in Mojokerto, East Java, during the 1970's contributed to the Ministry of Health and BKKBN's understanding of and experience with a cadre system of Primary Health Care. Ultimately in 1978 a decision was made to experiment further with a national Village Community Health Development Program (PKMD or Pembangunan Kesehatan Masyarakat Desa) with Community Health Volunteer Workers (Prokesa or Promotor Kesehatan Desa)*.

The PKMD program has added further to the experience in Indonesia of adapting the PHC concept to the unique needs, constraints and resources of Indonesian society. It has also pointed out the weaknesses and problems in implementing such a program in this complex country and has indicated areas of modification and provincial adaptation to be pursued in the Project. The concept of primary health care cadres administratively responsible to the village committee, with technical input, supervision and guidance from the Puskesmas, has been shown to be socially, culturally, and politically sound.

v) Village Family Planning (VFP) is a family planning information and contraceptive service program centered at the village level and run by village residents**. VFP has been in Java/Bali since 1975 and its current phase is focusing on strengthening sub-village groups and using satisfied acceptors as motivators. In mid-1977 initial activities were expanded to 10 large outer island provinces (including D.I. Aceh and Sumatera Barat), and in mid-1979 the early phases of training village leaders and expanding services outlets was begun in most of the remaining outer island provinces (including Nusa Tenggara Timur).

*An extensive discussion of the program can be found in Primary Health Care (Village Community Health Development) in Indonesia, Ministry of Health, Republic of Indonesia, prepared for International Conference on Primary Health Care, Alma Ata, U.S.S.R. Sept. 6-12, 1978, Jakarta July 1979.

**For a detailed discussion see, "Orientation Booklet" USAID/POP, June 1981.

VFP began because clinic based family planning services were not reaching the majority of villagers. The villagers assume responsibility for managing their own program. Influential village leaders (village chief, secretary, religious leaders, women leaders, school teachers, etc.) are trained to manage and monitor VFP. Furthermore, family planning behaviour is becoming institutionalized as a village social process. Village leaders are appointed as contraceptive distributors and trained to record/report contraceptive distribution. Contraceptive resupply depots are established in the village. Sub-village groups of satisfied acceptors are formed who recruit new members and establish neighborhood contraceptive resupply depots. Additional sub-village group activities are promoted to link family planning with total family welfare. These activities, along the lines of the PKK, P2WKSS, and the UPGK activities, include, among others; nutrition, income-generating projects, saving programs (arisan), sewing and handicrafts, functional literacy programs and even gamelan orchestras.

The Indonesian experience with VFP has been a positive one and as the program expands in the outer islands it is being integrated closely with the Department of Health, a process which can be enhanced by the CHIPPS Project in the three Project provinces. As with PKK, P2WKSS, UPGK, and PHC, Village Family Planning has been shown to be socially, culturally and politically sound, especially in the way it has institutionalized a delivery system run by villagers.

2. Spread Effects

The Project anticipates that as the various sub-project activities begin to be implemented in each province (see Part V -- Implementation Plan), the level of community participation in health/nutrition/family planning activities will continue to increase. The outer island provinces have had less experience with the integrated approach to these services than the provinces in Java and Bali, but based upon the spread effect of the VFP, UPGK, PHC, PKK, P2WKSS and other integrated programs in Java-Bali it is expected that the CHIPPS activities will continue to spread the community participation approach to health, nutrition and family planning services. Additionally, it will extend the community participation approach to health/nutrition services to the nursing schools in all three Project provinces, to the established medical school in Sumatera Barat, and perhaps to the new medical school being planned in D.I. Aceh. Through community participation teaching modules and well-supervised field experience for nursing and medical students, it is anticipated that the manpower who will later serve in rural communities will have an improved understanding of the needs and capabilities of villagers.

Also it is expected that the working relationship between the provincial department of health (Kanwil DepKes) and the provincial training institutions (medical and nursing schools); the Kanwil DepKes and the Central DepKes; the Kanwil DepKes and kabupaten, kecamatan and village staff; and the Kanwil DepKes and the Provincial Development Planning Board (BAPPEDA) will be strengthened through this Project's activities. As the provincial Health Officers gain experience in problem solving based on local initiatives to identify and respond to their specific health/nutrition/family planning priorities, it is expected that qualitative improvements will occur in the performance of the provincial health manpower, the delivery of rural health services, and the utilization of these services by the rural population, especially mothers and children.

3. Social Consequences and Benefits Incidence

The primary beneficiaries of this project will be women (15-49) and children under five in the three provinces who are the principal recipients of Project services and interventions. While the Project initially will introduce and modify services and interventions in pilot project areas, it is anticipated that the improvement of health services in each province, supported by an increased availability of trained paramedical personnel, has the potential of reaching roughly half of the 3,356,620 million women and children by 1990 and later extending to the entire population of the three provinces of 8,755,253 million persons.

The major social consequences of this Project will be reduced infant and child mortality/morbidity, increased utilization of rural health center services by rural populations, especially women and children, and an increased availability of trained paramedical personnel to staff rural health centers and deliver meaningful health/nutrition/family planning services to villagers through expanded Puskesmas-community interaction. Other possible social consequences include: reduced fertility; reduced maternal mortality; reduced incidence of communicable diseases through improvement of epidemiologic and control techniques; increased community participation in integrated health/nutrition/family planning activities; appropriate provincial/district/community responses to food production and consumption needs; increased ability of village PKK (Family Welfare Movement) to manage appropriate village level health-nutrition interventions; and an improved provincial ability to channel central government and local health/nutrition resources to the village level.

a) Target Population

The primary target population of the project in each of three provinces is all children under 5 years of age and all women aged 15-49. The size of these target groups is reported in the 1980 census* as follows:

Province	All women aged 15-49	Children under Five (0-4)	Total
D.I. Aceh	628,309	390,683	1,008,992
Nusa Tenggara Timur	646,831	422,580	1,069,411
Sumatera Barat	769,135	509,082	1,278,217
Total	2,034,275	1,322,345	3,356,620

b) Participation

As noted above, family planning, nutrition and increasing the role of women in promoting healthy, properous families are major integrated GOI development efforts. This integrated strategy includes food and nutrition, basic health care, communicable disease control, family planning, and to a lesser degree drinking water and environmental sanitation -- all components of a strategy that potentially could have a major impact on reducing levels of infant mortality.

The GOI has already committed itself to an integrated community participation strategy and there is participation in the planning, design, implementation and follow-up of the various efforts at the central, provincial, kabupaten, kecamatan and village levels. The Ministries of Health, Agriculture, Religion, Interior, and Education, the BKKBN (National Family Planning Coordinating Board), the Office of the Associate Minister for the Role of Women, and some private groups support the implementation of specific activities in the integrated programs.

Community participation efforts at the village level receive the support of village leaders, informal and religious leaders, and, where active, the PKK. Participation of sub-village groups (village cadres) is implemented through nutrition cadres, health cadres, family planning motivators, and other groups depending upon the level and focus of program implementation in

*Source: "Penduduk Indonesia Menurut Propinsi", Seri: L. No. 3, Biro Pusat Statistik, Jakarta, Mei 1981.

a particular village. Community participation has proven effective in Indonesia and the use of village workers, especially women through the PKK, is in place in many communities and is being expanded as a matter of official policy.

B. Technical Feasibility

This Project proposes to use no technical procedures that have not already been applied on numerous occasions in Indonesia by Indonesians. Feasibility will hinge on the Project's ability to expand significantly the number of health sector staff and community participants who can plan, organize, and apply those various techniques in a competent and sustained manner.

Not all of the technical skills needed to mount the broad range of activities this Project attempts are to be readily found in each province. Therefore, it will be necessary to use consultants from elsewhere in Indonesia and outside the country.

It will be desirable to station at least one long-term consultant in each province for most of the Project life. This should be a physician with broad public health experience in a developing country. He/she will provide technical expertise in those areas of his/her competence and will monitor and coordinate the various project components together with the GOI project officer(s) and the USAID project officer(s). He/she will coordinate the activities of the short-term consultants and will prepare for and followup the short-term consultants' assignments to maximize their impact.

Markedly increasing the output of PKs (newly trained and retrained) should be feasible. A potential obstacle is that there will not be enough places in the nursing teacher's schools (Java and South Sulawesi) to train the PK teachers, but PUSDIKLAT has given assurance that enough places will be made available for candidates from these three provinces.

In NTT because of the lesser development of the basic education system, there is the potential problem that there will not be a large enough pool of junior high school (SMP) graduates from which to recruit PK students. Although this may be true during the first years of the Project, provincial officials state that there will be little problem later since the school population is increasing rapidly.

That all new nurses are being trained as PKs and all existing field nurses are being converted to PKs obviously involves technical trade-offs. While all will have a more or less common training exposure, diversity of skills and experience will be narrowed and this can be a drawback in a

system that is still lacking initiative in the field. The PK curriculum is still very new, is untested over time, and is very centrally directed. It will need to strike a proper balance between central standardization and local adaptation. However, because of an exceptionally strong commitment to this program by the Department of Health, we feel that the probabilities for a positive maturation of this program are good.

With a shortage of skilled nursing school teachers there will be difficulties in properly supervising the students' field training, potentially the most important segment of their three year technical schooling. The Project is attempting to assure that enough teachers will be trained so that there will be enough teachers to permit some to spend adequate time supervising field training, or better, that some teachers will be assigned full-time to supervising students in the field.

COME (Consortium on Medical Education) has been active in several medical schools in Java, Bali and Sulawesi for several years and it has met with mixed success. Each program is different to some degree. Usual and expected problems have been student apathy, apathy by many faculty members, administrative and funding difficulties and imperfect coordination between the medical faculty and the local health service officials. The medical school and health services officials in Sumatera Barat are fully aware of these potential obstacles and give assurance that they will work to overcome them. This Project's planners have given great weight to the opinions of Rockefeller and WHO consultants with long experience in COME in Indonesia that the conditions are now appropriate in Sumbar for beginning such a program and that the chances for a successful start are good.

While in Sumatera Barat the majority of Puskesmas physicians are native to that province and will remain there after their obligatory rural experience, this is not so in NTT and D.I. Aceh where many Puskesmas doctors are from other provinces. This situation will improve in D.I. Aceh once the new medical school has begun graduating physicians, but this will not happen until the late 1980's. So aside from the COME program in Sumbar, and perhaps later in D.I. Aceh, training of the Puskesmas physicians will not be a major project output. The other Puskesmas staff members and the provincial and kabupaten health officials do tend to remain in the same province, even the same local areas, so the major Project inputs directed at these people should have sustained impact.

The PKK village women's movement is a major focus of Project actvity in NTT. This is felt to be especially critical in a province as little developed as NTT where poverty is often extreme and health services stretched very thin. The PKK leaders in NTT, led by the extremely vigorous and progressive Governor's wife (also a pediatrician), have already

demonstrated strong, active commitment to the Project and will ensure that PKK cadres will be utilized to carry out specific project activity.

As with the PKK village movement and community volunteer programs elsewhere in Indonesia, a major difficulty has been an inability to sustain the early, post training enthusiasm of the volunteers. We feel that a major reason, in the case of health/nutrition volunteer activities, has been the lack of support and interest from the Puskesmas. In NTT, and possibly the other two provinces, the Project is attempting to deal specifically with this problem.

Various survey activities will be carried out including village level surveys for nightblind children, surveys of highland areas for goiter and cretinism, and province-wide sample surveys for protein-calorie malnutrition. As one of the desired Project outputs is provincial self-sufficiency in performing and analyzing surveys, project-assisted surveying will stress simple procedures not requiring sophisticated, laboratory analyses or computer analysis. Consultants will be necessary initially for some survey design, organization, implementation and analysis but with training and experience the provincial staffs will eventually be able to assume all duties.

C. Economic Analysis

1. Introduction

In developing this project paper, we decided that the conventional use of cost-benefit analysis to justify AID's support for a health sector activity would not be as beneficial as a discussion of how the Project itself could institutionalize the process of measuring the cost effectiveness of specific health interventions and modes of health service delivery. Previous cost-benefit analyses of health sector activities in Indonesia have shown that there are social gains to the lowering of illness and mortality such as improved labor productivity, longer life longevity, and reduced patient loads. Other cost-benefit analyses have helped to identify the economic possibilities of preventive rather than curative forms of treatment. For example, prevention of diarrhea, which affects not only children but other family members as well, can have multiple benefits: to child mortality, to family earning, to the larger society. Likewise the benefits of reducing malnutrition are also long term since high levels of malnutrition are related to impaired mental and physical capacity. The complementarities between health services and family planning have been well documented, and for this Project would be reinforced by reduced maternal mortality and increased child survival.

In terms of improved quality of life and meeting basic needs, investments that Congress and A.I.D. have recognized as justified in and of themselves, this Project will have a selective focus on infants, women in the child-bearing ages and children under 5 years. We feel that much of the mortality and chronically debilitating morbidity of young children is preventable by focusing nutrition, health and sanitation interventions on the first few years of life. In the following discussion, we have suggested cost-effective approaches to the provincial programs for carrying out in a meaningful way, those interventions which could have maximum benefit for the health of rural populations in 3 provinces.

The Department of Health is concerned about the impacts of its programs and is interested in improving their cost-effectiveness. Our discussion focuses, therefore, upon one of the Project's major objectives, to strengthen the analytical capability of 3 Provincial health systems to increase the cost-effectiveness of their programs. The Project will assist the provincial staffs define the information requirements needed to improve existing health care delivery programs and suggest alternative approaches to interventions. Under this Project, design, implementation and assessment will be treated as interrelated on-going activities.

The Project will provide assistance to the Provincial staffs to expand their analytical capability. A capacity to make critical assessments of rural health needs and to design cost-effective programs will be stressed in the training and studies and field trials components of the Project. It is not sufficient to rely on external, ex-post facto evaluation; the process of assessment and innovation can be internalized at the provincial level.

We foresee that the Project in each Province will entail several components for which cost-effectiveness analyses will be desirable. In the following sections, several types of such analyses are identified.

2. Cost-Effectiveness of Health Delivery Services

The Indonesian government has developed and implemented several innovative rural health and nutrition programs. Yet many of these programs suffer from having been expanded too rapidly, without staff having been fully trained or even recruited, and most importantly, without having fully developed accurate estimates of the health and nutritional problems of each province. The central health programs sometimes are assumed to be equally relevant to all the diverse provinces of Indonesia. Some programs are best designed and implemented this way; others require provincial adaptation to ensure effectiveness.

Public funds spent on rural health services although still inadequate, represent a major and growing investment. Improvements in both unit cost reductions and increased program effectiveness would have significant social and economic benefits. Given the fact that few careful province-wide health/nutrition assessments have been made and that objective evaluation of program impacts is rare, it would not be surprising if the Government were getting a relatively low return on its investment. Given the severe manpower constraints on most Provinces, real improvements in program effectiveness will have to be selective. This Project anticipates helping the Province health officials responsible for health services delivery to assess selectively their priorities and target a portion of their resources, augmented by additional Loan and Counterpart funds, for some specific problems in order to obtain some measurable results. Application of some relatively simple economic analytical techniques such as cost-effectiveness analysis is expected to contribute to the attainment of this objective.

Examples from specific rural health programs dramatize the importance of this Project's purpose. At present there is no uniform functional system whereby the disease case load of each kecamatan Puskesmas or each kabupaten Hospital is routinely used to elicit expanded services in areas of greatest health need.

Similarly, the PKK (Family Welfare Movement), the governmental program that reaches closest to the rural family, does not yet routinely design its multi-faceted program interventions for the specific health or nutritional needs of a community or province. Vitamin A capsule allocations, for example, often are a function of decisions and funding determined in Jakarta and not of xerophthalmia's local epidemiology. Furthermore, there is no system to assess what mix of preventive and curative program interventions is best to alleviate diarrheal diseases which are so prevalent in all the provinces. Within the village drinking water program, as another example, there are several alternative construction technologies which need assessment to ensure effective and rapid program replication. Here, cost-effectiveness analysis of alternative construction designs could identify added efficiencies and savings in the health budget.

In describing rural health problems in this way we are also suggesting ways in which program success should be judged. Two success criteria come to mind. First, the success of a health care delivery program can be judged on the basis of the value of the service being delivered to its recipients. In other words, a program is more likely to succeed if the rural health staff perceives that it is offering something of value. A second way to judge "success" is to focus on people's felt needs. To the extent that these needs are served as expressed

through staff and client feedback, and by numbers of Puskesmas visits, etc., a program may be considered successful. Both of these concepts are rooted in an institutional ability to know the local health and nutrition needs and conditions of rural people. Both concepts can also be measured indirectly by evaluating the main criterion of success: measurable improvements in health and nutrition status.

As we have emphasized, a central objective of this Project is to assist provincial health officials introduce analytical techniques (and institutionalize them) so that existing health programs can be better targetted to serve people in greatest need of specific health services. The focusing of existing programs on a more limited number of objectives is one way to improve effectiveness, and to help make the case for progressively larger budget allocations for rural health in the future, in part because "success" could be more easily documented by declining disease incidence or prevalence rates. Depending on survey results, provincial health priorities could give greater attention to health problems of greater provincial prevalence, and de-emphasize those with less. Examples might include the incidence and prevalence of malaria, goiter, xerophthalmia, leprosy, tuberculosis, etc.

In order to match needs with capabilities, epidemiologic surveys of provincial health status and illness patterns are required within each province. These are needed to allow or encourage the de-emphasis of expenditures for low frequency or low morbidity diseases and the expansion of services for the more serious ones. A primary intention here is therefore, first, to help Project staff decide which data need to be collected at the village and kecamatan levels, in order to enhance programmatically useful health analyses by the provincial staffs.

Second, parallel with the need for health surveys is the need for nutrition surveys, including food availability and consumption patterns and practices, because nutritional improvement can be a very cost-effective way to reduce the incidence of several major diseases. Examples of nutrition survey subjects include protein calorie malnutrition, goiter, vitamin deficiences and nutritional anemia.

Third, studies are needed of the organizational and coordinational aspects of present health and health-related systems, between the PKK and Puskesmas, for example, where more referrals by the PKK to the Puskesmas could greatly improve the effective medical coverage for the most at-risk adults and children in each kecamatan. A study of the Dokabu's (the chief doctor for the kabupaten Hospital and the administrative chief of the kabupaten's entire health system) time would probably help illustrate how his administrative burdens presently are

overwhelming his medical responsibilities. Developing these three activities and utilizing their results will serve to improve two related Project activities in the kabupaten and provincial health offices: training and budget preparation.

As for the training of nurses and sanitation workers, improved analyses of health needs could be used to better direct curriculum content and the assignment of additional staff and staff time to the more serious health problems in the higher risk kecamatans. Doing so, should also serve to improve a sense of staff involvement, purpose and morale.

With respect to budget formulation, better health and nutritional information and analysis will have several benefits at each level of the provincial health system. At the Puskesmas level, for instance, a study on the prevelance of malaria could strengthen the claim for more materials, funds and staff to expand malaria control efforts.

Armed with concrete data on the seriousness of goiter and cretinism, for example, a Dokabu would be better able to argue for a larger share of the Bupati's discretionary budget as well as the kabupaten's development and routine budgets. Furthermore, such data may strengthen the kabupaten's health case at the annual development program reviews at the Dinas Kesehatan (province) level. And ultimately the same data and arguments can be used to alter central health programs which heretofore have not been optimally adapted to local differences in conditions and needs.

Better data and assessments of health problems will in time enable provincial health officials to argue for changes in on-going health programs and for the reallocation of funds once annual budgets have been approved. Pusat officials are not likely to accept provincial flexibility, the re-programming of funds, and ultimately larger requests, in the absence of supporting evidence from the provinces. (When asked if kabupaten officials could influence program directions, a Dokabu said "Tidak jadi" (It is not possible). Upon further questioning however, it became apparent that kabupaten and province officials do exercise opportunities to alter basic health program decisions.) Examples cited in NTT include reallocation of staff and funds for follow-up sweeps for drop outs from the immunization program, more funds for the purchase of reporting forms, and the reasssignment of staff training time away from DTT spraying lessons to Puskesmas courses.

The Dokabu's resource for health services in one kabupaten illustrates the budgetary flexibility under his control.

	FY 1980/81 Health Resources in Rp. Millions
Development Budget	
1. Kabupaten Development Funds	10
2. INPRES Drugs	19
3. Communicable Disease Control Program (Pusat)	6
4. Other Specific Health Programs (Pusat)	12
	47
Routine Budget	
1. Salaries	75
Total	Rp.122 million
	(Rp.976 per capita, or $1.60)

Within this approximate budget for FY 1980/81, the Dokabu has no statutory authority to influence salaries, quantity of INPRES Drugs, or Pusat programs directly, except in so far as he makes a case for reallocations of development funds at annual province level budget reviews. The Dokabu's only significant flexibility is with kabupaten funds, which are significant and which are subject to evidence of kabupaten need and pressure.

It is evident from the foregoing discussion that data collection and analyses are necessary and useful, even without taking the further step of conducting actual cost-effectiveness analyses. Thinking in cost-effectiveness terms is a major step forward in its own right. Opportunities will arise for cost-effectiveness studies in which case they should be done by the concerned health officials, with the assistance of consultants as appropriate. The first step is better data, and armed with better data and analyses, the provincial health service can take the additional step of conducting cost-effectiveness analyses as opportunities arise.

In advance of such analyses, attention is being increasingly paid to health program costs, which are often treated as "givens" without any real meaning, and to program impacts which are very hard to identify quantitatively. Health program costs may not appear "real" in the sense that provincial staff usually has little authority to guide or assess Pusat resources for provincial needs. An appreciation of costs and the impacts of the more effective allocation of resources will grow as provincial staffs are strengthened and as provincial data improve.

It is also important to understand that the "social" cost of financial and staff resources not used well can be very high in the sense that unmet health needs remain and tend to erode family and community well being.

With the strengthening of provincial disease prevalence data, the impacts of focused programs and of improved services will become more clearly identified. For malaria control, for example, the benefits of improved worker productivity and of the reduced burden on the health care system in the province and kabupaten can be readily identified and quantified. Such a benefit analysis would in turn indicate the order of magnitude of expenditures which should be spent to alleviate a specific health problem. Also, as health and nutrition surveys become routine, it will be useful to undertake assessments of alternative methods for achieving specific health objectives.

One of the largest expenditures of the health system is for staff (for new projects, staff costs can consume 80 to 90% of all expenditures). As this Project evolves it may prove useful to study staff costs and priorities in order to assess the possibility for improved services by the reallocation of staff to higher priority duties and functions.

3. Nutrition and Food Preparation

Adequate food and nutrition are fundamental to good health and are therefore, necessary targets for educational and service components of village programs, particularly the PKK and the Puskesmas. The potential for the Taman Gizi program to correct diet-related diseases of young children is one obvious example, one which suggests the potential for productive coordination between kabupaten and kecamatan level health services and between the programs of Health and Home Affairs Ministries. Goiter and xerophthalmia are other examples of nutritional diseases where the most effective health service in the long run should be targetted nutrition programs for gardens, cooking and eating habits. But it requires a provincial service sensitive to local needs to best advise the PKK, through the Puskesmas, on what lessons to convey and how. As these diseases are often region specific, disease and nutrition surveys would enable the provinces and the kabupaten services to influence other agricultural and educational related village programs. In short, there is ample scope in the provincial health service system for the inclusion of food program and policy issues .

As this Project evolves, opportunities will arise for coordination between the provincial health offices and those of Agriculture and BULOG. For example, staple food prices in the provinces vary by season and therefore the diet and its nutritional content vary as well. While it appears that very few village markets in NTT, for example, are empty of staples during the hunger months (musim lapar or paceklik), the price of corn, the staple for NTT, does double and the dependence of cities and towns upon BULOG's imported rice increases sharply. These seasonal food changes have important implications for children, as the age-weight evidence of the UPGK program is beginning to indicate, and therefore for nutrition and health services. People in towns may eat relatively

more rice in the post-harvest lean season as a consequence of seasonal price variations and poorer villagers may be forced to eat relatively more cassava and other less nutritious staples. Both groups may therefore suffer nutritionally (as well as in real income terms) in the lean season.

The nutritional consequences of seasonal food supply and cropping charateristics for NTT describe the dry upland agricultural patterns of this province, and highlight the potentially important links between health and agricultural programs. Because the irrigated rice area is commonly less than five percent of the total dry land crop area in NTT, regional food and agriculture policies and programs, particularly those of BULOG, have an important role to play in health improvement.

4. Matching Drug Supplies with Provincial Needs

The amount of the health sector's budget allocation for drugs is second only to staff expenditures, and can consume as much as 40% of a provincial governments' total health investment each year. Furthermore, the supply of modern drugs is the component of the rural health system which generates the most complaints; there are said to be too few drugs, of the wrong type, and of too little effectiveness. These real and perceived costs are compounded further by losses from expired drugs, poor prescription and utilization, and the "need" which medicines create for their own consumption.

A survey of drug needs in each province's health system would serve the twin purposes of making better use of the existing Rp. 150 per capita annual INPRES allocation, and could strengthen the logical case for larger provincial supplies of drugs in future requests. A study of the drug supply, needs and utilization patterns could help to improve the match between provincial drug needs (based in turn on disease and nutrition surveys) and the drug procurement, logistics and utilization systems.

D. Administrative Feasibility

1. Analysis of the GOI's Administrative arrangements

a) Ministry of Health (MOH)*

This Project will be administered for the GOI by the Department of Health (Depkes). A Project Implementation Unit (P.I.U.) will be established at the central level and a central level Project Coordinator will be designated to carry out specific responsibilities: (a) to keep all appropriate sections of the Department informed of project activities in their areas of

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*See Annex I for a description of the organizational structure of the Central and Provincial Departments of Health.

responsibility; (b) to coordinate the annual central project review and funding approval process; (c) to maintain financial accounting on activities in all three provinces; (d) to expedite contracting and procurement services for all three provinces; and (e) to arrange national-level technical assistance and support for the Project when needed.

A sub P.I.U. will be established in each province, led by the Head of the Provincial Health Services (KAKANWIL) as Project coordinator. The province PIUs will be technically and administratively responsible for the Project with inputs from the BAPPEDA and/or representatives from the Governor's office. The Chief Regency (Kabupaten) Medical Officers (DOKABU) will have responsibility for liaison with the kabupaten governments and for Project implementation appropriate for the local conditions in those kabupatens. Puskesmas doctors and staffs will provide day-to-day supervision of pilot-project surveys, studies and interventions in the communities they serve.

In NTT the Governor's wife, in her dual role as Director of PKK and as a Provincial Health official, will play a direct role in the PKK-Puskesmas pilot project activities. In Sumatera Barat and D.I. Aceh it is expected that provincial PKK leadership will be actively involved in planning and implementing PKK-Puskesmas project activity.

CHIPPS will help develop workable methods of decentralized planning and program administration. The Central Depkes sets policy, defines program guidelines, sets targets and allocates budgets by province. This guided framework augmented by USAID loan funds will provide provincial KANWIL officers added flexibility in designing their respective health/nutrition programs to accommodate specific provincial epidemiologic, socio-cultural and geographic requirements.

The Heads of the Provincial Health Services of Sumatera Barat and D.I. Aceh will have overall responsibility for administering funds used for the Community Medicine project activities as Coordinators of their respective PIUs. Although the medical schools in Indonesia are the responsibility of the Ministry of Education and Culture, arrangements with the health sector programs have been successfully accomplished in Community Medicine Programs at Facultas Kedokteran (FK) Gajah Mada and others. Since most of the COME activities supported by this Project are field activities in support of ongoing health sector programs (as well as instruction for the students), this administrative arrangement in CHIP-PS will help to assure that the COME field activities are relevant and useful in suppporting the government health programs' service delivery goals and methods.

b) Coordination with BKKBN and other Sectors

Some of the activities to be carried out under this project are multisectoral and, although coordinated by Depkes, will require inputs and coordination at the provincial level from BKKBN, and

Departments of Agriculture, Home Affairs, and Religion. The provincial PIUs will be responsible for coordinating the technical inputs of the relevant sectors and will receive support from the BAPPEDAs and the Governor's office to ensure efforts of sectoral coordination.

BAPPENAS, through its Bureau of Social Welfare, People's Housing and Health has provided important policy guidance in the design of CHIPPS and in the selection of the provinces. It was the BAPPENAS' desire to increase the ability of the Provincial Health Departments to plan and carry out problem analysis and interventions in the health/nutrition sector that has given CHIPPS much of its focus on the qualitative aspects of manpower development and health services delivery. It is expected that BAPPENAS will continue its active support for CHIPPS through input to the central P.I.U. and its yearly review of the provinces' budget proposals.

c) Implementing Agents

Major implementing agents will be the provincial KANWILS and Dinas Kesehatan with assistance from the central Depkes Jakarta.

Local private organizations have been recognized as being capable of providing expertise in training and production of educational materials for community participation programs. For example, Yayasan Indonesia Sejahtera (YIS), the Indonesian Welfare Foundation, has developed training manuals and educational materials for the BKKBN and UNICEF and has conducted courses for the training of trainers in family planning and nutrition. Save the Children Foundation has conducted community organization courses sponsored by BAPPEDA in D.I. Aceh and has conducted courses in nutrition training and traditional birth attendant training for the provincial BKKBN and DEPKES.

The Comprehensive Community Health Care Education Program at the University of Gajah Mada, the Community Medicine Programs at Diponegoro University and other universities will be able to provide assistance in planning the activities of the Community Medicine programs.

The Depkes Bureau of Planning coordinates all donor assistance to Depkes health/nutrition programs and provides guidance and assistance so that projects complement one another. Coordination will be maintained between UNICEF, WHO, UNFPA and UNDP efforts in primary health care, environmental hygiene, nutrition and family planning activities. USAID, UN, and Depkes staff are aware of these organizations' respective project activities and already have established open lines of communication to share information and project experience. Assistance from the World Bank, the Japanese, and the Dutch has been directed toward the building of nursing teachers' schools, new provincial nursing schools, and limited numbers of Perawat Kesehatan (PK) retraining programs. WHO

in-country advisors provide technical assistance to Depkes to strengthen the rural health system and to increase the utilization of health services.

2. A.I.D. Project Arrangements*

a) USAID Project Staff

Three USAID direct hire health officers will continue to administer and manage overall health-nutrition program activities. Given the complexity of the five-year CHIPPS undertaking, the USAID Health/Nutrition Office will continue to require at least one full time professional on Personal Services Contract. Each of the direct-hire officers will have some technical input into the Project. The contract professional has played a major role in the planning of CHIPPS and will continue to make inputs to CHIPPS project implementation and management. This contract position, presently funded under USAID O & E funds must be extended at least through FY 84 to ensure effective Project implementation and close USAID collaboration with the provincial and central health officials involved.

The USAID Office of Health and Nutrition will maintain close liaison with other USAID offices that are relevant to the multisectoral activities of CHIPPS. The Offices of Population, Agricultural Development, Voluntary and Humanitarian Programs and Rural Development will continue to make informal contributions toward CHIPPS project implementation.

b) Technical Assistance

USAID expects one full-time, long-term technical advisor in each province to provide major technical and administrative assistance. These 3 long-term technical advisors will be medical doctors with appropriate public health experience.

Some of the short-term technical assistance requirements of this Project can be obtained from within Indonesia. USAID, especially the Office of Population, already has had contracts with Indonesian professionals, universities, institutes, and selected Indonesian foundations in the health and nutrition field. USAID and the Depkes agree that this arrangement has the dual advantage of satisfying some CHIPPS technical assistance requirements and furthering the development of Indonesian technical and professional consulting skills. When appropriate Indonesian expertise is unavailable, short-term technical advisors from abroad will be utilized to assist with specific Project activities, training programs, or evaluation activity.

* See Annex J for a brief schedule of USAID's Project development process.

E. Environmental Concerns

1. Examination of Nature Scope and Magnitude of Environmental Impact

a) Project Description

This is a Project to improve the capabilities of provincial health officials to better target and manage their resources so as to improve their preventive and simple curative services and their influence on the health status of the rural population.

b) Identification and Evalution of Environmental Impacts

This Project will have no significant environmental impact. Some tube wells or simple village piped water systems might be provided, but nothing more complex than this.

2. Recommendation for Environmental Action

Because of the absence of environmental issues in this Project, an environmental assessment or impact statement will not be required and a "Negative Determination" is recommended.

F. Women in Development Concerns

The Project assistance will benefit directly women and children among the rural population in three provinces. This is documented throughout the Project Paper, especially in the Social Soundness Analysis. Women have been involved at all stages of project planning at the central Depkes level and in the provincial Health Offices. Throughout the Project women will play a role in planning, implementing, managing, monitoring and evaluating Project activities including training, surveys, trial interventions and policy recommendations for follow-up actions appropriate for each province.

The manpower training component of the Project will heavily involve women as both participants and recipients of Project activity, a major portion of which is aimed at increasing the availability of trained Perawat Kesehatan (PK) able to serve well in rural health centers (Puskesmas). Many of these are women. It can contribute to the opportunity to further develop the potential of nurses for health work that builds on women's strengths and skills as managers and communicators of health/nutrition/family planning services and messages. The field experience that will be developed as part of the manpower training component offers a potential for women to become more actively involved in understanding: 1) the dynamics of rural communities and 2) how their skills can be utilized to better serve the community through the Puskesmas and to contribute more fully to community self help activities.

The health services component of the Project will involve women at all stages of planning, implementing, and evaluating specific activities. All provinces will include PKK (Family Welfare Movement) and Puskesmas sub-activities that will first involve local women in leadership, community organization and participation training and then move this training into action programs that give women a unique opportunity to be health development leaders. Local women can be oriented through knowledge, skills, experience, and social consciousness to manage better their own health as well as that of family members. The mother as the principal health care agent, supported by the local PKK structure and with technical inputs and monitoring support from the Puskesmas, could provide women expanding influence as family and community health care providers. Shared experience of successful action in prevention of diseases like nutritional blindness, diarrheal diseases and in early detection and treatment of simple ailments should create an atmosphere of self-confidence. In some cases, it will be through local women that this Project can contribute to health/nutrition care becoming institutionalized as a village social process the way that family planning motivation has been institutionalized on Java/Bali.

PART IV - FINANCIAL PLAN

Detailed budgets were prepared by each Province for each component proposed for inclusion in the Project. In each case USAID staff met with the provincial health staffs to discuss the proposed components and their projected costs in great detail on several occasions. Each proposal and budget was also reviewed and approved by Depkes staff in Jakarta.

In some cases the estimated costs of activities are very precise because they are based on established GOI unit costs. This applies particularly to most training and travel which are based on a specific number of persons and on standard rates for per diem and honoraria. In other cases where there is more uncertainty, expecially Health Studies and Field Trials, costs cannot be as accurately projected. Although many of the subjects and locations for studies and trials have been identified, costs will not be known clearly until the activities are planned in detail. In such cases therefore, the budgets are estimated as accurately as possible but recognizing that they will be subject to change.

Considerable flexibility in budget management will be required for optimal Project implementation. Each year when the next fiscal year's implementation plan and budget is prepared the Project officers and USAID will be in a position to make modifications in the overall budget categories as necessary to achieve the Project objectives. Once the annual DIPs are established there is little opportunity for budget modification. Therefore, the annual planning and budgeting exercise will be very important.

ESTIMATED BUDGET
($ 000)

	A C E H		S U M B A R		N . T . T .		T O T A L	
	LOAN	COUNTER	LOAN	COUNTER	LOAN	COUNTER	LOAN	COUNTER
MANPOWER DEVELOPMENT*	730	750	705	600	700	600	2,135	1,950
LONG TERM CONSULTANTS	500	30	500	30	500	30	1,500	90
SHORT TERM CONSULTANTS	200	100	200	100	300	100	700	300
FELLOWSHIPS	150	150	150	150	150	150	450	450
OBSERVATION TRIPS AND SHORT COURSES	100	100	100	100	100	100	300	300
HEALTH SERVICES STUDIES, SURVEYS AND FIELD TRIALS	1,050	1,350	900	1,120	1,050	1,520	3,000	3,990
COMMUNITY MEDICINE	20	20	200	400	-	-	220	420
VEHICLES AND MAINTENANCE	-	250	-	250	-	250	-	750
EVALUATION	100	100	100	100	100	100	300	300
CONTINGENCY	150	150	145	150	100	150	395	450
T O T A L	3,000	3,000	3,000	3,000	3,000	3,000	9,000	9,000

*The estimated counterpart budget reflects quantitative manpower development expenditures or direct training costs. Additional counterpart budget will be provided for construction of new schools, renovations, major equipment, routine maintenance and operating costs and where appropriate additional student costs.

PROJECTED DISBURSEMENT SCHEDULE ($ 000)

YEARS

	I		II		III		IV + 1/2		T O T A L	
	LOAN	COUNT.	LOAN	COUNT.	LOAN	COUNT.	LOAN	COUNT.	LOAN	COUNT.
Manpower Development	400	300	600	400	700	500	435		2,135	1,950
Long Term Consultants	375	22	375	23	375	22	375	23	1,500	90
Short Term Consultants	100	50	250	100	250	100	100	50	700	300
Fellowships	50	50	150	150	150	150	100	100	450	450
Observation Trips and Short Courses	100	75	75	75	75	75	50	75	300	300
Health Services Studies, Surveys and Field Trials	650	700	850	900	750	1,100	750	1,290	3,000	3,990
Community Medicine	50	70	60	130	60	110	50	110	220	420
Vehicles and Maintenance	-	450	-	100	-	100		100	-	750
Evaluation	-		100	100	-		200	200	300	300
Contingency			100	100	100	200	195	150	395	450
T o t a l	1,725	1,717	2,560	2,078	2,460	2,357	2,255	2,848	9,000	9,000

PART V - IMPLEMENTATION PLAN

A. Implementation Process

1. Annual Plans and Budgets

As stated in Section IIID Administrative Feasibility, the Project will be administered by the Department of Health with a central Project Implementation Unit (PIU) in the Directorate of Community Health Services in Jakarta serving as the coordinating center and PIUs in each province headed by the Department's Provincial representative and Health Services Chief (Kakanwil) as Project Coordinator. For each year of the Project each province PIU will prepare an implementation plan and budgets to be submitted to Depkes in Jakarta as part of their regular annual budgeting process. This is begun in September when DUPs are prepared for activities to begin at the start of the next fiscal year in April. Following review and approval in Jakarta by Depkes and BAPPENAS, DIPs are established providing funds in the Depkes budget for Project implementation.

The Project implementation will follow that cycle. USAID will review and approve the provinces' annual implementation plans for the Project prepared as part of the DUP process. USAID's approval and confirmation that loan funds will be available according to the plans' budgets will be communicated to the Government in Project Implementation Letters (PIL). A separate PIL will be prepared referring to each province program specifically. The PILs will specify what costs will be eligible for reimbursement by Loan funds .

2. Loan Disbursement

Most local costs will be paid first by the Government with funds provided in the DIPs. Then, periodically, the provincial PIUs will submit vouchers to the central PIU for review and submission to USAID for reimbursement of those budget items previously agreed to in the annual plans and budgets. Some local costs may be incurred directly by the central PIU, such as contracting local consultants on behalf of a province in which case it would submit reimbursement claim directly to USAID.

Dollar costs for consultants and equipment for example, may be disbursed by AID in response to letter of commitment, or by direct disbursement, if so requested by the Government.

3. Contracting

Methods of contracting for consultant services will be defined in implementation letters (PILs). Long term consultants will probably be hired as personal services contractors. They may be contracted either directly by the Depkes PIU or by USAID at the request of the Government. Short term contractors available in Indonesia will probably be contracted by the Depkes PIU whereas foreign consultants may follow the same procedure, or be contracted by USAID if requested to do so by the Government. A contract with a single organization or consortium to provide all short term consultants required for the project will be considered because of the potential convenience and administrative efficiencies such an arrangement could provide.

4. Implementation Schedule

Although the Project will be for five years from the time of signing a Project Agreement in September 1981 it will cover only four and a half GOI fiscal years (April 1982 - September 1986). The first six months (October 1981 - March 1982) will be devoted to detailed planning and preparations. A schedule of key dates follows. Because the schedule is linked directly to actual dates of the GOI fiscal year and school schedules we will use real dates rather than elapsed time in months.

September 1981	- Project Agreement signed - Recruitment for long term consultants begun.
October 1981 - April 1982	- Initial conditions precedent to disbursement met. - Depkes Project Officer appointed. - Detailed plans and budgets for first year activities and more general schedule for subesequent years prepared. - DUPs and DIPs approved by Depkes and BAPPENAS. - Project financial, accounting and contracting procedures established in collaboration with USAID/OMF. - Candidates for long term degree training are nominated, tested in English if going to U.S. and training arrangements made. - Long term consultants identified, contracts signed.
April - June 1982	- Fiscal year 1982-1983 begins. Project funds available in Project bank accounts in provinces to initiate activities.

	-	Long term consultants arrive, begin language training proceed to provinces.
	-	Project activities begin: non-formal training, surveys, studies, intervention trials.
	-	Equipment ordered or purchased including vehicles.
July 1982	-	Academic year 1982-1983 begins. Courses begin for nurses, nursing teachers sanitarians and laboratory analysts.
	-	Long term fellowship trainees begin courses, in Indonesia.
August 1982	-	Detailed plans and budgets prepared for FY 1983-84 activities. New studies and intervention trials identified.
April 1983		FY 1983-1984 begins (Same as FY 82-83)
July 1983	-	Academic Year 1983-1984 begins.
		New nursing schools accept first classes.
August 1983	-	Planning begins for FY 1984-1985, including mid-term evaluation for June 1984.
April 1984	-	FY 1984-1985 begins.
	-	Mid-term evaluation designed and arranged.
June 1984	-	Mid-term evaluation conducted.
August 1984	-	Planning begins for FY 1985-1986
April 1985	-	FY 1985-1986 begins.
August 1985	-	Planning begins for FY 1986-1987 (Project Completion Date September 1986), including final evaluation.
April 1986	-	FY 1986-1987 begins.
May - June 1986	-	Final evaluation designed and arranged.
August - September 1986	-	Final evaluation conducted.
September 1986	-	Project completed.

B. Implementation Issues

Implementation procedures have been discussed thoroughly at all levels and are thought to be appropriate and feasible. For the most part, financial, procurement and training procedures will follow the normal Indonesian government system. Special attention will be taken to assure that any additional steps required by AID in connection with use of loan funds and involvement of USAID staff and expatriate consultants are taken in a timely manner. Several issues are discussed below

1. Access to Nusa Tenggara Timur Province

It will be very important for Project planning, implementation and evaluation purposes that USAID staff and expatriate consultants be permitted ready access to NTT Province. To date, in the course of Project preparation, USAID staff have made several visits to the Province. However in each instance an excessive amount of time and energy was expended to obtain security clearance to do so, including spending an extra day in Denpasar obtaining final clearance from the regional security authorities. For this Project, arrangements need to be made that will enable USAID staff and expatriate consultants to travel freely to NTT without the necessity of obtaining a separate clearance each time.

2. Contracting

The most efficient method of contracting short-term consultants for this Project has not yet been fully addressed. As mentioned above in section V.A it might be advantageous to contract with a single organization to provide all short-term consultants required. A decision about this will have to be made very early in the start-up phase so that arrangements can be made to proceed smoothly with whatever procedures are used.

VI. - EVALUATION PLAN

A. Schedule

Two major evaluations are planned; a mid-term evaluation in June 1984 and a final evaluation in June 1986. The first will focus exclusively on process or implementation issues, except to the extent that pilot interventions will have been completed and impact can be assessed, whereas the final evaluation will focus on both process and impact. Since this is essentially an institution building project, impacts will be sought in both institutional terms as well as improvements in health and nutritional status. Outside consultants will be asked to conduct these evaluations.

An annual Project review will be conducted each year at the time of preparing the next year's plans. Performance of the past year's activities will be assessed by component, achievements and shortcomings analyzed and corrective measures taken. The Project officers, consultants and USAID staff will participate in these exercises.

B. Baseline Data

Very little reliable baseline data are available pertaining to morbidity incidence and prevalence and mortality. Various small-scale surveys have been done but of varying quality and methodologies. D.I. Aceh and Sumatera Barat provinces were included in the nation-wide Vitamin A deficiency sample survey conducted in 1978. Nutritional status data from that survey for these two provinces have been analyzed and provide some broad measures against which to assess progress over the long term.

Baseline surveys of pilot project areas will be conducted for the community participation in PHC and the PKK-Puskesmas activities. These surveys will direct the operational aspects of the activities in each pilot project area and will provide measures against which to assess the impact of the Project interventions over time. In all pilot-project areas a community-based system for collecting vital statistics will be put in place as early as possible during the Project to provide measures of births and deaths.

Base line data on numbers of nurses and other paramedical personnel on hand and trained are available and will be used to measure progress toward meeting the quantitative manpower development targets. Assessments of progress toward meeting the more qualitative aspects of manpower development will be more difficult. We will rely on objective assessments of Project officers, consultants and USAID staff and the indirect indicators of effectiveness of health services delivery and impact on utilization of rural health centers.

C. Cost-effectiveness analyses

Because a major objective of the Project is to increase the capability of the Provincial Health Services to deliver effective services at reasonable costs, as discussed in Part III C, the Project will place considerable emphasis on conducting cost-effectiveness analysis as part of the evaluation program. This will be done in the following way. Prior to undertaking a particular pilot intervention, survey, study or training activity, the "effectiveness" of the activity will be established by defining a desired outcome or acceptable measure of success. The projected cost of the activity will also be calculated. Following completion of the activity, the outcome will be analyzed and quantified and actual costs calculated to determined its cost-effectiveness. Although at the outset there will be few standards against which to judge whether a certain cost-effectiveness result is acceptable, over time as experience is accumulated comparisons leading to more objectivity can be made. In this way we hope to provide a means of judging the return on investment of health sector budgets. By demonstrating such returns and making improvements in cost-effectiveness over time, it is expected that the Provinces and Depkes will be in a better position to argue effectively for larger allocations--at national, provincial and kabupaten levels.

AID 1020-20 (1-71)

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

ANNEX A

Project Title & Number: COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM (CHIPS) 497-0325

Life of Project:
From FY 81 to FY 86
Total U.S. Funding $ 9 million
Date Prepared: July 27, 1981

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: Improve Health and Nutrition status of rural population in provinces of Nusa Tenggara Timur, D.I.Aceh, and Sumatera Barat.	Measures of Goal Achievement: N.T.T., D.I. Aceh, and Sumbar achieve the following standards by 1990: - Decrease infant mortality rate to 75 per 1000 live births. - Double the number of rural women and children receiving effective health and nutrition services.	- Review and analysis of vital statistics on births and deaths in each province. - Nationally reported health statistics. - Baseline studies in project areas followed up by selected interventions and evaluations. - Provincial records of usage of rural health centers.	Assumptions for achieving goal targets: - A viable system of collecting vital statistics on births and deaths can be put in place in the project areas in the 3 provinces. - Continued strong commitment of GOI to community participation in delivery of health, nutrition, and family planning services at the provincial level and below. - Continued support of GOI to provincial sector planning that improves integrated services for family welfare. - Concurrent GOI and provincial socio-economic development efforts in project areas will contribute to increased family welfare.
Project Purpose: Accelerate and intensify the upgrading of the health sector services delivery systems of D.I. Aceh, Sumatera Barat and Nusa Tenggara Timur provinces.	Conditions that will indicate purpose has been achieved: End of project status. In N.T.T., D.I. Aceh and Sumbar: 1. There are an increased number of professional rural health workers, especially the PK (primary health nurse), who have had training that is appropriate for the rural communities in which they work. 2. The provincial public health system is better able technically, analytically and managerially to carry out sector programs. 3. Health/nutrition programs are better adapted to the often unique circumstances in these provinces. 4. Provincial initiative has been demonstrated in planning, carrying out and evaluating trial interventions for operational service delivery problems with inputs from community organizations.	1. - Provincial/Regional training facility records. - Provincial DepKes personnel records - Central DepKes personnel and Pusdiklat records 2. - Program evaluation - Provincial DepKes records - Central DepKes records 3. - Program evaluation - Analysis of special studies, surveys and field interventions 4. - Program evaluation - Special surveys and analysis.	Assumptions for achieving purpose: 1. - Provinces will be able to identify sufficient number of candidates to enter PK and SPPH training. - GOI will promptly appoint newly trained personnel as civil servants so they can be assigned to Puskesmas by the provincial DepKes. - Adequate continuing support and funding for maintaining training classes and field experience for students. 2. Motivation of provincial health official to qualitatively improve skills and capacity to deliver appropriate health/nutrition services in rural areas. 3. Appropriateness and validity of provincial DepKes selected health-nutrition intervention points. 4. Adequate flexibility in Central DepKes program planning and design to allow response to local initiative.
Outputs: 1. Quantitative Manpower Development (all provinces): - Increased number of paramedical personnel trained - Some provincial health officials and staff trained - Village volunteers and TBAs trained. 2. Qualitative Manpower Development (all provinces): - Field module developed for PK training - On the job skills developed by health personnel - Study tours for health personnel & PKP. 3. Health Sectoral System Improvement (all provinces) - Special studies, surveys, intervention trials - Vital statistics collection system - Community participation-Puskesmas system in place 4. Community Medicine - Community module and field training developed for medical students (Sumbar) - Some medical school faculty trained (Sumbar & D.I.Aceh)	Magnitude of Outputs: In NTT, D.I.Aceh, and Sumbar. 1. - 1580 PK, 125 nursing teachers, 85 sanitarians recruited, trained and assigned to Puskesmas - Estimated 45 health officials & staff trained - Estimated 500 village volunteers and 450 TBAs trained. 2. - 1 module per province prepared by end 1983 - Estimated 150 health personnel receive new skills - Study Tours completed by estimated 120 health personnel & PKP. 3. - Estimated 5-10 studies, surveys, trials conducted by health officials in each province - Province-wide vital statistics collection system designed - Estimated 12 Puskesmas system pilot-projects tested 4. - 1 module prepared by end of 1983 in Sumbar. - Estimated 8-12 medical school faculty trained (Sumbar & Aceh).	- Provincial training institute records - Provincial DepKes records - Pusdiklat records. - Project Reports - Consultants Reports - Baseline surveys and follow-up evaluations - Formal project evaluation - Frequent field visits to review and report on project implementation	Assumptions for achieving outputs: - Provincial DepKes annual Dup agreed on by MOH, GOI, and USAID and timely inputs provided. - Access to three provinces, particularly NTT, possible to USAID staff and outside long-term/short-term consultants. - Candidates available to be trained for paramedical positions in each provinces. - Provincial health staff can be trained in sufficient numbers to perform managerial, supervisory and operational tasks effectively. - MOH and Bappenas support for CHIP-PS continues. - No unusual natural calamities - Motivation of provincial staff to undertake additional project management and supervisory tasks continues.
Inputs: For N.T.T., D.I.Aceh and Sumbar support for: - Technical Assistance (long/short-term consultants) - Training (long and short term) - Manpower development of paramedical personnel - Selected Equipment and commodities - Field Studies, Trials, and Surveys - Community Medicine program. GOI contributions to manpower development, vehicles, and other sector improvement activities.	Implementation Target (Type and Quantity) Project Budget ($000)		

	Loan	Counterpart	Total
Manpower Development (est.1600 prs)	2,135	1,950	4,085
Other Training (est. 300 persons)	750	750	1,500
Field Studies & Trials (5-10 per province)	3,000	3,900	6,990
Technical Assistance (3 long-term/4 years; 123 prs.months short-term)	2,200	390	2,590
Community Medicine (2 programs)	220	420	640
Vehicles (11 per province)	-	750	750
Evaluations (2)	300	300	600
Contingency	335	450	-
Total	$9,000	$9,000	$18,000

- USAID Records - GOI Records - USAID audits and evaluations - Review of annual provincial Dup	Assumptions for providing inputs: - Timely provision of inputs (money, personnel, and commodities) in the amounts planned by GOI and USAID. - Personnel (particularly long and short term consultants and technical advisors) will be available when required. - GOI provides new nursing schools (SPK) required for some of the manpower development needs. - Continued GOI support to qualitative and quantitative manpower development; to community medicine; and to increased utilization of rural health centers. - Continued availability of USAID funds and staff necessary to monitor and evaluate these inputs.

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AGS:

SUBJECT: COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM (497-0325)

1. APAC MET JULY 3 AND APPROVED SUBJECT PID. APAC FULLY SUPPORTED PROPOSED PROJECT'S INNOVATIVE APPROACH TOWARD PROVISION OF COMMUNITY HEALTH SERVICES.

2. FOLLOWING GUIDANCE PROVIDED FOR DEVELOPMENT OF PP:

(A) PROJECT PURPOSE: THRUST OF PROJECT SHOULD BE TO REDUCE INFANT AND CHILD MORTALITY AND MORBIDITY IN LINE WITH ASIA BUREAU HEALTH STRATEGY. RECOGNIZE, OF COURSE PROGRAM CONTEXT ALSO WOULD INCLUDE ASSISTANCE FOR RELATED COMMUNITY HEALTH INTERVENTIONS.

(B) SELECTION OF PROVINCES: APAC SUPPORTED DESIRE FOR IMPLEMENTATION FLEXIBILITY BUT ASSUMED THAT THREE PROVINCES IN WHICH PROJECT WILL OPERATE AND PRINCIPAL PROBLEMS/POSSIBLE INTERVENTIONS WOULD BE IDENTIFIED PRIOR TO SUBMISSION OF PP. MISSION SHOULD TAKE ADEQUATE TIME TO INVESTIGATE INSTITUTIONAL CAPACITY AND HEALTH

PROBLEMS IN SELECTED PROVINCES IN PREPARATION OF PP. IT ALL THREE PROVINCIAL PROGRAMS CANNOT BE AGREED TO IN ADVANCE, AT LEAST TWO, WITH FIRM POSSIBILITIES FOR THIRD, SHOULD BE. APAC SUGGESTED ONE PROVINCE WITHOUT MEDICAL COLLEGE BE SELECTED TO TEST FEASIBILITY OF INTERVENTIONS IN AREAS WHERE MEDICAL SCHOOL PERSONNEL NOT AVAILABLE FROM LOCAL COLLEGE.

(C) OPERATIONAL RELATIONSHIP TO FAMILY PLANNING PROGRAM IN EACH PROVINCE SHOULD BE OUTLINED IN PP.

(D) REPLICABILITY: PP SHOULD INDICATE STRATEGY FOR EVALUATING RELATIVE EFFECTIVENESS OF ALTERNATIVE HEALTH INTERVENTIONS BEING TESTED AND EXPLAIN HOW GOI WOULD BE ABLE TO REPLICATE EFFORTS ELSEWHERE.

(E) RELATIONSHIP TO MEDICAL SCHOOLS: CONCERN WAS EXPRESSED THAT EQUIPMENT NOT BE MAJOR ELEMENT OF MEDICAL SCHOOL SUPPORT COMPONENT. PP SHOULD OUTLINE RESPONSIBILITIES OF MEDICAL SCHOOLS IN PROJECT AND IDENTIFY SUPPORT PROJECT WILL PROVIDE TO THEM.

(F) COST SHARING: APAC SUPPORTED 50-50 COST SHARING FORMULA INCLUDED IN PID AND AGREED THAT PROJECT SHOULD BE DESIGNED TO PROVIDE FOR INCREASING GOI CASH CONTRIBUTION TO PROJECT AS IT PROCEEDS TO HELP ENSURE GOI WILL BE FULLY FINANCING ACTIVITIES WHEN AID ASSISTANCE TERMINATES.

(G) FUNDING FLEXIBILITY: PP SHOULD OUTLINE SYSTEM FOR FLEXIBLE AND QUICK MOVEMENT OF AID AND GOI FUNDS TO PROVINCES.

3. FUNDING PRIORITY: FY 82 ABS INCLUDES PROJECT IN AAPL RATHER THAN MINIMUM PACKAGE. APAC AGREED THAT PROJECT SHOULD HAVE HIGH PRIORITY FOR FUNDING AMONG NEW PROJECTS SINCE IT WILL REPRESENT FIRST PROJECT IN USAID PORTFOLIO FOCUSSED ON PROVISION OF COMMUNITY HEALTH SERVICES. MISSION SHOULD INDICATE NOW WHETHER ADEQUATE GRANT AND LOAN FUNDS WILL BE PROGRAMMED FOR PROJECT WITHIN CURRENT FY 81 PLANNING LEVEL TO INITIATE PROJECT. OTHERWISE PROJECT WILL HAVE TO BE DELAYED. APAC ALSO CONSIDERED THAT IN VIEW OF EXPERIMENTAL NATURE OF PROJECT, LOP COST SHOULD BE KEPT BELOW USG 15 MILLION. MISSION SHOULD ADVISE AID/W

PRIOR TO INITIATING PROJECT DESIGN WHETHER NECESSARY PROGRAMMING ADJUSTMENTS WILL BE MADE.

4. PLEASE SUBMIT IEE AS SOON AS POSSIBLE.

5. IN VIEW OF AID/W INTEREST IN INNOVATIVE ASSISTANCE APPROACH CONTEMPLATED AND UNCERTAINTIES REGARDING PROJECT SCOPE AND IMPLEMENTATION, MISSION SHOULD SUBMIT PP FOR AA/ASIA AUTHORIZATION. CHRISTOPHER

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Annex C

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REPUBLIC OF INDONESIA
NATIONAL DEVELOPMENT PLANNING AGENCY
JAKARTA, INDONESIA

No. : 1301 /D.I/6/1981

Jakarta, June 27 , 1981

Mr. Robert C. Simpson
Acting Director
US Agency for International
Development
c/o US Embassy
Jakarta

USAID ROUTING		
TO	Act	Info
DIR		✓
D/D		✓
LA		✓
ECON		
OMF		✓
PRO		✓
OMF/F		✓
OMF/C		
OMF/A		
RD		
POP		
HN	✓	
EHR		
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DA		
VHP		
PTE		
AGR		
JAO/ADM		
PER		
GSO		
InfoC		
C & R		

Dear Mr. Simpson,

Subject : Comprehensive Health Improvement Program-Provinces Specific.

This is a request of the Government of Indonesia for financial assistance of up to US$ 9,000,000 (nine million US dollars).

The main purpose of the financial assistance is to strengthen various aspects of primary health/nutrition delivery systems of the provinces of Nusa Tenggara Timur, West Sumatra, and Aceh, with a view to reducing infant and young child mortality rate and doubling of the number of rural women and children receiving health/nutrition services.

Hoping for your prompt approval, we thank you for your kind cooperation.

Yours sincerely,

BADAN PERENCANAAN PEMBANGUNAN NASIONAL * REPUBLIK INDONESIA

Saleh Afiff
Deputy Chairman

cc. : - Secretary General, Ministry of Health
- Bureau of Planning, Ministry of Health
- Dit.Gen. Community Health Services, Ministry of Health
- Pusdiklat, Ministry of Health
- Dit.Gen. P3M, Ministry of Health
- Dit. External Funds, Dit.Gen. of External Monetary Affairs, Ministry of Finance
- Dit.Gen. of External Economic, Social & Cultural Relations, Ministry of Foreign Affairs

Annex D

PROJECT AUTHORIZATION

INDONESIA

COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM - PROVINCE SPECIFIC
PROJECT NO. 497-0325

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Comprehensive Health Improvement Program - Province Specific for Indonesia involving planned obligations of not to exceed $ 9 million in loan funds over a five year period from date of authorization, subject to the availability of funds in accordance with the AID/OYB allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project consists of strengthening the capabilities of the Government of Indonesia to deliver health services in three provinces by increasing the number of paramedical personnel serving in these provinces and by improving the capability of provincial health officials to target, manage and evaluate specific health and nutrition activities.

3. The Project Agreement, which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with AID regulations and Delegations of Authority shall be subject to the following essential terms and major conditions, together with such other terms and conditions as AID may deem appropriate.

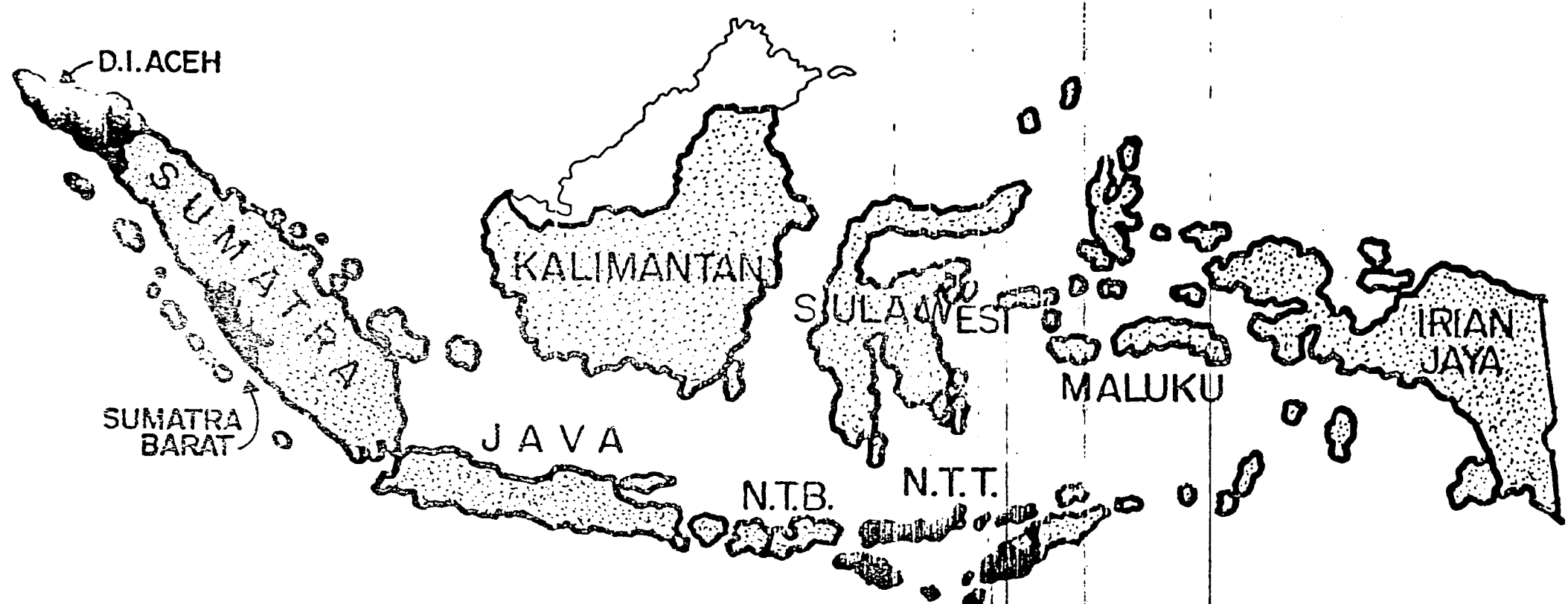
4. a. Interest Rate and Terms of Repayment

The Government of Indonesia shall repay the Loan to AID in U.S. Dollars within forty (40) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Government of Indonesia shall pay to AID in U.S. dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three precent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Goods and Services

Goods and services financed by AID under the project shall have their source and origin in Indonesia or in countries included in A.I.D. Geographic Code 941, except as A.I.D may otherwise agree in writing.

INDONESIA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SUMATRA BARAT
KALIMANTAN
SULAWESI
MALUKU
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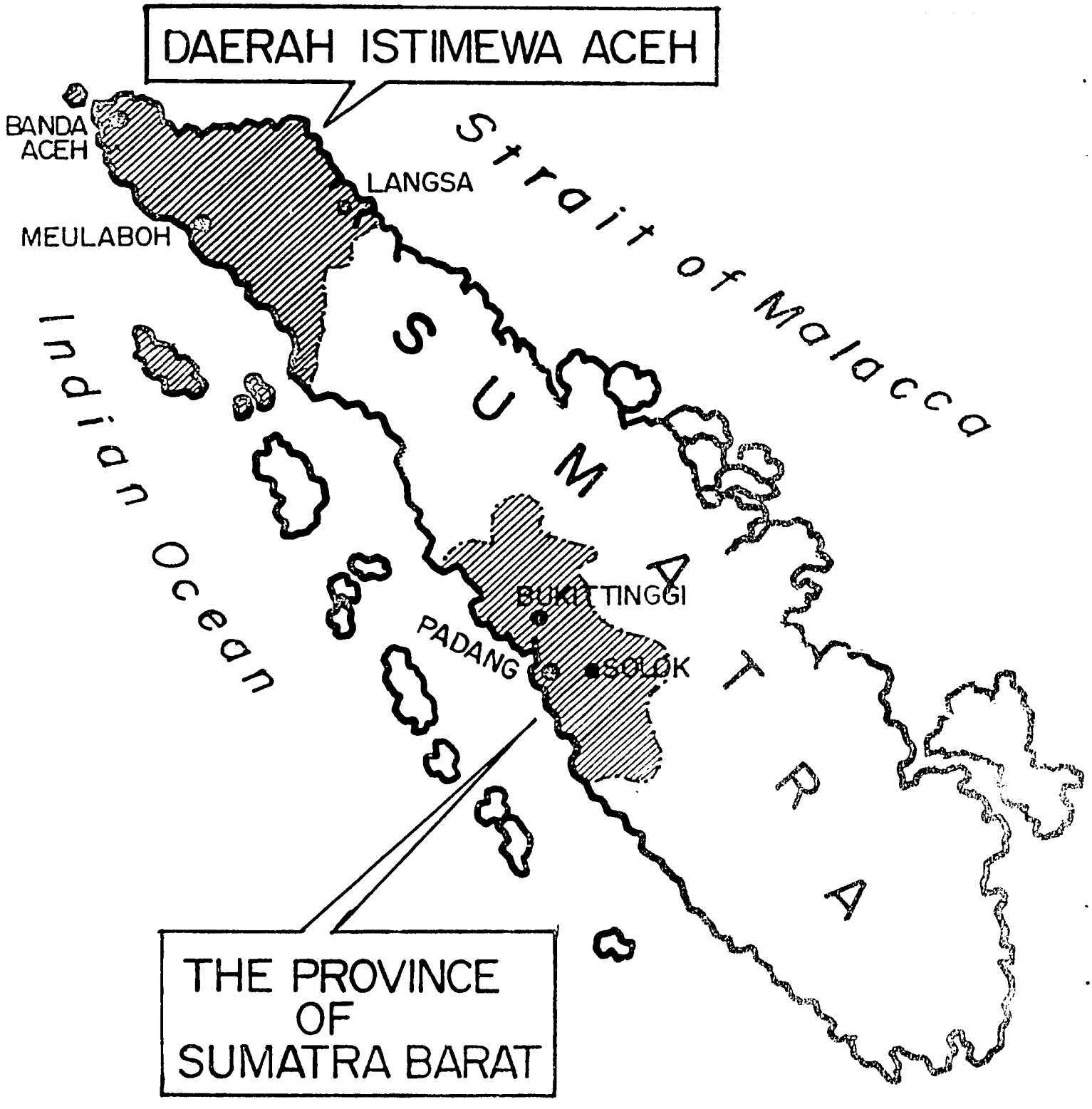
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BANDA ACEH
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MEULABOH
Strait of Malacca
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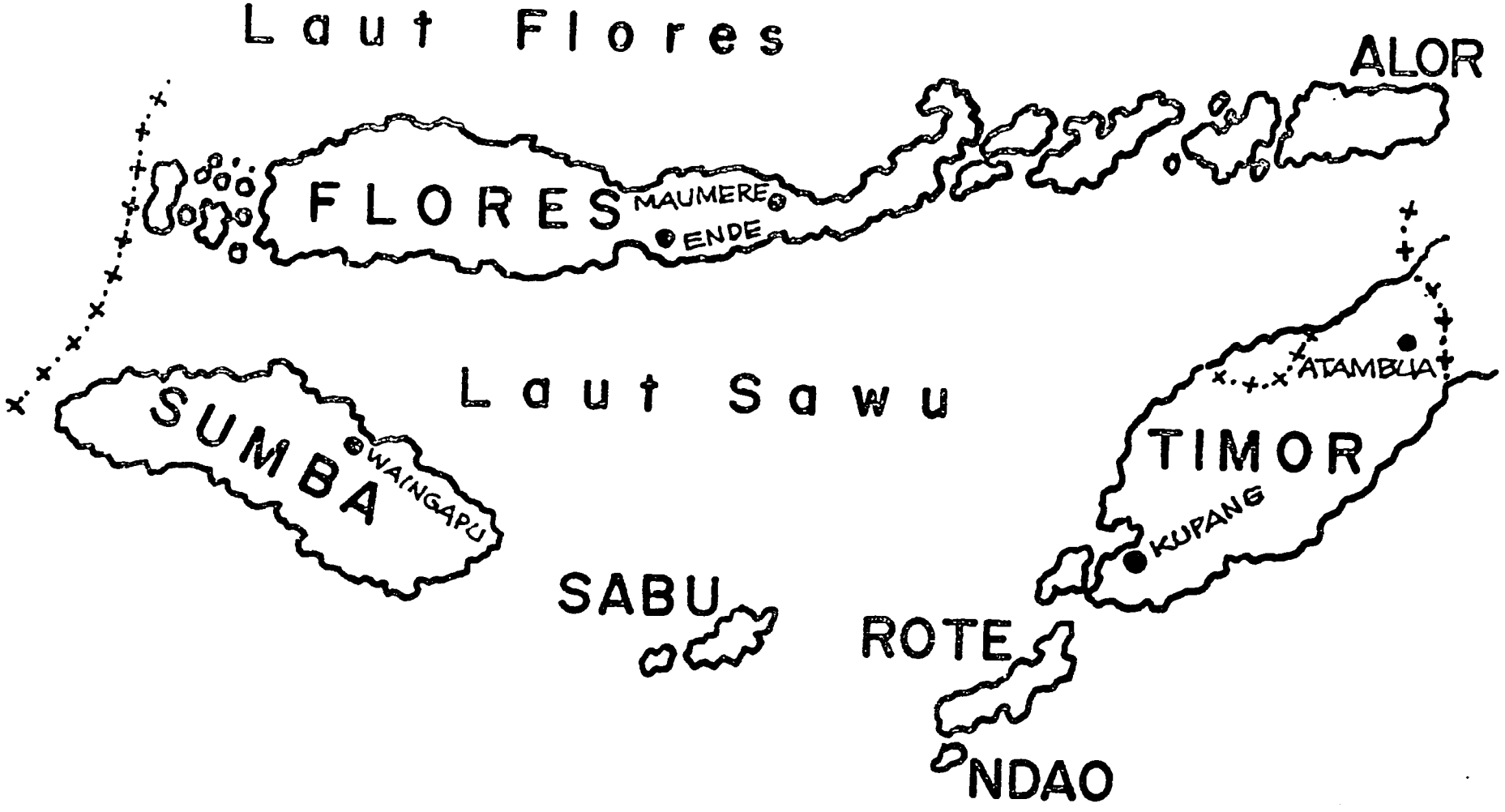
PADANG
SOLOK
THE PROVINCE OF SUMATRA BARAT

THE PROVINCE OF NUSA TENGGARA TIMUR



Annex F

Province Specific Descriptions -- D.I. Aceh

1. Background Description

Daerah Istimewa Aceh or the special province of Aceh is the northernmost province in Indonesia, being located on the tip of Sumatera opposite the Malay peninsula. D.I. Aceh is one of the more sparsely populated province in Indonesia with a land area of 55,392 square kilometers, a population of 2,611,271 million and a population density of 47 per square kilometer. The two major ethno-linguistic groups are the Acehnese and the Gayo with minor groups of the Simalur Sikhule and Malays.

Much of the area is covered by rugged mountains and jungles which are still inhabited by tigers and elephants. Infrastructure is a major impediment to development, with roads, bridges, and irrigation systems in poor or neglected condition. Fertile land and available water create a favorable agriculture situation, and indeed approximately 80 percent of D.I. Aceh's predominantly rural population is employed in agriculture. Almost all Acehnese farmers have access to land either through land ownership or share cropping arrangements, but holdings are small and fragmented. The ongoing Provincial Development Program (PDP) in D.I. Aceh assisted by USAID is addressing the issues of increased food production and alternative socio-economic opportunities for rural families (see Project Paper AID-ALC/P-2242 for more extensive discussion). Road building projects, being undertaken with foreign assistance, are helping with provincial infrastructure development, especially creating access to markets for goods. Roughly, land use in Daerah Istimewa Aceh is 10% agricultural, 75% forest, 1% cities and villages, 8% grassland, and 6% lakes and rivers. Among the principal agriculture products are: rice, fruits, vegetables, various nuts and beans, and corn. From the forest and plantations come: coconuts, coffee, sugar cane, rubber, cloves and tobacco.

Despite the enormous agricultural potential that exists in D.I. Aceh, the actual nutrition situation is far below what would be expected in a food rich area. The Xeropthalmia National Survey carried out in 1978 revealed the prevalence of blinding xeropthalmia to be 48.4/10,000, the highest in Indonesia. While no province wide nutrition surveys have been carried out to date, the experience with the Usaha Perbaikan Gizi Keluarga (UPGK - Nutrition Improvement Program) since 1979 indicates that protein calorie malnutrition among children is wide-spread, nutritional blindness and night blindness persist, and goiter and nutritional anemia are endemic. The generally low nutrition status, especially among women and children, coupled with the communicable disease burden and low standards of environmental sanitation, are exacerbated further by a general low level of education and strong

traditional food beliefs and practices, many of which concern the feeding of mothers and children.

Historically D.I. Aceh has maintained an autonomy and independence that is unique to Indonesia. During their 300 year colonialization of Indonesia, the Dutch were never able to completely occupy Aceh, as attested to by the long and bitter colonial war that spanned four decades (1873-1913). Indeed Dutch Troops were still stationed in Banda Aceh and controlled the coastal areas but guerrila warfare in the interior continued right up to the time of the Japanese invasion in 1942. During the 1930's the Islamic modernist movement led by Daud Beureuch emerged and played an important role in Aceh politics until ultimately in 1961 an agreement was made with the central government creating Daerah Istimewa Aceh as a separate province, and not as a part of the province of North Sumatera as had been done at the time of Independence*.

Freedom and independence are valued characteristics of the Acehnese and resistance to outside influences encourages the perpetuation of traditional values and activities. The Acehnese perception of themselves as an independent people is strengthened by their Islamic religious conviction that all believers are equal before God. Their acknowledged attitude to people and things not intrinsicly Acehnese heighten the need for development programs being designed for D.I. Aceh that actively encourage local support and participation.

Daerah Istimewa Aceh has a reputation in other parts of Indonesia for having the most intensively Muslim population in the country. This characterization tends to suggest that the province is repressive in its treatment of women, opposed to progress, and dominated by fervent religious leaders. The reality is that D.I. Aceh maintains a balance between strong religious beliefs and practices and a receptivity to socio-economic development that occurs without corrupting traditional values, especially values concerning the family. Women can participate in all sectors of development activities and are not restricted from training or educational opportunities because of their sex. Religious leaders do play a large role as opinion leaders in the community and their involvement in planning cannot be ignored. The support and involvement of the local ulama are a prerequisite for all community activities, whether supported by the central government, local government, or private efforts.

Achenese women have power through the traditional social system. Daughters receive a house from their parents at the time of their marriage, and also own rice fields

* Extensive discussion of Acehnese history and customs are found in: Anthony Reid, The Blood of the People, Oxford University Press, 1979; and James Siegel, The Rope of God, Univ. of Calif. Press, 1969.

and other properties. After marriage, a husband lives with his wife's family (in her parent's house or the gifted house) and subsequently is relatively powerless in the home, especially in the upbringing of the children and house maintenance. Men are frequently out of the villages for long periods of time going to the east coast or west coast for trading and business (merantau) and returning every 2-3 months to visit.

In rural society women are considered brides until the birth of their first child. After birth many women are confined to the house for 45 days during which time her body is "roasted" -- a process involving wrapping the abdomen with a long white cloth and placing a wrapped hot stone on it to reduce pain and shrink the uterus. A bamboo bed is made for the mother to lie on and a fire kept burning under it day and night for a week or more. During this time a special hot herbal drink is given to reduce pain and swelling. This treatment is believed to restore bodily trimness and health quickly. Post-partum dietary restrictions vary within the province, but generally protein foods like fish and eggs are prohibited, as are fruits like pineapple and papaya, and the intake of water -- all practices that are detrimental to good maternal nutrition and the establishment and sustaining of lactation.

2. Health Manpower and Facilities

Regional Government organization:

10	Regencies (Kabupaten)
2	Municipalities (Kotamadya)
129	Sub-districts (Kecamatan)
5462	Villages (Desa)

Health Manpower Situation: (March 1980)

Doctors	=	139
Nursing teachers	=	9
Nurses	=	236
Midwives	=	196
Sanitarians	=	129
Laboratory Technicians	=	6

Health Facilities:

Puskesmas	=	137
BKIA	=	33
Policlinic	=	135
Mobile Puskesmas	=	-
General Hospital (Type B)	=	0
General Hospital (Type C&D)	=	9 with 626 beds
Mental Hospital	=	1

Health Education Facilities : (March 1980)

Nursing School	=	1 (Dept. of Health)
		1 (to be opened by Dept. of Health late 1981)

School of Medicine = 1 being planned
Laboratory School = 1 (being run by D.I. Aceh without Dept. of Health support).

3. Health Status

Estimated population coverage with safe water (1980) - 9% of rural population.

Average Puskesmas patients per day - 30
Target " " " " by 1984 - 75

Weight for age data on children less than 5 years old - at beginning of UPGK program during 1980 (not scientifically sampled):

"Adequate" Nutrition	- 48.7%
"Moderate" Malnutrition	- 44.1%
"Serious" Malnutrition	- 7.2%

Goiter surveys in schools in highland areas - 40-80 school children have goiter in some schools.

Xerophthalmia (Vit. A deficiency eye disease) prevalence among children in rural Aceh:

Bitot's spot	2.4%
X2-X3 stage	48.4 per 10,000
X5 stage	16.1 per 10,000

Rabies - approximately 75% of animal brains from suspected animals sent for examination are positive for rabies.

Estimated prevalence of active pulmonary tuberculosis: 6 per 1000.

Estimated cases leprosy currently under treatment: 400.

Estimated prevalence of yaws cases: 0.5%.

Estimated prevalence of malaria in rural areas: 10-40%.

Dengue Hemorhagic Fever now endemic in 5 kabupatens (first seen in 1975).

Annex F

Province Specific Description -- Sumatera Barat

1. Background Description

The province of Sumatera Barat is located in the middle portion of the west coast of Sumatera. A population of 3,406,816 million occupies 49,778 square kilometers with a population density of 68 per square kilometer. However, the population is very unevenly distributed throughout the province with approximately 66% of the population living on 25% of the total area. For example in the coastal lowlands between Padang and Pariaman, and in the highlands within the triangle of Bukittinggi - Payakumbuh - Solok, population density may exceed 400 inhabitants/km2. By contrast, huge uninhabited forest areas still exist toward the periphery of the province.

Inland this rugged volcanic terrain is scattered with sheltered valleys, gorges, mountain streams, fields and villages perched on top of deep ravines. Approximately 15% of the land is inhabited and used for agriculture, 72% is forests, and the rest is alang-alang grass savannas, waste land, and water areas. Basic infrastructure in Sumatera Barat is relatively good with roads linking up major cities and towns. Major development concerns are improved agricultural production and expanded trade to raise the economic standard of the predominantly rural population.

Sumatera Barat is located right at the equator and the weather is characterized as typically humid and tropical. Precipitation is high. This combination of warmth and water guarantee a wide range of agricultural activities throughout the year. Rich volcanic soil make soil conditions in some areas of Sumatera Barat highly favorably for agricultural production, whereas in the other areas poor soils prevail*. USAID is supporting the development of the agricultural potential in Sumatera Barat through assistance to a regional agriculture research station which addresses the particular agro-climatic factors of the province. (For a more extensive discussion see USAID Project Paper, Indonesia - Sumatera Agriculture Research (497-0263) Sept. 1977).

Historically agriculture has dominated the economy of Sumatera Barat, originating in the development of the highly civilized Minangkabau kingdom which had intensive agricultural production systems. Today 70-80% of the work force is employed in agriculture, either part time or full time. All major export

* An extended discussion of land use can be found in Ulrich Scholz, Some Consideration about Landuse in the Province of West Sumatera, Padang, 1980.

commodities from the province come from agricultural production and other sectors such as industry and mining play an important, but minor, part in trade. The most important food crop is wet rice which comprises 47% of the total agriculturally used area of Sumatera Barat. Next in importance are cassava, upland rice, chili, maize and groundnuts. The most important cash crops are rubber, coconut, spices (cinnamon, cloves, nutmeg) and coffee. Most of the agricultural production is done by peasants or small land holders, rather than through large estate production. The majority of small landholders achieve full or partial self-support with rood crops and balance this with additional cash-crops. Neither purely subsistance oriented farms nor purely market oriented farms are the norm.

Sumatera Barat is almost entirely ethnic Minangkabau, a strong matrilineal society which has a reputation for being one of the best educated, vigorous groups in Indonesia. Converted to Islam during the Muslim invasions, it continues to be one of the most devoutly Islamic provinces in Indonesia. The Minangkabau's strong adherence to their local custom which regards the grandmother as the grand matriarch of the family is in contrast to customary Islamic tradition that accords women little access to property and power. Minangkabau women keep property within a cooperative group, the matrilineal, which persists through time. Daughters inherit the property which is worked collectively and kept as family capital. In addition to managing the domain of the house, women also own the fields and shops. The social organization within families is based upon regarding a child (male or female) as a member of the mother's family group with rights of inheritance. The fathers's group regards the child as a blood relative without any rights of inheritance. The mother's brother is the most important male in the family and gives advice on business transactions and the marriage of children since the real father stays out of family affairs. A brother is responsible for the eucation of his sister's children. Likewise his wife's brother is responsible for the education of his children, a reciprocal system that maintains certain male privileges and responsibilities.

The matrilineal nature of the Minangkabau has its historical roots in the outmigration (merantau) of Minangkabau men to other areas to do business, study or to seek fame and fortune. Wives and daughters have managed the home and property. Low industrial development coupled with increased population pressure has driven many men to other provinces, particularly Java, to find employment. It is estimated that roughly half of the male population have migrated outside of Sumatera Barat, and indeed Minangkabaus can be found throughout the islands of Indonesia, providing much of the leadership and competing widely as traders and businessmen.
In Minangkabau tradition the 3 influential elements in the Community are:

a) Ninik mamak (community leaders)
b) Ulamas (religious leaders)
c) Cerdik Pandai (scholars - teachers, civil servants, etc).

Most of the these formal leaders are male. Two other elements of village leadership are:

a) Bundo Kandung (blood mother) - female leaders of villages.
b) Pemuda (Youth) - represented by various organizations.

2. Health Manpower and Facilities

Regional government organization:

8 Regencies (Kabupaten)
6 Municipalities (Kota Madya)
90 Sub-districts (Kecamatan)
3516 Villages (Desa)

1981 Health Manpower Situation:

Doctors	= 405	
Public Health Masters (MPH)	= 9	
Nursing teachers	= 23	(work at the 2 nursing school)
	= 21	(work in other health units)
Nurses and Midwives	=1,117	(trained under previous system; need to be retrained in 3 month course)
Auxillary Nurses	= 517	(trained under previous system; need supplementary training, 1 year course)
Nurse/midwife	= 110	(trained under new system)

1981 Health Facilities:

Puskesmas	= 116	(target by end of Pelita III = 135)
BKIA	= 232	
Policlinic	= 171	
Mobile Puskesmas	= 27	
Family Planning Clinics	= 181	
General Hospital (Type B)	= 1	with 542 beds
General Hospital (Types C&D)	= 9	with 941 beds
Mental Hospital	= 1	with 100 beds

Health Education Facilities:

School of Medicine	=	1,	output ± 50/doctors/yr
Faculty of Pharmacy	=	1,	output ± 15/yr
Nursing School	=	2	(Dept. of Health)
		1	(Armed Forces)
Provincial Training Center	=	1	(Opened in Oct. 1980 by Department of Health Training and Education Center)

3. Health Status

Estimated infant mortality rate: 100-120 per thousand live births.

Prevalence of Endemic Goiter: as high as 80% in some areas.

Incidence rate of cretin births: unknown.

Estimate of protein-calorie nutrition status in children under 5 years: 40% moderately malnourished
5% severely malnourished.

Potable water supply in rural areas: less than 10% have access.

Proportion of rural population using sanitary excreta disposal: ...5%.

Cholera cases reported (1979)	-	922
Malaria cases reported (1979)	-	19,000
Leprosy cases reported (1979)	-....	1,000 (new cases 92)
Yaws cases reported (1979)	-	1,422
Bites to humans from suspected rabid animals (1979)	-	2,168

Percentage of total visits to non-hospital clinic related to tuberculosis (1979) - 6%.

Annex F

Province Specific Description -- Nusa Tenggara Timur

1. Background Description

The province of Nusa Tenggara Timur (NTT) is comprised of 111 inhabited islands stretching approximately 700 kilometers from east to west in southeastern Indonesia. The outer arc formed by uplifted coral reefs with thin, generally unfertile soil, includes the major islands of Sumba, Sabu, Rote and Timor. The inner arc, part of a volcanic chain with much richer soils, includes the large island of Flores and other smaller islands such as Komodo, Solor, Adonara, Lomblen, Pantar and Alor. With the exception of the few relatively flat islands like Rote and Sabu, the topography of NTT is mountainous and ruggedly dissected, making overland communication difficult. Inter-island communication is likewise complicated, dependent as it is on boat travel which can be lengthy, irregular and next-to-impossible due to treacherous seas during the 3-4 month rainy season.

The climate is affected by NTT's proximity to Australia and is characterized by short, intermittent rains from December to March, and a long dry season over the rest of the year. The subsequent semi-arid conditions are in sharp contrast to the tropical environment of most of Indonesia. The rainy season is referred to as musim barat (the west season) since the rains arrive with westerly winds. Because of this the western end of islands, especially West Flores and West Sumba, tend to receive much more rainfall. A great variability in climate from region to region within the province and from year to year, results in a diversity of micro-climates. These climatic factors contribute to the fragility of the terrain, quite young in geologic terms, which is easily eroded if stripped of a protective cover of vegetation.

A population of 2,737,166 million is sparsely scattered over the rugged terrain of these islands of 47,876 square kilometers with a population density of 57 per square kilometer. The separateness of these islands scattered over a large expanse of sea contributes to the diversity of the ethno-linguistic groups in NTT. Major populations include the Manggarai Nagadnese, Endenese, Sikkanese, Solorese (all on Flores and adjoining islands), Sumbanese, Sabunese, Rotinese, Atoni (Timorese) and Tettum. Other smaller groups are the Helong, Kemaq and Bunaq on Timor, and the Ndaonese. On Alor alone there are approximately 28 separate ethno-lingusitic groups. The long history of both Catholic and Protestant missionary activity has resulted in approximately 60% of the population joining Catholic churches and 29% Protestant churches. About 8% of the population is Muslim, in contrast to the dominance of Islam nationally, and

the balance consists of indigenous belief systems, the most powerful being the Merapu in East Sumba.

Most of the people of NTT are shifting cultivators who grow corn, tubers and rice by cutting and burning scrub forest, planting with a dibble stick, harvesting the same plot of land for a year or two and moving on to a new location. Exceptions are the unique economies of the Rotinese, Sabunese and Ndaonese which support denser populations through the intensive exploitation of sugar-producing palms (lontar) in combination with seaweed and honey gathering, offshore fishing and small animal husbandry.

In the drier areas such as East Flores, and especially West Timor where overgrazing by cattle introduced by the Dutch has aggravated the derioration of the swidden system, population pressures have resulted in an annual lapar biasa (ordinary hunger period) of two to three months. This period may turn into a lapar luar biasa (an extraordinary hunger period) or lapar betul (a true famine) when climatic conditions are unfavorable. The climatic cycle and micro-climatic diversity of NTT contributes to the frequent occurrence in one part or another of the province of a natural disaster: an extended drought, destructive winds, or flash flooding due to watershed destruction.

NTT is one of the poorest provinces of Indonesia. Given the low per capita income in monetary terms, and the high cost of living index (134 versus the Jakarta standard of 100), the 2 1/2 million people of NTT have the lowest per capita gross domestic product in real terms for all of Indonesia. In 1972 this amounted to Rp, 14,194 (US $34.20) versus the next lowest, Rp. 22,193 (US $53.48). Calculated strictly by crude population and gross regional domestic product at constant 1971 prices, per capita income in NTT grew from Rp. 13,328 (US $32.12) in 1971 to only Rp. 16,245 (US $39.14) in 1975, still less than US $40 per year.

Of the 1971 work force of 980,758 persons -- amounting to 43% of the total population and 62% of those 10 years of age or over -- 5% were urban based and 95% rural. Sectorally, 82% were living directly from the land and sea, the great majority being farmers. Farming is the dominant sector not only in the rural areas (84%) but also in the urban zones (34%). Social services (including government) and industry were the second largest employers with approximately 6% of the labor force each. While services are concentrated in the urban areas, industry is reportedly spread more evenly, employing 7% of the urban workers and 5% of the rural. However, if we note that the great majority (85% by official figures) of the rural "industrial" workers are women, it is most likely that the cottage industry of weaving textiles has been included here. Since most of these "textile workers" are the women of farm families who are

heavily involved in agriculture during the rainy season, it is quite likely that farming as a major source of livelihood is even more dominant than the statistics indicate. The long dry season and unemployment in the rural areas result in a considerable amount of labor migration. Rotinese and Sabunese in particular, after tapping their palms, migrate seasonally as petty traders, and the men of Ndao leave that island at the beginning of the dry season to fashion jewelry for the people of the Timor areas. Timorese and Alorese also migrate as occasional laborers and servants. In addition to migrant laborers and traders, a large number of youths from throughout NTT travel to Kupang, often initially to attend school. Whether due to financial problems or the irrelevance of school curricula to practical job opportunities, many of these youths drop out to seek work. Some may secure jobs as drivers, temporary office help, or part-time laborers, but many join the ranks of unemployed youths who live off other urban relatives who might be employed. In 1975 it was estimated that 55% of the population was uneducated and only 39% graduated from Elementary School.

With the assistance of USAID, the PDP program is being implemented in NTT to provide technical assistance in agricultural development, district food reserve system, irrigation, forest products and food crops, livestock, fisheries and rural industries, and also to improve local capabilities to plan and administer rural development programs (See Project Paper AID/BAS-007 for more extensive discussion).

2. Health Manpower and Facilities

Regional Government organization:

12	Regencies (Kabupaten)
98	Sub-districts (Kecamatan)
1720	Villages

Health Manpower Situation (Oct, 1980):

Doctors	= 99	(Government)
	7	(Private)*
Nursing teachers	= 10	(Government)
	2	(Private)
Nurses	= 239	(Government)
	90	(Private)
Midwife	= 192	(Government)
	43	(Private)
Auxillary nurses	= 517	(Government)
	127	(Private)
Assistant nurse	= 123	(Government)
	8	(Private)

* Private means mostly church related.

Sanitarians	= 54	
Laboratory Technicians	= 5	
1981 Health Facilities:		
Puskesmas	= 119	
BKIA	= 111	(Government)
	33	(Private)
Policlinics	= 243	(Government)
	78	(Private)
Mobile Puskesmas	= -	
General Hospital (Government)		= 13
General Hospital (Private)	= 11	
Health Education Facilities:		
Nursing School	= 2	(Dept. of Health)
	1	(Private)

3. Health Status

Estimated (non-scientific sampling) nutrition status of children 5 year old: 60-70% malnourished.

Estimated (non-scientitic sampling) nutrition status of school children: 15% malnourished
6% seriously malnourished.

Estimated population with access to safe drinking water: 8%.

Estimated prevalence of malaria among patients visiting Puskesmas: 30%.

Estimated percent of pregnant women in Puskesmas coverage area that come into contact with health system: 25%.

Estimated coverage of children under 5 years in Puskesmas coverage area that come into contact with the health system: 8%.

Estimated coverage of deliveries attended by health personnel: 25%.

Average daily caloric intake per day (from a food balance sheet): 1440 calories.

Prevalence of goiter in some villages: up to 50%
" " cretins in some villages: 1%.

Estimated prevalence of leprosy in province (random survey by WHO 1978/79): 4 per thousand or 10,050 cases of which 3,340 are lepromatous type.

Estimated prevalence of leprosy in TTU kabupaten: 41 per thousand.

Estimated prevalence of yaws: Up to 1% in highest kabupatens.

Annex G

HEALTH DEVELOPMENT BUDGETS PROVIDED BY DEPARTMENT OF HEALTH TO D.I. ACEH, SUMATERA BARAT, N.T.T. 1979/80 TO 1981/82 ($ 000)

	Daerah Istimewa Aceh			Sumatera Barat			Nusa Tenggara Timur		
	79/80	80/81	81/82	79/80	80/81	81/82	79/80	80/81	81/82
1. Women's Role, Social Welfare and Health Education Program.									
- Health Manpower Education Development Project.	48	78	96	-	240	149	-	-	90
2. Health Counseling Program.									
- Social Health Counseling Project.	24	37	48	48	72	72	28	43	48
3. Health Service Program.									
- Medicine storage, health equipment and supply development project.	-	-	108	-	-	94	-	-	149
- Provincial regional and municipal general hospital developmment project.	960	435	1,357	640	766	994	1,304	1,435	1,178
- Central general hospital development project.	-	-	-	720	1,361	990	-	-	-
- Health laboratory services development project.	9	16	16	-	16	16	-	-	-
- Mental health services development project.	150	320	442	64	96	270	-	-	-
- Health centers development project.	205	288	376	246	320	464	193	320	440
4. Communicable and prevalent disease in the area eradication program.									
- Communicable disease eradication project.	221	392	562	326	524	822	181	383	545

	Daerah Istimewa Aceh			Sumatera Barat			Nusa Tenggara Timur		
	79/80	80/81	81/82	79/80	80/81	81/82	79/80	80/81	81/82
5. Nutrition Development.									
- Nutrition Development.	16	56	88	13	150	144	9	48	72
6. Food and Drug Control.									
- Food and Drug Control.	26	64	48	26	64	83	64	64	48
7. Clean Water Supply.									
- Clean Water Supply.	-	-	78	40	50	52	19	174	267
8. Resettlements Environmental Health.									
- Resettlements Environmental Health.	-	-	-	8	19	16	-	-	-
9. Governmental apparatus and efficiency control program.									
- General and statistical planning project	5	6	12	6	7	14	7	7	14
10. Government physical infrastructure development program.									
- Physical work facility infrastructure project.	-	-	345	-	-	142	-	-	441
T O T A L $	1,664	1,692	3,577	2,137	3,685	4,330	1,804	2,474	3,291

Formal Manpower Training Schools and Courses
NUSA TENGGARA TIMUR

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Sekolah Perawat Kesehatan - regular 3 year course	Approximately 80 from three schools in Kupang, Ende and Lela.	If two new schools are begun, they will still not be graduating classes by Project completion date. If present schools are enlarged, then output can be increased earlier. Issue not yet decided by GOI.	Estimated 160-240 additional student years (either in new schools or as additional students in present schools).	$250,000 toward supporting 160 additional students years.	$ 128,000 supporting a) 80 additional students b) construction of new schools, renovations, major capital equipment, transportation, maintenance and additional student costs.	Project completion Date: Sept. 1986 (Loan can not fund academic year '86-87)

# of students	10/81-6/82	7/82-6/83	7/83-6/84	7/84-6/85	7/85-6/86	7/86-10/86
(new) SPK Waingapu	-	-	-	40	80	
(new) SPK Atambua	-	-	-	-	40	
				40	120	

Total = 160 new students years
Possibly = 240 new student years if output can be increased earlier.

	Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
	3 month retraining course for nurses and midwives trained under previous system. (in Kupang school)	0	60 (2 groups of 30)	240 additional students for 3 month course	$96,000 toward supporting 120 students (30 students per year for 4 years)	$105,000 toward supporting 120 students. Will also pay for any additional operating expenses for the school(s) where course taught.	

# of students	10/81-6/82	7/82-6/83	7/83-6/84	7/84-6/85	7/85-6/86	7/86-10/86
	-	-	60	60	60	60

Total = 240
Note: Project can assist these courses during '86-87 because 3 month course can be completed before Project completion date.

	Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
	Supplementary 1 year training for auxiliary nurses to upgrade them to PK (in Ende school)	0	30	90 (30 per year for 3 years)	$112,000 to support one class of 30 for three years	Additional operating and maintenance costs in SPK. Vehicle and maintenance. Additional capital equipment necessary	

# of students	10/81-6/82	6/82-6/83	6/83-6/84	6/84-6/85	6/85-6/86	6/86-10/86
	-	-	30	30	30	

Total = 90

Type of Training	Current graduates per year.	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Nursing School Teachers Training: - 1 year course and - 6 week course	0	Variable	Up to 55; the ratio of 1 year courses and 6 week courses not yet determined	$70,000 toward supporting training of up to 55 teachers	$35,000 toward supporting these same 55 teachers	
Field Training for SPK students at SPK Kupang, SPK Ende and any new SPKs	60 from SPK Kupang and Ende	Unknown - depends whether new schools built or present schools enlarged	Estimated 160-240 students years	$90,000 for four academic years. Costs for student transport and living costs in field, additional costs for faculty to instruct in field.	GOI will continue to pay costs it now assumes for field training of 60 nursing school 3rd. year students. GOI will assume additional costs for new students field training not covered by Loan funds, including vehicle costs, per diem and honoraria for cooperating Puskesmas staff-estimated at $30,000	
Equipment for nursing Schools (Kupang, Ende plus any any new schools)	-	-	-	$50,000 for teaching equipment, physical exam equipment, simple audiovisual equipment.	All major capital equipment including buildings and building renovations, additional equipment, vehicles and vehicle maintenance costs.	

Type of Training	Current graduates per year.	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Rural Sanitarian Training (SFFH - Denpasar)	2	12	40	$19,200 toward educational expenses for 40 additional students	$45,000 toward educational expenses, transportation, and living expenses for these 40 additional students	Acedemic Year During Project Life 10/81-6/82 / 7/82-6/83 / 7/83-6/84 / 7/84-6/85 / 7/85-6/86 / 7/86-10/86 # of students: 2 / 12 / 12 / 12 / 12 Total # of additional students above the 2 per year now supported: - / 10 / 10 / 10 / 10 Total Additional students = 40
Formal Midwifery (Bidan)	0	20	40	-	$64,000 for all associated costs	Academic Year During Project Life 10/81-6/82 / 7/82-6/83 / 7/83-6/84 / 7/84-6/85 / 7/85-6/86 / 7/86-10/86 # of students: - / - / - / 20 / 20 Total = 40

Formal Manpower Training Schools and Courses
SUMATERA BARAT

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Sekolah Perawat Kesehatan - regular 3 year course	60 (30 each from SPK Padang and SPK Bukittinggi)	90 (60 from SPK Padang; 30 from SPK Bukittinggi)	270 additional student years	$223,200 supporting 180 additional student years atudent years.	$111,600 supporting a) 90 additional student years, b) additional operational expenses and vehicles	Project Completion Date: Sept. 1986 (Loan cannot fund academic year '86-'87.

Padang SPK	10/81-6/82	7/82-6/83	7/83-6/84	7/84-6/85	7/85-6/86	7/86-10/86
Total students in 3 classes	90	120	150	180	180	
# of additional students	-	30	60	90	90	

Total additional student years = 270

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
3 month retraining course for nurses and midwives trained under previous system.	60 (2 groups of 30) presently from SPK Padang and SPK Bukittinggi.	180 (6 groups of 30) from Padang, Bukittinggi and Solok.	390 additional students completing the 3 month course.	$144,000 supporting 180 additional students	$168,000 supporting a) 210 additional students. b) additional operating expenses of the school and any renovation or construction at Solok.	

	10/81-6/82	7/82-6/83	7/83-6/84	7/84-6/85	7/85-6/86	7/86-10/86
Total # of students completing 3 month course	60	90	180	180	180	
Additional students above the 60 per year presently completing course	-	30	120	120	120	

Total new students = 390

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Supplementary 1-year Training for auxiliary nurses to upgrade them to PK	30 (from SPK Padang)	90 (from Padang, Bukittinggi and Solok)	240 additional student years	$186,000 supporting 150 additional student years student	$111,600 supporting a) 90 additional student years; b) additional operating expenses, vehicle expenses and any construction or renovation necessary for schools.	# completing course each year: 10/81-6/82: 30; 7/82-6/83: 90; 7/83-6/84: 90; 7/84-6/85: 90; 7/85-6/86: 90; 7/86-10/86: # additional students: 10/81-6/82: -; 7/82-6/83: 60; 7/83-6/84: 60; 7/84-6/85: 60; 7/85-6/86: 60; 7/86-10/86: Total additional students = 240
Nursing School Teachers Training courses: - 1 year course, and - 6 week course		Variable	Up to 25, the ratio of 1 year and 6 week courses not yet determined	$32,000 supporting training of up to 25 teachers	Any additional costs beyond the USAID Loan funds	
Field Training SPK students at Padang and Bukittinggi			-	$60,000 for four academic years. Costs for student transport and living costs in field. Costs for new faculty (for 2-3 years) responsible for field training instruction and for teacher transport.	Vehicles and maintenance, honoraria and per diem for Puskesmas and Kabupaten staff	Second and third year student field training can be supported under this Project, as can be the development of a pre-field experience teaching module.

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Equipment for Nursing Schools (Padang, Bukittinggi and Solok, if Solok used for retraining and supplementary training	-	-	-	$50,000 teaching equipment, including simple laboratory equipment, physical exam equipment, simple audivisual equipment, etc.	All major capital equipment including buildings and building renovations. Vehicle and vehicle maintenance. Any additional equipment.	Equipment can be used for regular SPK students as well as supplementary and retraining students.
For BLKN (Provincial Health Training Center)	-	-	-	$10,000 for audiovisual and instructional equipment	All course expenses, capital expenses and other equipment.	Expenses to be suitable for instruction in non-hospital oriented courses.

Formal Manpower Training Schools and Courses
DAERAH ISTIMEWA ACEH

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Sekolah Perawat Kesehatan - regular 3 year course	30 (from SPK Banda Aceh, but size of class already increased to 60 per year by provincial government)	120 (60 from SPK Banda Aceh; 30 from SPK Meulaboh; 30 from Langsa, but this school still tentative).	510 estimated additional student years given a) increased size of classes at Banda Aceh, b) Meulaboh (beginning '81-82) fills its 3 classes of 30 students, and c) SPK Langsa is opened for '83-84 academic year	$222,000 toward supporting 180 additional student years	$409,000 supporting a) 330 additional student years. b) GOI also responsible for any building construction or renovation, other major capital equipment.	Project Completion Date: Sept. 1986 (Loan can not fund academic year '86-87).

# of students in school (all 3 years) :	10/81-6/82	7/82-6/83	7/83-6/84	7/84-6/85	7/85-6/86	7/86-10/86
a) Banda Aceh	150	180	180	180	180	
b) Meulaboh	30	60	90	90	90	
c) Langsa	-	-	30	60	90	
Total	180	240	300	330	360	
# of students additional to the 180 already being supported by central and provincial governments.	0	60	120	150	180	

Total = 510 additional student years.

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget
3 month re-training course for nurses and midwives trained under previous system	0	60	210	$96,000 toward supporting 120 students - 30 per year beginning 1982.	$85,000 supporting a) 90 students and b) operating expenses at schools.

# of students	10/81-6/82	7/82-6/83	7/83-6/84	7/84-6/85	7/85-6/86	7/86-10/86
	0	30	60	60	60	

Total = 210 students

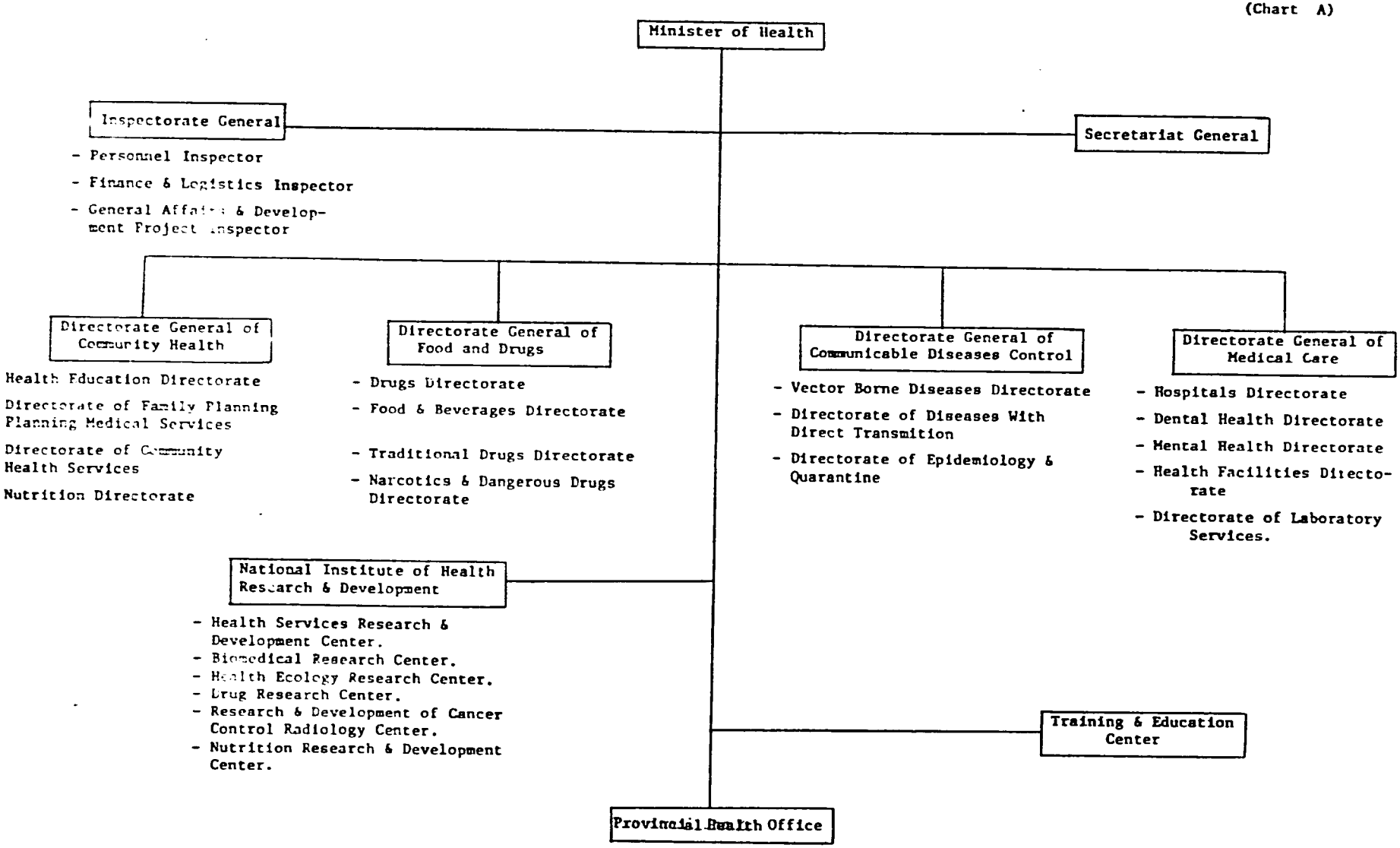
Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes
Supplementary 1 year training for auxiliary nurses to upgrade them to PK	0	30	120 (30 per year for 4 years)	$111,600 supporting 90 students in years '82-83, '83-84 and '84-85.	$45,000 supporting a) 30 students in year '85-86 and b) additional operating expenses at SPK.	10/81-6/82: # of students = - 7/82-6/83: 30 7/83-6/84: 30 7/84-6/85: 30 7/85-6/86: 30 7/86-10/86: Total = 120 students.
Nursing School Teachers Training: - 1 year course, and - 6 week course		Variable	Up to 45; the ratio of 1 year courses and 6 week courses not yet determined.	$60,000 supporting training of of these 45 teachers	$13,000 supporting training of 45 teachers	
Field Training for SPK students at SPK Banda Aceh, SPK Meulaboh and SPK Langsa	30	120	N/A	$72,000 for 4 academic years toward student transport and living costs in field and additional costs for faculty to instruct in the field	GOI will assume costs for per diem, honoraria and other costs for Puskesmas staff, vehicle and other student and faculty costs not covered by Loan funds Estimate $30,000	

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	
Equipment for Nursing Schools (Banda Aceh and Meulaboh)	-	-	-	$54,000 for teaching equipment, including simple laboratory equipment, physical exam equipment simple audiovisual equipment etc.	All major capital equipment including building construction and renovation, furniture, other equipment.	
Rural Sanitarian Training (SPPH in Medan or Lampung)	-	-	45	$50,400 for educational costs and travel expenses	$5,000 for students' pocket money line item	
Laboratory Technician Training at SMAK, Banda Aceh (a) Regular 2 year course	40	40	0	Total $58,000 ($18,000 for educational expenses over a period of 3 years plus $40,000 for equipment for training students for work in field laboratories).	$58,000 for educational expenses, and equipment	Costs for this schooling now assumed by the province and by the students. During life of project, central Ministry of Health budget will assume most of these annual costs.

Type of Training	Current graduates per year	Annual graduates by EOP (Sept. '86)	Total additional student load during Project	Loan Budget	Counterpart Budget	Notes.
(b) 1-3 month training course for Puskesmas workers in field laboratory techniques	variable	20	80	$6000 toward supporting these 80 students	$6000 toward supporting these students, and operational costs at SMAK	

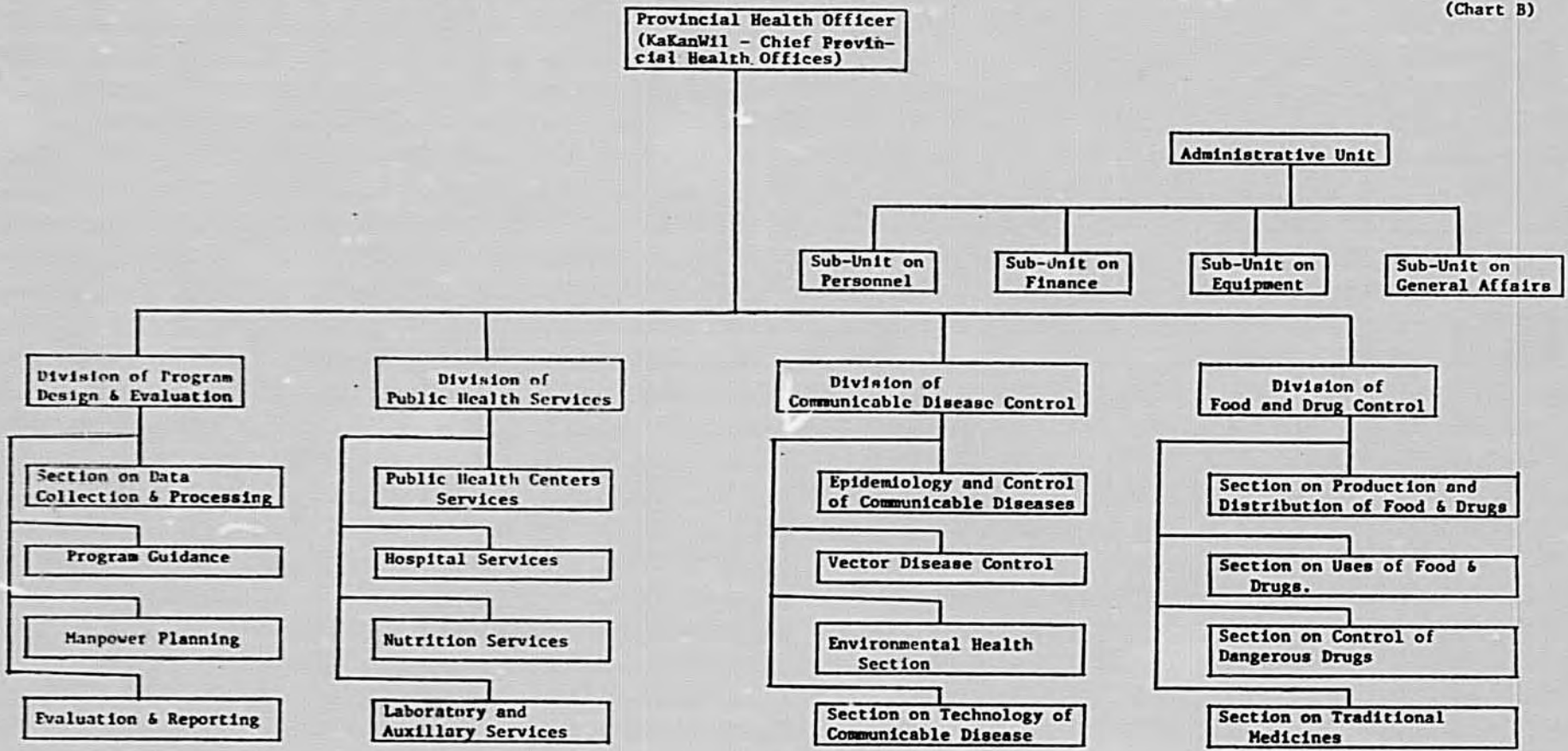
ORGANIZATIONAL STRUCTURE - MINISTRY OF HEALTH INDONESIA

ANNEX I
(Chart A)



ORGANIZATIONAL STRUCTURE - PROVINCIAL HEALTH OFFICE

ANNEX I
(Chart B)



Annex J

CHIPPS PROJECT DEVELOPMENT PROCESS

July 3 , 1980	PID approved in AID Washington
July - October, 1980	Meetings with Depkes and Bappenas to establish agreement for Project development.
Oct.27 - Nov. 2,1980	D.Calder, R.Pratt in NTT with Dr.Diapari, Depkes.
Dec. 7 - 13	Calder in NTT
Jan.26 - Feb.7, 1981	M.Gingerich in NTT
Feb. 2 - 7	Calder, Pratt joint Gingerich in NTT
Feb.10	Calder, M.Gingerich, Pratt meet Dr. Nafsiah Mboy of NTT in Jakarta.
Feb.12 - 20	Calder in D.I. Aceh
Feb.16 - 20	Pratt in D.I. Aceh
March 16 - 20	All provincial Kakanwils in Jakarta for National Health Meeting. Calder, Gingerich, Pratt, have series of meetings with Kakanwils from 3 provinces.
March 30 - April 6	Dr. George Curlin, AID/W and Dr. Tony Sadjimin, Univ. Gajah Mada in NTT. (Reports on file)
April 6 - 10	Dr. Curlin and Dr. Adi Sasongko, University of Indonesia in NTT (Report on file)
April 7 - 11	Calder & Gingerich in D.I.Aceh
April 10-16	Dr. Adi Sasongko in NTT (Report on File)
April 20-26	Dr. Curlin in D.I. Aceh (Report on File)
April 20-24	Gingerich and Pratt in NTT with Ny.Stien Wuntu, Pusdiklat Depkes.
April 28-May 2	Calder and Gingerich in Sumatera Barat
May 8	Sumatera Barat Representative mets in Jakarta with USAID.
May 11 - 14	Regional Pusdiklat meeting to discuss Manpower Training needs. (Included D.I. Aceh and Sumbar).

May 12 - 13	USAID assistance for CHIPPS discussed at IGGI meetings in Amsterdam.
May 19 - 23	Calder and Gingerich in D.I. Aceh
May 19 - 22	N.Studzinski in Sumatera Barat
May 18 - 21	Regional Pusdiklat Meeting to discuss Manpower Training needs (Included NTT)
June 1 - 6	D.Calder, J.Stepanek in NTT
June 1 - 7	Dr. Tony Sadjimin in Sumatera Barat (Report on File)
June 10 - 13	Dr. Gatot NTT planning officer, in Jakarta. Meetings with Calder and Gingerich at USAID, Depkes and Bappenas.
June 23 - 25	Studzinski in Sumatera Barat
July 20 - 24	Dr. James Levinson in NTT (Report in preparation)
Sept. 1981	Dr. Robert Northrup scheduled to be in Sumatera Barat and D.I.Aceh.

AID HANDBOOK 3, App 5C(2)	TRANS. MEMO NO. 3:32	EFFECTIVE DATE July 7, 1979	PAGE NO. 5C(2)-1

5C(2) - PI

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? Yes
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PRODUCT? Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure)?	a) CN submitted 7/24/81 b) Yes
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	a) Yes b) Yes
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	Not necessary
4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?	N.A.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	N.A
6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	a) NA b) No c) No d) No e) No f) No
8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	N.A.
9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.	GOI is contributing 50% of total project cost towards local currency requirements
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes
12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?	NA

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

a) Rural poor will participate in benefits of expanded improved health services delivery.

B.1.a.

basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b) Project will encourage participation of villagers in collaborative health improvement activities.

c) develop capacity of provincial authorities to define and resolve their health problems.

d) women will be major participants in program both as change agents on providers of services and recipients.

c) NA

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

Project is solely designed to carry out this portion of the FAA (104.c.)

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(ii) to help alleviate energy problems;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster;

B.1.b.(4).

(v) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(vi) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

c. [107] Is appropriate effort placed on use of appropriate technology? — Yes

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)? — Yes

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to the Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? — No

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental and political processes essential to self-government. — Health problems of the people have been adequately defined to demonstrate important need for improvement which is often expressed by them. The health officials and community members have demonstrated capacity to perform at sufficiently high level if motivated and supported.

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase or productive capacities and self-sustaining economic growth? — Improved health status will contribute directly to increased labor productivity.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects. — Indonesia has excellent prospects for repaying the loan with its substantial oil resources.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? — NA

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102?

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?