FINAL EVALUATION REPORT

for

CHILD SURVIVAL VII PROJECT
(OTR # PDC -0500-A-00-1 007-00)

INDONESIA

OCTOBER 5, 1994

TABLE OF CONTENTS

APPENDICES

GLOSSARY

ADRA ..... Adventist Development and Relief Agency
ANC ..... Antenatal Care
Bidan ..... Midwife
Bidan Desa ..... Village Midwife
Desa ..... Village
DHO ..... District Health Office
DIP ..... Detailed Implementation Plan
DPT ..... Diphtheria-Pertussis-Tetanus Vaccine
DMO ..... District Medical Officer
Dukun ..... Traditional Healer
Dukun Bersalin ..... Traditional Birth Attendant
EOP ..... End of Project
EPI ..... Expanded Program of Immunization
HIS ..... Health Information System
Ibu Hamil ..... Pregnant Mother
IMR ..... Infant Mortality Rate
Jurim ..... Vaccinator
Kaders ..... Village Health Workers (Volunteers)
Kartu Ibu Hamil ..... Pregnant Mother's Card
Kecamatan ..... Sub-District
KMS ..... Road-to-Health Chart
LBW ..... Low Birth Weight
LKMD ..... Village Development Council
LLU ..... Loma Linda University
MIS ..... Management Information System
MMR ..... Maternal Mortality Ratio
MOH ..... Ministry of Health
OPV ..... Oral Polio Vaccine
Pedoman Hidup Sehat ..... "Facts for Life"
PHC ..... Primary Health Care
PKK ..... Family Life Education Committee
PKMD ..... Village Community Health Development
Posyandu ..... Village Integrated Health Post
Polindes ..... Village Maternity Center
Puskesmas (PKM) ..... Primary Community Health Center
PVO ..... Private Voluntary Organization
Rp. ..... Rupiah = local currency (Rp 2,150 = US$l .OO)
RR ..... Recording/Reporting
TBA ..... Traditional Birth Attendant
TT ..... TetanusToxoid
UNICEF ..... United Nations Children's Fund
USAID ..... United States Agency for International Development
WRA ..... Women of Reproductive Age
YIS ..... Yayasan Indonesia Sejahtera

EXECUTIVE SUMMARY

Project Background

Building on a remarkable track record of successful USAID-funded projects beginning in 1981, ADRA/Indonesia was awarded a Child Survival (CS) Ill grant (1987-l 990) to support diarrhea1 disease control and immunization efforts in 17 primary health centers (puskesmas) in Minahasa district, North Sulawesi, Indonesia. CS VII (the current project, 1991-4) represents a natural outgrowth and expansion of CS Ill in terms of geographic coverage, program interventions and approaches.

The CS VII was prepared specifically in response to and with the active collaboration of the Ministry of Health (MOH provincial and district personnel) of Minahasa district and Sangihe Talaud District. The project area under CS VII covered 34 subdistricts, 667 villages and 50 primary health centers serving a total population of 867,268 persons.

The project's focus on key child survival interventions (maternal and pediatric immunization and nutrition services, the complete range of maternal services, safe water supply and management support) occurred in the broader context of:

1. supporting Ministry of Health staff (in upgrading skills, training and refresher programs for different categories of workers, supervision, health information system management), and,

2. strengthening the "community health system" in order to increase awareness and consequently to enhance effective utilization of available resources.

Accomplishments and Impact

In light of the stated objectives (Section I: Al), the project has demonstrated a positive overall impact. This observation is documented in the detailed description of accomplishments relative to each objective (see Section I: A2).

In summary, significant gains (compared to baseline data) were noted in terms of knowledge and practice Child Survival indicators of maternal and pediatric immunization, moderate improvements in the area of breastfeeding and weaning practices, and marginal changes in modern contraceptive usage.

Although the utilization of qualified professionals and traditional birth attendants (TBAs) for delivery services showed a uniformly consistent pattern over the course of the project period, qualitative assessments revealed significant improvements in the appropriateness and timeliness of referral of high risk obstetric cases by TBAs. (This has been corroborated by MOH data reflecting lowered maternal death rates.) This

finding may be attributable, in part, to the project's TBA training and refresher programs for at least 74% (800 of 1085) of all known/registered TBAs within the project field area and for assistance in their regular supervision. Equipped with UNICEF-type delivery kits and weighing scales, these trained TBAs represent a major success of the project. (These TBAs were also able to correctly identify 43% of newborns as having low birth weight.)

The project can be also indirectly credited with the improvements in the quality (accuracy, completeness) and timeliness of health-related reports generated at the district offices of the MOH as a result of efforts to improve the health information management systems, Although the district MOH offices are not fully utilizing the existing resources (computer hardware and software) at present for lack of time and trained personnel, plans are being made to overcome these temporary obstacles.

Other project accomplishments are in the area of I. improvements in safe water supply in 8 of I I targeted villages; 2. malaria prophylaxis for 300 pregnant women in the highly endemic Tamako area; and, 3. some increases in the percentage of mothers possessing antenatal cards.

Regular interaction by project staff with other private voluntary agencies before and during the project implementation is a positive step in effectively coordinating health and other related activities in a given area. USAID/Indonesia also deserves credit for establishing a mechanism (the 6-monthly PVO workshop) that facilitates this networking process.

As noted in Section I: A3.1.2, the close, continuing collaboration and enthusiastic support from the Ministry of Health at every level (Central, provincial, district, subdistrict, village and community) is perhaps the single most important factor that has contributed to the project's present success and potential for sustainability. By ensuring that project objectives and approaches were congruent with those of the MOH, and by working closely with MOH personnel, the project staff and the implementing PVO have provided an example of an efficient, effective, and sustainable child survival program.

Concerns (C) and Recommendations (R)

I. **c** Under-utilization of health information system management at the district
R Provide additional training and personnel support (if possible) to the MOH

2. **c** Need for improvement in 2-way communication and feedback at different levels (PVO, MOH, Project, USAID et al)
R Establish regular, timely mechanisms for bi-directional information exchange and sharing among all stakeholders

3.	**c**	Lack of consistent use of assessment tools in training activities
	R	Develop (where necessary) and regularly use standardized tools to assess effectiveness, retention etc
4.	**c**	Lack of adequate training and/or experience among some project staff
	R	Screen and recruit appropriately qualified and experienced personnel and regularly supervise/evaluate their work
5.	**c**	Some degree of ambiguity with regard to the role of key personnel at various organizational levels of the PVO
	R	Describe clearly-defined roles, responsibilities and functions at all levels
6.	**C**	Need to monitor that technical assistance given to the project is consistent with the written detailed implementation plan and relevant USAID guidelines
	R	Provide appropriate orientation to technical support staff, consultants and project staff
7.	**c**	inadequate technical, audiovisual and literature resources, health education tools and supplies to support CS activities in the field
	R	Establish a comprehensive, well-equipped Resource center
8.	**C**	Limited motivation for and understanding of program planning and proposal preparation at the project/country level
	D	Provide necessary technical assistance (eg workshops) to support such efforts at the peripheral levels
9.	**c**	Lack of formal agreements with the MOH (and other entities) on the continuation of key CS activities
	R	Obtain written commitments from concerned bodies regarding the sustainability of the program
IO.	**c**	Need for closer, regular supervision, technical support and refresher training for all community/village-based workers
	R	Provision of assistance in needed areas, particularly for the midwife, in view of the recent MOH trend emphasizing the midwife's critical role in overall health care delivery and in TBA supervision
II.	**c**	Small improvements in contraceptive usage
	R	Develop innovative approaches to boost acceptance of family planning methods

I2 c Need for small enterprise development initiatives to augment CS interventions and enhance social-economic welfare of communities
R Plan and establish appropriate, feasible income-generating programs

13. C Pending work to be completed on the water supply project
R Expedite completion of work in the three remaining villages

INTRODUCTION AND BACKGROUND

ADRA/Indonesia's involvement in USAID-funded projects dates back to a 6-year Child Health project in Bandung (1981-7) and a number of projects in other sites (see Section I: A3.1.3). The present Child Survival (CS) VII project (1991-4) builds on an earlier CS Ill (I 987-90) effort which focussed on diarrhea1 disease control and immunization in the communities served by 17 primary health centers (puskesmas) of Minahasa district, North Sulawesi.

Developed in collaboration with the Ministry of Health (MOH) personnel at the provincial and district levels of government, CS VII represents a natural outgrowth and expansion of CS Ill in terms of geographic coverage, program interventions and approaches.

The project area under CS VII includes

1. 27 subdistricts, 40 puskesmas and 565 villages of Minahasa district (population 742,026: 1991) and
2. 7 subdistricts, IO puskesmas and 102 villages of Sangir Besar (population 125,242: 1991), the most populated island of Sangihe Talaud district.

The project's emphasis on key child survival interventions (maternal and pediatric immunization/nutrition, maternal services, safe water supply and management support) occurs in the broader context of

1. supporting MOH staff (in upgrading skills, training and refresher programs for various workers, supervision, health information system management) and
2. strengthening what is described as the "community health system" to enhance effective utilization of resources.

The award of the CS VII grant is justified for a number of reasons:

1. The community needs (as documented in the base-line survey and other national/district data)
2. The rapport that has been carefully built between ADRA/I and the local communities

3. The MOH's strong support and willingness to participate
4. The existence of a well-organized health care infrastructure
5. A capable PVO with a strong track record of accomplishments
6. A feasible proposal that addresses and enables sustainability of key interventions

The specific objectives of the grant are stated under Section I:Al .

EVALUATION METHODOLOGY

The purpose of this Final evaluation (as given in the Scope of Work) is "to address three crucial issues: effectiveness, sustainability, and lessons learned." This document has been prepared in accordance with the guidelines designed by USAID for the final evaluation of Child Survival projects.

The evaluation team (named in Section Ill: Al) consisted of members representing ADRA/International, ADRA/Indonesia, CS VII project, Ministry of Health and Loma Linda University. (Although invited, there was no USAID representative on the team.) They provided a balanced range of experience, culture and perspective which is evident in this report. Their ongoing, collective input, observations, critique and review is gratefully acknowledged.

The following data sources were utilized:

Project documents (including the Detailed Implementation Plan, Annual Report, Mid-term Evaluation Report, Trip Reports, Base-line and Final 30-cluster Survey Evaluation data, and other relevant documents) from the ADRA/International office and the local project site;

Presentations of reports by project staff based in Minahasa and Sangir Besar supplemented by MOH-generated data;

Published and unpublished literature relating to the project, the interventions, child survival approaches, and country demographic/health-related statistics;

Site visits to as many different sites (facilities, centers, clinics, villages, homes, water project stations) as possible within the project area given the limitations of time and distance; (mode of travel via airplane, taxi, boat and on foot). Special effort was made to visit both easily accessible and remote project sites to observe various activities (PKK or LKMD meetings, TBA refresher program, District MOH staff planning session, clinic operations at the primary health centers [puskesmas], village integrated health posts [posyandu), and village maternity centers [polindes], etc). (See **Appendix** 5 for a maps of the various evaluation sites.)

Focal group discussions, structured and participant observations, practical demonstrations coupled with key informant interviews with project staff, members from local communities, village leaders and their wives (who act as the chairpersons of the local women's group, PKK), representatives from local community-based committees and organizations (LKMD, PKK, posyandu and water committees etc), school children, mothers, traditional birth attendants (female and male), village volunteers (kaders), community-based midwives, nurses, physicians, vaccinators, MOH staff at various organizational levels and at various sites, representatives from the police and armed forces who support MOH activities as volunteers, a cross section of the general population through planned and chance encounters, ADRA/International, ADRA/Far Eastern Division and ADRA/Indonesia personnel, and USAID personnel, Jakarta;

Other information resources (reference books, MOH supplements on district-related data, USAID 1993 Report to Congress etc).

A daily log of activities and observations was maintained as a database from which relevant information was abstracted for the final evaluation report. Two rounds of draft copies of the final report were shared both among members of the evaluation team and senior project staff for critique and review. A deliberate attempt was made to ensure that the evaluation process was both participatory and strategic in focus.

Oral presentations of the preliminary final report were made at a joint meeting of all CS VII project staff and MOH staff (district and provincial levels). A separate debriefing session was held for USAID personnel at Jakarta (Ms Barbara J Spaid, Chief, Health and Nutrition Division, Office of Human and Institutional Resources Development and Ms Sri Durjati).

SUSTAINABILITY ISSUES

Please see Section II of the attached Child Survival Final Evaluation guidelines.

SECTION I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. <u>Project Accomplishments</u>

A1. State the objectives of the project, as outlined in the Detailed Implementation Plan.

1.1 95% of newborns begin vaccination series/receiving BCG within 2 months of delivery.

1.2 90% of pregnant women had TT2.

1.3 85% of mothers practicing exclusive breastfeeding up to the age of 4 months.

1.4 85% of trained TBAs practicing weighing of newborns.

1.5 95% of eligible couples are family planning acceptors.
1.6 85% of pregnant women having 3 ANC visits (to trained TBA or to midwife/Puskesmas doctor).
1.7 85% of pregnant women have had at least one ANC visit by a midwife or Puskesmas doctor.
1.8 Increase the percentage of mothers (who) utilize trained TBA or qualified professional at delivery by 20%.
1.9 70% of trained TBAs show records which indicate appropriate referral for high risk and/or emergency.
1.10 11 villages in Sangir having improved potable water sources.
1.11 70% of pregnant women receiving malaria prophylaxis in highly endemic areas.
1.12 90% of PKM submit a monthly summary of key indicators to the DHO.
1.13 80% of TBAs trained with expanded curriculum have monthly supervisory visit.

The DIP also states 4 specific "sustainability outputs" involving approaches that would assist in achieving the above objectives.

Al .a Strengthened community relationships among the desa leadership (desa leader, LKMD and PKK), the posyandu and the TBA, collectively referred to as 'the community health system.'
A1.b MOH staff trained and experienced in training of TBAs for an expanded role within the limits of government policy.
Al .c Expanded role of TBAs within the limits of government policy.
Al .d Trained community health mobilizers effectively utilizing local community structures for health promotion of specific MCH behaviors; increased demand for appropriate services.

A2. State the accomplishments of the project related to each objective.

A3. Compare project accomplishments with objectives and explain the differences. Describe any circumstances which may have aided or hindered the project in meeting these objectives.

The objectives may be categorized as those relating to

1. Immunization (maternal and pediatric)
2. Nutrition (maternal and pediatric)
3. Maternal services (including malaria prophylaxis)
4. Safe water sources
5. Management functions (reporting and supervision).

The following assessment is based on a review of all evidence (qualitative and quantitative) as given in the earlier section, Evaluation Methodology. In keeping with the format used in earlier documents, reference is made to each geographic area separately, Minahasa (M) and Sangir Besar (S).

2.1 Although only 85/72% (M/S) of infants received BCG by 3 months of age, 86/84% (M/S) were immunized before becoming a year old.

Compared to baseline survey data (1991), there is evidence of significant improvement in the relevant Child Survival indicators of

a. EPI Access (DPTI rate): 68/79% (M/S)
b. EPI Coveraae (OPV3 rate): 44/73% (M/S)
c. EPI Measles coveraae and (Immunization completion): 69/84% (M/S)
d. EPI Drop Out Rate: 0% (M and S)
e. Immunization knowledge: Timeliness of measles vaccine: 83/82% (M/S)

These achievements are even more notable given the comparative national data for these indices (Table 1).

2.2 The percentage of mothers who received two doses (card-documented) of Tetanus toxoid were 89196% (M/S). These figures are nearly double that of country-wide estimates (Table 1). The percentage of mothers who knew that tetanus toxoid protects both the child and the mother was 78/90% (M/S), two to four times higher than baseline values.

2.3 Exclusive breastfeeding until the age of 4 months was practiced among 71/67% (M/S). Although these percentages are less than the objective (85%) they represent marked increases over the baseline data. In addition, a higher percentage of mothers (81/89% M/S) reported initiation of breastfeeding within the first 8 hours after birth.

The percentage of infants (5-9 months old) who are being given solid or semi-solid foods are 92/100% (M/S); these data are more than twice that of baseline figures.

The rates for persistence of breastfeeding (ie of children between 20-24 months of age) have remained uniformly high (>90%) during the project.

The rates from the 1994 survey compare very favorably with national estimates (Table 1).

2.4 All ADRA-trained TBAs (600 in Minahasa District and 200 in Sangir) know how to weigh newborns and have been provided with weighing scales and delivery kits. Based on available information, all trained TBAs are regularly practicing this skill. These trained TBAs conducted 8091 deliveries between April 1992 and June 1994 and correctly identified 3507 (or 43%) of these newborns as being in the low birth weight group (ie < 2500 grams birth weight).

2.5 The modern contraceptive usage proportion among eligible mothers, currently 80/79% (M/S), falls short of the stated objective. While the rates have remained fairly constant during the project, the usage prevalence is much higher than the national average of **50% (Appendix 1: Table 1).**

2.6 From the survey findings, it was not possible to assess this objective. However, about 95% of pregnant women in both project areas (M and S) have 2 or more documented antenatal visits.

2.7 All the mothers (100/100% M/S) had at least one antenatal visit prior to the birth of the child (card documented). The percentage of mothers who knew that pregnant women should start antenatal care before the third trimester revealed only a marginal increase in the final evaluation (90/92% M/S).

A women's health card is an important instrument to evaluate access and coverage. Although the percentage of mothers with a health card (31/47% M/S) is between 7(M)-26(S) times greater than that observed in 1991, more effort needs to be directed in this specific area. ADRA deferred its decision to print the women's health cards after learning that the MOH was introducing these cards in September 1993. It is assumed that over time these percentages would increase as the cards become more widely available.

2.8 The percentage of mothers who utilize qualified professionals (physician, nurse, midwife) is presently estimated to be 67151% (M/S). Given the inability to distinguish between "trained" and "untrained" TBAs from the survey instrument, the estimated percentages of deliveries attended by a TBA are 33/48% (M/S). Of the 1085 known ("registered") TBAs in the two districts, 800 (74%) have participated in the ADRA training and refresher programs.

A consistent pattern of utilization of qualified professionals versus TBAs is apparent over the 3-year period, 1991-4.

These data must also been studied in the context of national data which states that only 32% of deliveries were attended by trained health personnel (ie professional and TBA taken together).

2.9 Qualitative assessments based on the views of midwives, nurses and physicians indicate that the majority of TBA-initiated referrals for high/risk and emergency obstetric care appear to be appropriate and timely. Corroborative evidence is also available from the estimated decrease in maternal mortality ratios and from interviews with TBAs and the community.

2.10 Of the 11 targeted villages in Sangir Besar, preparatory work (eg the protection or "capping" of the spring, construction of the storage or sedimentation tank etc) has been completed in 8 villages. The pipes (constituting part of ADRA/I's match) is reported to have arrived at the port; however, some major delays as a result of bureaucratic red-tape have prevented the pipes from being cleared and transported to the project sites. The storage tank attached to an existing spring was also repaired.

2.11 The malaria prophylaxis project was a focused activity (designed as a randomized clinical trial) involving around 300 pregnant women in the Tamako area (Sangir Besar), a highly endemic area. The objectives of the study were to demonstrate that the use of chloroquine prophylaxis in pregnancy reduces the incidence of malaria, increases birth weight and hemoglobin. This program/study has been absorbed into the Sangihe Talaud district health services since 1993 (after the midterm evaluation) and is being continued by Dr Paul Manoempil (DHO) in fulfillment of his MPH dissertation requirement at the National University of Singapore.

2.12 All puskesmas (government health centers) submit monthly reports of key indicators to the DHO. The DHOs noted a significant improvement both in the quality of data (accuracy, completeness) and in the timely/regular submission of reports.

Credit may be given to the project for specific efforts in providing intensive training in setting up and managing health information systems to MOH staff (particularly, from the Recording and Reporting Department) at the provincial, district and subdistrict levels with special emphasis on Child Survival activities and interventions. In addition, the project staff conducted a comprehensive survey of TBAs (number, practices etc) and a determination of neonatal deaths in two districts from September 1993 to January 1994 as part of neonatal tetanus surveillance. These findings were useful to the MOH in verifying their own data as well as in planning appropriate programs for these communities.

2.13 All trained TBAs have at least a monthly supervisory visit. In addition to the monthly opportunity afforded via the posyandu (village integrated health post), TBAs are also supervised and offered technical support (as needed) in their respective villages.

3.1 Circumstances/Factors that AIDED the project in meeting the objectives

A3.1.1 The Local Community

Significant participation and involvement of communities in various project activities illustrated by a few examples:

- The water supply project in Sangir Besar: contribution of labor or manpower and all construction materials (except pipes)
- Construction and maintenance of the polindes (or village maternity center)
- Regular public announcements by the village chief regarding forthcoming health activities, eg immunization
- Active community organizations that provide necessary administrative support, supervision, eg the LKMD (Village development council), the PKK (village women's club chaired by the chiefs wife), the posyandu and polindes committees
- Motivated community-based health workers, eg the TBAs, the kaders (volunteers)
- The receptiveness of the individual families to project activities and the consequent utilization of health and other related services

A3.1.2 The Ministry of Health (MOH)

The close, continuing collaboration and enthusiastic support from the MOH at every level (Central, Provincial, District, Sub-District, village or community) is perhaps the single most important factor that has contributed to the project's present success and future sustainability. Evidence to support this observation:

- Efficient and effective coordination and planning of program activities using the existing health infrastructure (including personnel, facilities, supplies, equipment, vehicles, training/instructional materials etc)
- Involvement and support for the various training programs for health personnel and their ongoing supervision
- Strong commitment (official and personal) at all levels to improve the health status of the community (specific departments: Maternal/Child Health, Family Planning, Nutrition, Immunization and Health Education)
- Use of practical approaches to achieve objectives. For example, the jurim (or vaccinator, a uni-purpose health worker) who does not meet his

monthly immunization target will conduct a door-to-door "sweeping" operation focusing on defaulters; use of a simple pictorial form (to identify high-risk pregnancies for referral) to simplify recording/reporting by illiterate TBAs

- Clear statement of job description and responsibilities for each staff

A3.1.3 ADRA

ADWIndonesia has demonstrated a track record of successful USAID-funded projects dating back to the 6-year Child Health project in Bandung (1981-7). ADRA/Indonesia has been involved with other USAID projects in Kupang (1986-89), Alor (1988-91), Irian Jaya (1989-91) and Child Survival Ill (1987-90) focussing on diarrhea1 disease control and immunization in 17 puskesmas located in the Minahasa district. CS VII (the current project) represents a natural outgrowth and expansion of the previous project in terms of geographic coverage, program interventions and approaches.

Complementing the experience and skills gained through program planning and management, ADWIndonesia has successfully created and maintained close, working relationships with

- the local communities in Minahasa and Sangihe Talaud districts;
- the MOH personnel at all organizational levels;
- other PVOs and agencies involved in similar work (eg, PATH, UNICEF, PCI and through the USAID-sponsored PVO Network Program);
- ADRA/International and ADRA/Far Eastern Division which have provided regular, ongoing technical support throughout the project; and
- USAID/Indonesia.

The remarkable rapport with the community enjoyed by ADRA staff was specifically noted during the current evaluation. The receptiveness and support of the people is no doubt a function of the significant time and effort spent by ADRA personnel (in conjunction with MOH staff) in acquiring knowledge of their beliefs and practices, gaining their confidence and acceptance, understanding their felt needs and collaboratively creating feasible solutions.

A3.1.4 USAID

The financial and technical support provided by USAID (Headquarters and Country) personnel is gratefully acknowledged. USAID/Indonesia also helped establish an effective mechanism (a 6-monthly workshop) for local PVOs to interact, problem-solve and network. ADRA/Indonesia had the opportunity to host a workshop in Bandung in October 1992. Project staff also attended the most recent workshop held in Lombok, September 8-10, 1994. USAID assisted the Project Director to attend a training workshop in Farmington, New Mexico, USA in June 1992.

A3.1.5 The Government of Indonesia

Ranking fourth in population among all countries (191 million in 1992), Indonesians inhabit more than 6000 of the 13,600 islands and live in a predominantly (70%) rural environment. The country has had a stable political climate and a rapidly growing economy (The 1991-based GNP per capita is US$ 610). According to Dennis de Tray, director of resident World Bank mission in Indonesia, the country has succeeded in lowering the percentage of people living below the poverty line from 60% of its population in 1970 to 15% in 1990 (The Jakarta Post, September 16, 1994).

The government has improved inland transportation by constructing new roads. The efforts of the Ministry of Health in formulating and implementing a functional model of socialized medicine are noteworthy. In 1945, less than 10% of Indonesia's people could read or write. Following sustained educational efforts, the literacy rate (1990) for males and females is 88% and 75% respectively. The percentage of mothers who are literate in the project site (1994) continues to be very high (93/98% M/S). All these factors, taken together, have enhanced the project's ability to achieve stated goals.

A3.2 **Circumstances/Factors that HINDERED the project**

A3.2.1 A sub-optimal Health Information System (HIS) which is weakest in the more peripheral, remote project areas. This results in inaccurate and incomplete reporting.

A3.2.2 Inadequate staffing of health facilities particularly in remote areas. The problem is aggravated by a rapid turnover rate for nurse/midwives and the absence of polindes (village maternity center) in all villages.

A3.2.3 Traditional, social-cultural customs, beliefs and practices that adversely impact on project activities. Resistance to change among the older, decision-makers including some TBAs, some of whom are illiterate. At the request of the MOH, the project has adopted certain villages categorized by the government as lagging behind in health care availability and consequently having lower health status. The additional challenges presented by these communities, have resulted in relatively slower rates of progress and change in health status indicators.

A3.2.4 Transportation still presents serious problems especially in the rural, remote areas and those which may be reached only by boat. Furthermore, the ocean is known to be rough during nearly 9 months in the year making travel very hazardous. The two project districts, located in North Sulawesi province, are linked by a not-so-dependable airline (flying thrice a week) and by a 12-hour boat ride. A project vehicle in Minahasa District broke down in March 1994 and has not been repaired

for want of a part. As a result, the project has had to rely on hiring local transport in recent months. The other project vehicles (4 motorcycles) are in working condition.

A3.2.5 The Indonesian motto "Bhinneka Tunggal Ika" ("Unity in Diversity") is illustrated by the fact that within the Indonesian population there are more than 300 different ethnic groups and 250 distinct languages and that most of the world's major religions are practiced here (87% Muslim; 9% Christian; 2% Hindu; Buddhist and other 2%), in addition to a wide range of indigenous ones. This diversity poses additional challenges to the project.

A3.2.6 Unforeseen delays in procuring the pipes (for the water supply project) and obtaining clearance at the port.

A3.2.7 Implementation of new short-term program activities based on the recommendation of technical consultants or in response to local requests but not included in the original DIP. Examples include the CHILD-to-child program, the de-worming project, village health insurance and drug posts. These activities (laudable as they are) detracted from efforts to fulfil originally stated objectives.

A4. Describe unintended benefits of project activities.

Other than the programs referred to under Section A3.2.7, there have been no unintended benefits of project activities. If any, this project has only served to strengthen and enhance the quality and coverage of health care services for targeted mothers and children which constitutes the very basis for this intervention.

A5. Attach a copy of the project's Final Evaluation Survey, and state the results for each relevant indicator. Please be sure the results include numerator and denominator information, as well as percentages for each indicator.

Please refer to **Appendix 1 (Table 1)** for a report of relevant child survival indicators for Minahasa and Sangir.

Also attached is a copy of the Projects Final Evaluation Survey (Dr Solomon Wako, ADRA/I et al. **Appendix** 2 TO BE ATTACHED BY DR WAKO)

SECTION I B. Project Expenditures

B1. Attach a pipeline analysis of project expenditures.

Please see **Appendix 1: Table 2.**

B2. Compare the budget contained in the approved DIP with the actual expenditures of the project. Were some categories of expenditures much higher or lower than originally planned? Please explain.

Subsequent to the initial budget submitted along with the original DIP, a revised budget was prepared and sent to USAID for approval. To date, formal approval of the revised budget has not been received. The pipe-line analysis (Table 2) is based on the revised budget.

Clarifications on certain line items:

1. The budget for expatriate services/consultants is underspent. However, this figure does not include the expenses that will be incurred with the end of project audit-related expenses.

2. The budget for evaluation appears to be grossly overspent. (The figure includes the estimated costs of the current evaluation.) It appears that the costs of conducting 3 evaluations (base-line, mid-term and final) may have been be underestimated.

3. Administrative/Personnel (under Program costs) expenses are greater than that budgeted, reflecting, in part, the travel and related expenses incurred as a result of significant input from ADRA/Far Eastern Division during the initial part of the project. This was necessitated by certain unforeseen, temporary administrative changes in ADRA/Indonesia personnel directly responsible for the CS VII project. It should be noted, however, that these additional costs are borne by the PVO and not USAID.

4. In-country travel costs exceed the budget by $5644.50. This may be explained by the lower estimated costs in the initial budget and the need to hire vehicles because of frequent breakdown of the project jeep (which was acquired under the earlier CS III project.) The jeep has not been in use for the last 5 months due to the lack of a part.

5. Overall, 15% of the budget has been underspent.

B3. Were project finances properly handled?

Yes, in general, project funds were handled in a competent manner.

- Timely, and regular technical assistance has been provided by the following people from ADRA/I: Robert Brock, Elwin David, Ed Baber who travelled to Indonesia on, July 1992, December 1993, February 1994 respectively. They assisted in the setting up of the AAA accounting system and the training of necessary personnel.
- Preparation of monthly statements of project finances with copies sent to ADRA/Indonesia, ADRA/FED and ADRA/I. The statements were also presented during monthly staff meetings.
- The project has been audited annually (two, so far) by Peter Christiansen, a USAID-approved auditor. The end of project audit is scheduled for October 21-3, 1994. Only a draft copy of the first annual audit is available. There are no obvious discrepancies. No other audited statements are available at present.
- Project finances are managed by Ms. Debbie Jacobs, a college graduate accountant with over 8 years experience. She maintains adequate internal control mechanisms.

B4. Were there lessons learned regarding project expenditures that might be helpful to other PVO projects, or relevant to USAID's support strategy?

Budget items should be carefully estimated (with appropriate justification) as early as possible in the planning process and be closely related to the specific program activities.

SECTION I C. Lessons Learned

Outline the main lessons learned (regarding the entire project) which are applicable to other PVO C.S. projects, and/or relevant to USAID's support of these projects.

C.I Successful projects (such as the one under review) have the following ingredients:

a. Maintain proactive relations with all stakeholders. (See Section I A3.1.3)
b. Develop sustainable activities that are community-based and -supported. (See Section II)
c. Ensure that program objectives are congruent with those of the relevant government ministry mandates.
d. Avoid creating a dual or parallel health care delivery system.

e. Enable the PVO to function as a catalyst or facilitator in promoting change.
f. Promote interaction of the implementing PVO with other PVOs/or peer agencies.
g. Are based on clearly stated objectives and feasible methodologies which finally allow for critical evaluation.
h. Underline the need to train other "trainers" and to provide ongoing refresher education.
i. Employ good management practices (including regular supervision).
j. See Section I B4.

SECTION II. PROJECT SUSTAINABILITY

A. Community Participation

A1. Please identify community leaders and members interviewed and indicate which group(s) the leaders represent.

Please refer to **Appendix 1 Table** 3 for details.

A2. Which child survival activities do community members and leaders perceive as being effective in meeting current health needs?

A2.1 The expanded role (specifically in health education and promotion) of TBAs (and kaders) and their additional training and supervision.
A2.2 A functioning PKK (village women's club) which takes an active role in health-related activities.
A2.3 The regular contacts with community leaders (formal and informal) and in promoting community participation in decision-making (eg in the water project in Sangir).
A2.4 The increased access to maternity services (through the polindes) and MCH services (through the posyandu).

A3. What activities did the PVO carry out 1. to enable the communities to better meet their basic health needs and 2. increase their ability to sustain effective child survival project activities?

A3.1.1 Assisted the MOH in increasing/expanding the quality/coverage of health care services particularly in remote, medically under-served communities.
A3.1.2 Provided technical support, training and some limited equipment for health personnel (midwives, TBAs and kaders).

A3.1.3 Participated in specific activities addressing basic health needs (eg the water project, malaria prophylaxis for mothers, Vitamin supplementation for new mothers etc).

A3.2.1 By working closely with the MOH in training programs (midwives, TBAs), in health education/promotion activities, and in the provision of health care services (at the polindes, posyandu and puskesmas). (A evaluation team member, Dr Bonny Kalenseng, Director of Puskesmas, reported that at a Central MOH meeting he recently attended, a resolution was passed to budget for all training activities in the project areas beginning October 1, 1994: documentation awaited.)

A3.2.2 By ensuring broad-based community participation and support (in the form of personnel, time, facilities, supervisory committees and other local resources) in all program activities (eg the water project, establishing polindes).

A3.2.3 By focused training and orientation programs for community-based workers (TBAs, midwives, kaders), the project helped increase health-related knowledge, modify health behaviors and promote increased demand for and utilization of available heath care services. (Please see **APPENDIX 1 Table 4A and 4B)**

A4. How did communities participate in the 1. design, 2. implementation and/or 3. evaluation of child survival activities?

A4.1 The CS VII was, in effect, a response to a proposal from the provincial and district health officials and was based on a review of regular community-based reports of health status and discussion with formal and informal community leaders and other members. The needs and approaches were further refined during intersectoral meetings (PKK, LKMD and counterparts in the development sector.)

A4.2 The CS VII interventions were designed to ensure community participation. This occurred in the form of planning and construction of polindes (villages maternity centers), procurement of supplies and construction relative to the water supply project, holding regular meetings of the PKK, LKMD, polindes and water committees to provide management support, support for the training of community-based workers (TBAs, kaders) and an increased utilization of their services.

A4.3 The community actively participated in the formal 30- cluster survey (baseline and final evaluations) and other ongoing qualitative assessments by project staff. Regular discussions and feedback were also given during the monthly posyandu meetings.

A5. 1. What is the number of functioning health committees in the project area? 2. How often has each met during the past six months? 3. Please comment on whether committee members seem representative of their communities.

A5.1

Committee	Minahasa	Sanair Besar
LKMD (Health)	565	102
PKK (Women's Gp) 565	102	
Posyandu	1253	195
Polindes	33	24
Water		11

A5.2 Except for the polindes committee which meets two times or more per month during the initial period (ie prior to the construction or acquiring of the facility), all other committees meet once a month.

A5.3 In general, committee members are selected to represent a cross-section of the local community as well as its leaders.

A6. What are the most significant issues currently being addressed by these health committees?

The LKMD subcommittee on health and the PKK address current health and developmental needs in the community (including the need to initiate income-generating activities) and to determine methods to increase the effectiveness of the posyandu and polindes. The water and polindes committees address planning, implementation and maintenance issues.

A7. Please give specific examples of the methods used by the committees, and of their precise role in providing direction to the project.

The committees arrive at a decision by consensus after discussions among members and after receiving considerable input from the community as well. The committees assist in management, administrative and supervisory functions (eg delegation of specific responsibilities, collection of funds, review of problems, and interaction with the project staff, MOH-related and other governmental personnel).

A8. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

The community (in the 11 targeted villages) has established a committee and contributed labor, supplies (except pipes) and other financial support for the construction and maintenance of clean water supply. Similarly, the polindes (village maternity center) is either constructed as a new building or an existing facility acquired

solely as a community investment. Fees are charged for services provided and a polindes committee provides management support.

Some of the responsibilities of the PKK (Village women's club) includes preparation of food for the nutritional supplementation program at the monthly posyandu, motivation of mothers (along with their children) to attend regularly (for antenatal care, immunizations, nutritional monitoring etc), and collection of money to support the annual refresher training program for TBAs from their respective communities.

A9. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

Despite the relatively low social-economic environment in rural areas, the project has registered noteworthy successes, in part, due to the commitment of the community (and the committees) towards achieving better, healthier living conditions. Those communities which have specifically benefitted from establishing polindeses and/or from improved water supply rightfully take pride and a sense of ownership in these accomplishments. The high levels of literacy (both male and female) have also effectively complemented the project's health education and promotion efforts, and consequently led to better utilization of services. Such an enlightened, committed community, given the necessary minimal technical support and opportunities, could serve as a model for economic self-sufficiency and an efficacious primary health care system.

SECTION II B. Ability and Willinaness of Counterpart Institutions to Sustain Activities

B1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.

Please see APPENDIX 1 Table 3.

B2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)?

B2.1 The project has developed and maintained functional linkages with Ministry of Health (Village, sub-district, district, province levels), Ministry of Family Planning (Provincial level), Ministry of Women's Affairs and Ministry of Education & Culture (District level, and other PVOs: PATH (weighing scales, training modules etc); Helen Keller International (Vitamin A supplementation); YIS, an Indonesian-based foundation (project field staff training); and the USAID-sponsored PVO network which meets every 6 monthly.

B3. What **are** the key local institutions the PVO expects to take part in sustaining project activities?

83.1 The primary agency will be the Ministry of Health at the various levels which has pledged continued support for all of the project-related activities, including the training programs. (Written confirmation of this commitment is not yet available.) The major points in the health care delivery system (puskesmas, subpuskesmas, posyandu, polindes) will continue to provide necessary services to the community.
It must be noted that at the village level there is an integrated, intersectoral system involving the Armed Forces (who donate 3 months in the year for community service), the Police and government health and developmental agencies working together with the community.

83.2 The ultimate responsibility in sustaining project activities will rest with the community - its leaders, kaders (volunteers), TBAs, and the various active committees (LKMD, PKK, polindes, water etc). The current picture augurs well for future viability of key activities.

B4. Which child survival project activities do MOH personnel and other staff in key local institutions (including counterpart organizations) perceive as being effective?

The training and orientation programs for various categories of health personnel as part of the overall human resource development efforts.

Training programs for implementing a functional health information system **and** the general support (at various levels) to ensure reliable, accurate and complete reporting of key health, vital statistics and demographic data.

Specific mention was made about the usefulness of the baseline and final evaluation in terms of the methodology used and the findings. A comparative review of survey data with MOH-generated information is being planned.

B5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once USAID funding terminates?

Please see response to Section I A3, Section II B4 and **Appendix 1 Table 4A and B** which summarizes the training, refresher and orientation programs conducted by the project.

B6. What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

Please see Section II. A3, A4, A9 and B3.

B7. Are there any project activities that counterpart organizations perceive as effective?

Not applicable.

B8. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

As discussed earlier, the project mission and activities have been consonant with those of the Ministry of Health from the beginning. As such, the project and the MOH have been closely integrated throughout the life of the project. As the project winds down, the MOH is fully capable of and committed to continuing all key project activities.

B9. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

To our knowledge, the assumption that MOH would sustain project activities after September 30, 1994 has not been documented although verbal assurances have been received from health officials at the Provincial and District levels.

B10. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

Not applicable.

Bl 1. Identify in-country agencies which worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

Ministry of Health (various levels)
ADRA/Indonesia/Far Eastern Division/International
Johns Hopkins University
Loma Linda University
School of Medicine, Gadjah Mada University
Project staff CS VII including 2 staff who are seconded from the MOH (serving as MCH Coordinators in the project for each District).

SECTION II C. Attempts to Increase Efficiencv

C1. What strategies did the PVO implement to reduce costs, increase productivity, or otherwise make the project efficient?

C1.1 Maintaining close collaborative linkages with the Ministry of Health (all levels) in proactive planning, implementation and evaluation activities thus avoiding duplication of scarce resources and services. This constitutes the one most effective strategy.

C1.2 Promoting involvement and active participation of the community in all program activities (examples given earlier).

C1.3 Strengthening community-based health infrastructure systems (personnel, other resources,).

C1.4 Focussing on training programs for different categories of health workers (particularly TBAs, midwives, kaders) by incorporating the training-of-trainers concept as an primary approach.

C1.5 Emphasizing health promotion and education in all program activities and training.

C1.6 Networking with other PVOs (eg PATH), adopting their successful strategies, benefiting from their experience, and by sharing resources (scales, training materials etc).

C1.7 Project work schedules were also so planned to allow for multiple activities to be satisfactorily completed using the minimum of visits to the field (thus cutting down fuel costs, time, vehicular wear-and-tear etc).

c2. What are the reasons for the success or failure of the attempts to increase efficiency of this project?

Please see response to C1.

There was some MOH-generated shifts in program emphases almost midway through the project implementation (eg the introduction of the polindes program and the new role of the village nurse/midwife as a key player in health care delivery.) Project staff had to adapt and modify certain strategies to incorporate the changes.

Additionally, project staff took upon themselves to implement various suggestions and recommendations from individual technical consultants. Some of these valid ideas, however, did not fall within the original DIP guidelines and resulted in temporary deviations from the primary objectives. Valuable time was also lost in the pursuit of these extra-DIP activities.

c3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to USAID's support of these projects?

Please see responses to C1 and C2.

SECTION II D. Other

F1. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

F2. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

F3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

The responses to the above questions have been covered adequately earlier, particularly in Section II (sustainability).

III. EVALUATION TEAM

A1. Identify by names, titles and institutional affiliations all members of the final evaluation team.

Solomon Wako, PhD, Director of Evaluation, ADRA/International
Iim Heriyana, MA, MHSc, Country Director, ADRA/Indonesia
Roosye Raranta Senduk, MPH, Project Director, CS VII, Manado
Bonny Kalensang, MD, MCH Project Coordinator for Minahasa (also seconded doctor from MOH for CS VII)
Wenang Tansuria, Project Coordinator for Sangir (also seconded doctor from MOH for CS VII)
Jayakaran S Job, MD, DrPH, FACPM, Loma Linda University, External consultant

A2. Identify the author of the evaluation report.

Jayakaran S. Job, MD, DrPH, FACPM (primary author) with significant input, critique and review from every member of the evaluation team.