

**JAYAWIJAYA WOMEN AND THEIR CHILDREN'S
HEALTH PROJECT**

**Project Documentation Consultancy
Primary Health Care Model**

by

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GLOSSARY & ACRONYMS

AIDS	: Acquired Immunodeficiency Syndrome
AIDAB	: Agency for International Development Assistance Bureau
AusAID	: Australian Agency for International Development
Bappeda	: Badan Perencanaan Pembangunan Daerah (District or Provincial Development Board)
Bappenas	: Badan Perencanaan Pembangunan Nasional (National Development Planning Board)
Bangdes	: Pembangunan Desa (Village Development)
Bidan Desa	: Village midwife
BKKBN	: Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordination Board)
Camat	: Chief of Subdistrict
CBR	: Crude Birth Rate
CMP	: Case Management Protocol
Dana Sehat	: Village health insurance fund
Dikswa	: Pendidikan Swakarsa (self learning course for nursing)
Diploma III	: Continuation Course for Nurses (who have already a nursing school diploma)
DHO	: District Health Office (Kandep)
DHS	: District Health Service (Dinas)
DIK	: Daftar Isian Kegiatan (Routine budget)
DIP	: Daftar Isian Proyek (Development budget)
IDT	: Inpres Desa Tertinggal (Presidential Instruction to assist poor villages)
GOI	: Government of Indonesia
IMR	: Infant Mortality Rate
Inpres	: Instruksi Presiden Presidential Instruction)
HFA	: Health For All
HIS	: Health Information System
JPS	: Jaringan Pengaman Sosial (Social Safety Net)
Kabupaten	: District
Kanwil Depkes	: Kantor Wilayah Departemen Kesehatan (Regional Office of MOH)
Kecamatan	: Sub-district
Kelurahan	: Ward or administrative unit in a municipality equivalent to a village.
LEISA	: Low External Input Sloping Agriculture
LKMD	: Lembaga Ketahanan Masyarakat Desa (Village Community Resilience Agency)
MAF	: Missions Aviation Fellowship
Mantri	: Male nurse /health assistant
MCH	: Mother and child health

MOH	: Ministry of Health
MMR	: Maternal Mortality Rate
MSF	: Medicines Sans Frontiers
NGO	: Non Governmental Organization
NIHRD	: National Institute of Health Research and Development
PHC	: Primary Health Care
PKK	: Pendidikan Kesejahteraan Keluarga (Family Welfare Education Movement)
PKMD	: Pembangunan Kesehatan Masyarakat Desa (Village Community Health Development)
PLA	: Participatory Learning Activities
Posyandu	: Pos Pelayanan Terpadu (Integrated service post)
POD	: Pos Obat Desa (Village Drug Post)
PRA	: Participatory Rural Appraisal
Prokesa	: Promotor Kesehatan Desa (Village Health Promotor)
Puskesmas	: Pusat Kesehatan Masyarakat (Community Health Centre)
Pustu	: Puskesmas Pembantu (Community Health Sub-centre.
PTT	: Pegawai Tidak Tetap (Non-permanent staff) e.g. PTT Doctors who are contracted to work in rural areas for 3 years
PPSE	: Panitia Pembangunan Sosial Ekonomi (Committee for Social Economic Development)
Repelita	: Rencana Pembangunan Lima Tahun (Five Year Development Plan)
Satgas Papua	: Satuan Tugas Papua (Papua Task Force)
SPK	: Sekolah Perawat Kesehatan (Health Nursing School)
UNDP	: United Nations Development Programme
UNICEF	: United Nations Children's Fund
UNV	: United Nations Volunteers
UPGK	: Usaha Peningkatan Gizi Keluarga (Movement For Family Nutrition Improvement)
WATCH	: Women and Their Children's Health
WHO	: World Health Organization
WVA	: World Vision Australia
WVII	: World Vision Indonesia International
YAKKUM	: Yayasan Kristen Untuk Kesejahteraan Umum (Christian General Welfare Foundation)
YKB(IRJA)	: Yayasan Kesehatan Bethesda (Bethesda Health Foundation in Irian Jaya)
YIS	: Yayasan Indonesia Sejahtera (Indonesian Welfare Foundation)

**JAYAWIJAYA WATCH - KANGGIME EXTENSION PROJECT
PRIMARY HEALTH CARE MODEL
PROJECT DOCUMENTATION CONSULTANCY**

**by
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1. Introduction

Jayawijaya district is located in the central highlands of Irian Jaya/Papua Province. It has an area of 52,916 km² or larger than the provinces of West Java and Banten combined. Geographically it is a rugged mountainous area with altitudes varying between 100m and 4,750m and has a population of around 426,640. The population density is 8 per km². Administratively the district is divided into 28 sub-districts, 274 villages and 5 kelurahans (urban villages).

Maternal and infant mortality in the district is high (estimated at 450 per 100.000 live births and 98 per 1000 live births respectively). Major health problems include respiratory infections, diarrhea, malnutrition, and increasing incidence of malaria. The district is poorly serviced with health centres and travel is difficult; the population is scattered and human resource levels are low. Added to this list are the problems of poverty, social change and dislocation, women's low status, low education, low nutritional status, lack of clean water, poor sanitation, periodic famine, spread of sexually transmitted diseases (including AIDS) and political unrest.

The Jayawijaya WATCH (Women and Their Children's Health) project started in 1991 and has been working in this context to address many of the issues listed above in the frame of an integrated and primary health care approach. The project is funded by the Australian Agency for International Development (AusAID), and administered under the umbrella of the bilateral program with the government of Indonesia. The project is managed through World Vision Australia (WVA) and implemented by World Vision International Indonesia (WVII) in collaboration with the Indonesia Department of Health in the district of Jayawijaya. The total cost of the project (1991-2000) was almost AUD\$ 2.7 million.

The essence of the project is a concern for primary health care (PHC), especially for women and children. The project is seeking not only to assist in solving clinical problems but also the root causes of ill-health such as poverty, gender imbalance and lack of community organization. The activities have had to adapt to the dynamic social and political conditions. The current situation where the drive towards autonomous districts and the development of a more vocal independence movement have made this a complex district. The project is particularly challenging because of the intercultural context in

which it is embedded.

The clash in Wamena between the Papuan task force (Satgas Papua) and government forces in October 2000 led to the evacuation of all project staff and a premature closure of the project.

The writer was asked in December 2000 to describe and analyze the developments of the primary health care model as used by the WATCH project in Jayawijaya district and the extent to which this has formed a new model, appropriate for the highlands in Irian Jaya/Papua.

The writer was in Wamena and Kanggime from 19 July to 4 August 1999 for a project documentation consultancy where he observed some activities of the WATCH project and met over 50 staff members of WATCH, government officials and representatives of non-government organizations collaborating with the project.

Between 15 December 2000 and 15 January 2001 the writer studied the documents related to the project available from the WVII office in Jakarta and he also interviewed some officials from the Ministry of Health, UNICEF and project staff in Jakarta.

2. History of the Jayawijaya WATCH project

2.1 Project Origin

A review of the history of the project was prepared by Sarah L. Hewat and Robert J. Hewat and this can be summarized as follows.

The project was first conceived in mid 1989 in response to a call by AIDAB (AusAID since 1995) for submissions for projects in eastern Indonesia focussing on women and their children's health. World Vision Australia (WVA) and World Vision International Indonesia (WVII) established a feasibility team and selected Jayawijaya district as an appropriate location for two reasons. First, the 5th National Five Year Development Plan (Repelita V) had identified, Jayawijaya as an extreme backward region which was to be a high priority target for development programs by all sectors. Secondly, WVII had extensive experience in the district having worked on five projects there since mid 1970s.

The project would have to be implemented and managed under a partnership arrangement with the Provincial and District Health Offices and would be responsible both to AusAID and the Indonesian Ministry of Health (MOH). The project would however still maintain a strong NGO orientation and would rely heavily on the basis of networks already established by WVII in the government sector in Jayawijaya. Secondly, the area to be covered by the project was increased significantly. Originally, on the advice of WVII staff with experience of the difficulties involved in working in Jayawijaya, the project had restricted its focus to the western part of the district (9 of the 13 sub-districts in 1990). AusAID requested that the project cover all 13 sub-districts. This greatly increased

the logistical and cultural challenges to be faced by the project. Final approval for the project was granted in December 1990.

2.2 WATCH I (July 1991 - August 1994)

Funding for the project was allocated in June 1991. WVA and WVII needed several months to establish the project (recruitment of staff, procurement of equipment, developing administrative and reporting systems and logistical arrangements) and it was not until November 1991 that activities in the field began.

During WATCH I, the project targeted communities throughout all sub-districts (a few villages in every sub-district) with interventions focussed on five major areas :

- Maternal and child health - to extend and improve the quality of formal health services.
- Village level preventive health - to develop the capacity of target communities and the formal health sector to extend the coverage of health care to remote rural communities.
- Women in development - to enhance the role of women in Jayawijaya district.
- Community development - to facilitate village based initiatives to address the causes of poor health
- Project management, including monitoring and evaluation

In February 1994, the project was reviewed by Dr. Michael Dibley, an Australian epidemiologist working at Gadjah Mada University in Yogyakarta. His review pointed out a number of strengths and problems of WATCH I.

The strengths included a highly motivated team, a well developed strategy for community development, an innovative approach to gender in development and a potential model for primary health care and community development in the highlands of Irian Jaya.

The problems faced by the project included: insufficient field staff and technical input to conduct activities in all the sub-districts, inadequate community preparation, the lack of a strategy for progressive involvement of local Irianese, the lack of effective coordination with other community development programs in the district and a weak monitoring and evaluation system.

In his report he recommended that the project be extended in order to refine the approach to developing a packet of community development, gender role change and health care interventions for highland communities in Irian Jaya and to document the impact of the project on the health and nutrition of women and children.

2.3 WATCH II (September 1994-September 1997)

Based on Dr. Dibley's recommendation, the project was extended for a further three years. WATCH II maintained the goals and purposes as well as the general approach that had been employed and developed during WATCH I. Some changes were made to

specific interventions so as to build upon the strengths and overcome the key problems which had been pointed out in the review or had been learned through the experience of WATCH I. In particular, WATCH II focused more on nutrition enhancing activities, developing treatment protocols of 30 prevalent diseases, and on improving the monitoring and evaluation of the project .

In early 1997 a number of senior officials in Irian Jaya and the Bupati of Irian Jaya requested that the project be extended for another two year period. Their requests were based on two major observations : the PHC model still required further development, testing and consolidation and greater skill transfer to government and NGO personnel was necessary to ensure sustainability.

In December 1997 an independent consultant, Ms. Gaynor Dawson, conducted a review of WATCH II. The main findings of her report can be summarized as follows:

- a. the project was well managed with high quality committed staff, who were well regarded by all levels of government and enjoyed good working relationship with its government counterpart the District Health Office;
- b. staff were overextended and had difficulty implementing and supervising the activities;
- c. There were delays in activities and development of key components as well as slippage in personnel replacement;
- d. Some interventions to strengthen the formal health sector (training of nurses, health information system and standard treatment protocols) were close to sustainable;
- e. There were weaknesses in the collection and evaluation of data as well as the supervision of monitoring;
- f. There was some concern regarding the sustainability of community activities

Ms. Dawson recommended that the project be extended in order to consolidate interventions to date, maximize their sustainability and impact and allow further time for documentation of the PHC model. She also recommended that during the next phase, rather than focussing in the Kurima sub-district, where transportation and other problems would severely hamper project activities, the project should be almost entirely focused on the newly formed sub-districts of Kanggime and Kembu/Mamit, which formerly were parts of Karubaga Sub-district.

2.4 Interim Extension Phase (October 1997-October 1998)

This phase between WATCH II and the start of WATCH III or Kanggime extension project.

This period coincided with the drought caused by El Nino or ENSO (El Nino Southern Oscillation). The drought severely affected communities throughout Jayawijaya by causing crop failures, forest fires and a malaria epidemic.

The situation was declared a disaster and all sectors in the Jayawijaya district were invited by the government to participate in the disaster relief operations and made

significant contributions to this effort. The WATCH project staff assisted the District Health Office and International NGOs like Medicines Sans Frontiers (MSF) and Merlin in controlling the malaria epidemic, and food distribution. The case management protocols (CMP) prepared by WATCH were used by the health workers/teams sent to the disaster areas.

Many activities of the project were continued during this phase, like training courses for nurses, midwives, traditional birth attendants and health cadres, gender sensitivity training, safe water supply, and other community development activities.

2.5 WATCH III - Kanggime Extension (November 1998-October 2000)

This phase of the project sought to consolidate the PHC model by focussing project interventions in two newly formed subdistricts, Kanggime and Kembu/Mamit. Kanggime sub-district has a population of around 16,000, while Mamit has around 11,000 people. They all belong to the Western Dani and live scattered in 30 villages.

The population is recognized as being generally more receptive to innovations and change, and WATCH interventions, especially since community development activities had been undertaken since 1992. In 1998 105 community development groups were formed in collaboration with the local churches in Kanggime and Mamit. Each group consisted of 10 families and around 30% of the groups started activities like planting of nutrition plots.

Other programs such as IDT (Poor Village Development), Bangdes (Village Development) and JPS (Social Safety Net) brought money from the government. As there was insufficient capacity of the local government to give guidance on the implementation of those government funds, it very often consisted of distributing money to the people who were close to the village and sub-district officials. Although not severely affected by the drought, Kanggime and Mamit also received some food assistance.

Influenced by all those programs, the people became more “lazy” and “cargoism” became more prominent. The people also expected WATCH to distribute money and goods and it became very difficult to ensure community participation. Several community development cadres even refused to participate in the exposure study trip to East Java.

There are also problems which stemmed from the rise of the independence aspirations and activities of the Satgas Papua (Papua Task Force). The clash between government forces and Satgas Papua in Wamena lead to the complete evacuation of the WATCH staff from Jayawijaya in October 2000.

3 The Primary Health Care (PHC) Concept

The World Health Assembly in 1977 endorsed the goal of Health For All (HFA) by the year 2000 and Primary Health Care (PHC) as the strategy to achieve the goal. Primary

Health Care is not a new concept, but many people are confused about its meaning. The confusion arises because PHC has different meanings in different contexts, and these have changed over time. It was given international status when it was launched at the WHO-UNICEF Conference on PHC in Alma Ata in 1978.

According to the Alma Ata Declaration, PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country could afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

The PHC approach can be further clarified by looking at five underlying principles:

- equity : equal access to care
- community participation : communities gaining greater responsibility for their health
- health promotion and prevention : greater attention to these aspects of health activities alongside curative services.
- Appropriate technology : this does not mean "low" technology but rather technology that is acceptable and sustainable.
- Multi-sector approach : improvement in health status requires activities of many sectors, not the health sector alone.

The critical components of essential health care include at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

Selective PHC, a term that has arisen after Alma Ata, is a euphemism for the single disease and specific program approach. It is based upon a professional and cost-effective outlook that focuses on particular diseases and health technologies, such as oral rehydration for diarrhea, immunizations, safe motherhood, child survival, etc. Selective PHC is a part of general or comprehensive PHC, but it is not the whole of it, nor a substitute for it. It disconnects PHC from the broader process of social development and community empowerment

A critique of PHC was the difficulty in quantifying the results of integrated community-based programs. Bilateral donors were uneasy about the slow pace of the process of community participation necessary for PHC to succeed. In addition, many of the more authoritarian governments in developing countries looked upon community empowerment and demand processes as forces likely to undermine their control, not only over health but, ultimately, the entire political system. Government bureaucracies, whether at national or local levels, were unaccustomed to work as peers with people at the community level and therefore found it difficult to develop the needed institutional mechanisms. Health improvement in developing countries has to relate to the political

economy of health, and the PHC approach cannot make significant progress until these fundamental social-political issues are acted upon.

4 PHC in Indonesia

4.1 Early activities

PHC is not an entirely new concept in Indonesia. The utilization of traditional birth attendants and volunteer village hygienists started in the 1930s in Java (intensive rural hygiene project in Purwokerto). The concept of comprehensive maternal and child health services to be delivered by modern trained midwives was initiated in the early 1950s in Yogyakarta. The need to integrate curative and preventive services and the importance of community participation was realized and pilot projects were initiated e.g. in Bandung (1951) and Bekasi (1956).

4.2 The Solo experience (“Dana Sehat” or health insurance scheme)

During the late 1960s, a Solo (central Java) based voluntary organization, YAKKUM, took the first steps towards developing a community health program which is simple, inexpensive, acceptable to the community and appropriate to its needs. The initial program was initiated in Kerten (a kelurahan in Solo) as a community health insurance fund called “Dana Sehat”, but it gradually expanded its activities to cover a wide range of preventive, promotion and curative health care activities and small scale economic development schemes in other parts of the city. However, not all activities were successful. The lack of local government support, the concern of private medical practitioners and paramedics who had private practices and the overuse of medical services by some members were some of the factors of failure of the scheme in some areas.

The “Solo model” could be replicated by following the five basic stages of program developed and pioneered in Kerten :

- a. Preparation of the community health team, involving motivation, team building, and training.
- b. Getting to know the people and their problems through observation, informal discussions, and attendance at meetings.
- c. Motivating the community leaders and people through informal discussions and talks at meetings using audiovisual aids.
- d. Preparing the community to assume major responsibility for the programs through training of committee members and volunteer health workers, discussions and meetings.
- e. Program implementation by community based volunteer health workers.

Friction within the board of YAKKUM, which led to the resignation of the leader and

several members of the project teams, caused a stagnation of Dana Sehat in Solo. Meanwhile, however, the Solo Dana Sehat program was attracting interest from health professionals, government officials and community leaders from other areas in Indonesia and overseas. Dr. Gunawan Nugroho, the first leader of the project contributed a chapter on the Solo experience in the WHO publication : "Health by the people" (1975). By 1977 a curious paradox had been reached : while Dana Sehat in Solo had stagnated, the program was receiving national and international acclaim, and the approach was being applied in other parts of Indonesia.

The principles of Dana Sehat have been adopted by the government. Voluntary agencies, however, still have a role to play in ensuring that the social impact of the program is maximized so that the people participate meaningfully in achieving healthier lives.

4.3 The Banjarnegara experience

The district of Banjarnegara, situated in a mountainous area in Central Java, has a population of 678,000 living in 279 villages, mostly as small farmers or agricultural laborers. In 1971 the district had a typical health problem of high IMR (150 per 1000), low nutritional status, high incidence of infectious diseases and low utilization of government health services.

The community health program was started in the small town of Klampok by Dr. Yahya Wardoyo of YAKKUM in 1971. The response of the population was lukewarm : a few appreciated the curative service but there was no interest for a Dana Sehat scheme and community health. A community survey indicated that the people were much more concerned about agriculture than health. The YAKKUM team changed their approach by providing funds and technical guidance to increase rice production. Other schemes followed : the planting of fruit and clove trees, a revolving fund for purchasing goats and finally health activities starting with training of volunteer health workers who began a nutrition improvement program for under-five children. Meanwhile in a neighbouring village, a government doctor (Dr. Elias Winoto) was reaching similar conclusions. The people started to organize their own health care activities after the government doctor gave more interest to the people's daily problems and income generating activities.

In 1974 the newly appointed Bupati of Banjarnegara suggested that the district health service should consider ways of replicating the Klampok approach to other villages of the district. The Bupati established a committee called the PPSE (Committee for Social-Economic Development) which was given the task of promoting cooperation between government and voluntary agencies for the community health program (based on the Klampok model). The Bupati himself chaired the PPSE with the District Health Officer (Dr. Arif Haliman) as executive director in charge of day to day activities. Other members of PPSE include the heads of BAPPEDA (District Planning Board), and the Services for Agriculture, Animal Husbandry, Fisheries, Education, and Rural Development as well as the representatives from voluntary agencies (YAKKUM and YIS).

The establishment of PPSE eliminated some bureaucratic problems and provided the operational structure needed for the District Health Service to promote community health activities on an integrated basis throughout the district. The general operational pattern was to invest first in human resources, as in Klampok, before moving into program planning and implementation. The first step was thus to train government staff in the basic principles of community health management. Then followed the process of outreach to communities through cadre training sessions in the villages.

Training of cadres was not simply a matter of imparting technical knowledge and skills. It also had to provide trainees with a theoretical framework within which they and their communities could establish PHC activities according to local needs and capacities. No village was expected to implement simultaneously, across-the-board, all the activities which could form part of a PHC program, such as first aid posts, village drug posts, nutrition surveillance and education, installation of safe water supplies, construction of latrines, road and housing improvements, home garden intensification, animal husbandry, agricultural schemes, school health programs, credit unions, etc. Each community worked out the “mix” of activities most appropriate, and new activities were added as the people felt more confident of their organizational capacity.

As of 1980, a total of 4000 health and nutrition cadres were trained and the number of villages running PHC activities grew from 2 to 210.

The effectiveness of the program was indicated by changes in morbidity, mortality, birth rate and nutritional status of children. Monitoring of key health indicators in 10 sample villages from 1972 until 1980 showed important changes :

- The Infant Mortality Rate (IMR) was reduced from 176 to 80 per 1000 during this period.
- The Maternal Mortality Rate (MMR) was also halved from 490 to 240 per 100,000 births.
- The Crude Birth Rate (CBR), however, remained constant at 26 per 1000 during the period. This is an anomaly, as family planning was widely promoted in the period. This may be due to under-reporting of births in the early 1970s.
- As the program has expanded, the proportion of under-fives whose weight increased during one month increases from 42.6% to 61.3%.

The PHC program, although in general successful, has faced a lot of problems and constraints such as :

- a. Problem in maintaining community participation and motivation on the one hand, and staff performance and morale on the other. These need regular supervision and follow-up.
- b. Bureaucratic procedures and lack of incentives for staff to work in PHC
- c. Lack of participation of the poorest groups in the community.
- d. Interdepartmental rivalries, vertical planning/financing, frequent transfer of government officials and lack of financial and personnel resources for re-orienting and re-training officials in ways of cooperating across bureaucratic dividing lines.

- e. Shortages of funds for extension of the activities to cover the whole district.
- f. Frictions between voluntary agencies and the government and sensitivities of a political and religious nature.

The existence of PPSE can minimize this problem, but does not eliminate it entirely.

The Solo and Banjarnegara PHC programs have used different organizational structures, yet both programs have important elements for success in common, namely :

- a. The importance of a supportive local political climate;
- b. Decentralized, multi-sector planning;
- c. Material support from the community (self reliance) and flexible supplementary financing (from donor agencies).
- d. Regular follow up and maintenance of managerial and technical guidance based on the multi-sector approach.
- e. Provision of incentives and rewards. This need not be financial. Increased knowledge and skills, greater social status, wider contacts and the fulfillment of religious obligations have been sufficient justification for thousands of volunteers to spend hours each week working for better health and living standards within their communities.
- f. Indicators of results and success :
These mostly reflect action, i.e. largely process such as number of active cadres, vital events, attendance at weighing posts, current users of family planning and weight increases for nutritional surveillance. All are comprehensible and easy to measure and compare by the community, in contrast to IMR, MMR and morbidity rates which are more sophisticated indicators and technically more difficult to measure.
- g. Willingness by government to collaborate with NGOs
- h. Readiness of NGOs to be cooperative with the government

The following lessons have emerged for the NGOs/voluntary agencies :

- They must keep a low profile and avoid taking too much credit for achievements;
- They must thoroughly understand the intricacies of the government administrative machinery and adjust their own work styles and procedures to fit in;
- They must accept the role of “gap filler”, taking on tasks for which the government is not yet equipped;
- They must be prepared to change their function as the government takes on new responsibilities and as new needs arise.

4.4 The Karanganyar Project

The Karanganyar project was initiated by the Health Services Research and Development Center (Puslitbang Yankes) of the National Institute of Health Research & Development (Badan Litbangkes) in 1973 with the objective to improve the total health care delivery system in a district (kabupaten). Special efforts were made to ensure community participation by conducting household surveys and discussing community health problems with the village leaders. Inspired by the Solo and Banjarnegara experiences the Karanganyar project also promote the establishment of Dana Sehat schemes and the training and utilization of volunteer health cadres called “prokesa” (Village health

promoters). One prokesa is responsible for 10 to 20 families. The training of prokesa is done in the villages and includes first aid skills, treatment of common ailments, personal hygiene, nutrition and environmental sanitation. The Karanganyar project demonstrated in the 5 villages of the district that many village health problems can be overcome by means of mutual assistance or “gotong royong” with the utilization of prokesa as an important element.

4.5 The Inpres Puskesmas Program

In 1968 the National Health Conference formalized the Puskesmas (Community Health Center) concept. The Puskesmas was defined as a unit of health services which provides accessible, comprehensive and integrated curative and preventive health care within a geographical area which is a subdistrict or part of a sub-district. Smaller units, called Pusat Kesehatan Pembantu or Pustu (health sub centers) were established to provide limited services for a smaller section of the subdistrict, e.g. villages. Puskesmas were expected to perform thirteen basic health services: medical care, MCH, family planning, communicable disease control, environmental health, nutrition, health education, dental health, school health, mental health, laboratories services, community health nursing, recording and reporting.

During the Second Five Year Plan (1974-1978), the development of health centers was substantially accelerated with a Presidential Instruction (Inpres Puskesmas). Newly graduated physicians are appointed to lead the Puskesmas in all sub-districts. As of 1995 a total of 7076 Puskesmas and 20353 Pustu have been established. These facilities have provided better access to modern medical care with health outcomes showing marked improvements, e.g. the IMR fell from 80 to 50 per 1000 between the late 1970s to the mid 1990s. But the MMR remains at the level of 390 per 100,000 and the health services have not performed as well as in other ASEAN countries. (see Januar Achmad's book : Hollow Development).

4.6 The Village Community Health Development Program (PKMD)

Inspired by the experiences in Solo, Banjarnegara and Karanganyar and also on the advice of the World Health Organization which has completed an organizational study on basic health services, the Ministry of Health set up a working committee to plan and develop a viable Village Community Health Development Program (PKMD) in 1975. The National Health Conference in 1976 accepted the VCHD or PKMD as an operational form of PHC consisting of activities based on self reliance and mutual help and carried out through inter-sector coordination to meet the health needs of the community.

These activities include the 8 WHO basic health services : education of the public, local endemic disease prevention and control, immunization, maternal and child health care, family planning, provision of essential drugs, nutrition and food production, treatment of common diseases and injuries, safe water supply and sanitation. In addition, the PKMD program included activities such as village health insurance (“Dana Sehat”), village drug post (“pos obat desa”), training of community health workers (kaders) and income

generating activities like credit unions, better agriculture, animal husbandry, fisheries, and home industries, which were usually the entry points to introducing various self-help health programs in the community.

A national conference on PKMD was held in 1977 and the conference adopted PKMD as a strategy for health development and integral part of overall village development under the umbrella of the Village Community Resilience Body or LKMD. The LKMD is a forum for rural development activities under the chairmanship of the village head or Lurah under the coordination of the Camat or sub-district head.

The PKMD was to be implemented nationwide in 1978. During the Third Five Year Development Plan or Repelita III (1979-1984) the MOH aimed to cover one third of Indonesia's 67,000 villages with PKMD. An inventory in 1983 indicated that PKMD activities were implemented in all 27 provinces, 132 districts (44%), 429 sub-districts (12,3%) and 1,793 villages (2,7%). The target of Repelita III has not been met.

4.7. The integrated Health Post or Posyandu Movement.

The MOH and BKKBN (National Family Planning Coordination Board) developed an integrated family planning-health services program (KB-Kes) to be field tested in 3 provinces in 1983.

In 1984 the MOH and the BKKBN signed a Memorandum of Understanding for cooperation. Five major areas for integration and cooperation between MOH and BKKBN were identified : nutrition, family planning, immunization, diarrhea disease management (oral rehydration) and mother child health care (antenatal care and weighing of under fives).

All these services were to be offered in one place at one time (once a month) in the integrated health post or "posyandu".

The main goals were to reduce infant mortality, improve the nutritional status of children, improve the health of pregnant and lactating mothers and provide family planning services. Community development according to PKMD concept was not included.

Posyandu is run by health cadres supported by the local health center staff. The majority of health cadres were women and members of the PKK or Family Welfare Movement. Around 1.5 million health cadres associated with PKK were actively involved supporting over 250,000 posyandus in 1998.

Through the posyandus, Indonesia achieved remarkable improvement in its immunization coverage (over 80% in 1990). Family Planning participation increased, reaching 50% of current users. Knowledge and use of oral rehydration increased considerably with sharp decrease in deaths due to diarrhoea and malnutrition e.g. vitamin A deficiency decreased significantly.

The PKK Movement was awarded the Sasakawa Health Prize by WHO and the Maurice

Pate Award by UNICEF in 1988 for its role in posyandu.

A concern is the maternal mortality rate which has not been significantly reduced. A program of “safe motherhood” was initiated in the early 1990s. This new effort focussed on increasing the number and improving the capacity of village based midwives (“Bidan di desa”). This program is now getting support from donor agencies like UNICEF, WHO, World Bank and bilateral donors.

4.8. The Asmat PHC Development Project

This project was funded by UNDP and implemented by the Directorate General of Community Health of MOH in collaboration with the Irian Jaya Provincial Health Office. The main objective of the project was to strengthen the national capabilities of development of comprehensive PHC intervention packages to meet the health needs of the people who live in remote areas in Irian Jaya and Maluku (the two most eastern provinces of Indonesia).

The emphasis of project development was placed on (1) identification and development of appropriate health interventions relevant to the geographical remoteness of various islands as well as to the local traditional values; (2) strengthening of existing health infrastructure both from government as well as NGOs operating in the areas so as to provide effective and efficient PHC services; (3) increasing the awareness and strengthening of the concept of living together and belonging to each other through various community development activities.

The project covered 4 sub-districts of Merauke district with a total population of around 50,000 spread in 50 villages over an area of 20,514 square km or half of West Java. The Asmat area consists of swampland and mangrove forests and the villages are located along the banks of the many rivers. Canoes and small motor boats are the only means of transport. The Asmat people are mostly hunter-gatherers and are famous for their beautiful wood carvings.

The project started in June 1992 for the duration of 4 years and was extended for 2 years until June 1998.

The target beneficiaries were the community and individuals living in the 4 sub-districts who were provided with the facilities to improve their health status. The staff of the sub-district health centers as well as a number of health volunteers or cadres from the villages received training in various forms to upgrade their knowledge and skills and the appropriate means to deliver health services. The NGOs (including missionaries) benefited by participating in project activities.

The total UNDP contribution was around US.D 1,079,200, while the GOI counterpart funds amounted to around IDR 1 billion or USD 400,000 (for salaries of personnel, official travel, construction/renovation and operational costs).

Although the original design of the project was to develop a comprehensive PHC program in the area, it soon became obvious that it could not achieve its objectives as the original design did not sufficiently consider the local pragmatic economies and realities in the field.

Some of the weaknesses were :

- a. Too much centralization and bypassing of the District level administration
- b. Little consultation and involvement of local government, other sectors and NGOs (including missions) in the design and implementation of the project
- c. Lack of understanding of social-cultural factors.
- d. Difficulties in recruiting suitable staff and consultants
- e. Inappropriate use of international volunteers for community development activities (Indonesian volunteers would have been much cheaper and culturally appropriate)
- f. Insufficient local budget allocation for operational and maintenance costs
- g. Inappropriate location of project team in the province rather than in the district or on site of the project
- h. Conflicts of aims and rules related to rigid bureaucratic rules (DIP/DIK)
- i. The feelings of insecurity of PTT doctors resulting in a high turn over of health center managers and doctors
- j. Insufficient supervision of health cadres and trained TBAs

In spite of all the difficulties and delays in implementation, there were some notable achievements in improving health care in the region :

- a. Better health infrastructure (renovation and upgrading of health centers and health sub-centres). This has resulted in increased visits of health centers/sub centers and increased immunization coverage.
- b. Improved training of village midwives (Bidan C) at the health centers that ultimately produced 50 village midwives to be distributed in the villages.
- c. Better facilities and increased clinical skills at Agats Health Center enabling it to become a referral center for the Asmat region.
- d. Increase of health manpower (doctors and midwives). The better health facilities attracted some PTT doctors to work in the area.
- e. More than 200 health cadres were trained
- f. Development of a model of delivering health care in remote areas like the Asmat with motorized canoes and use of radio-communication and thus ensuring better supervision, increase in coverage of immunization and health care.

5. The WATCH Project as a PHC model

The goal of the project was to improve the health and nutritional status of women and children in the highlands of Jayawijaya.

The purpose of the project was to develop and implement an integrated and appropriate PHC model for the highlands of Irian Jaya.

There were three general areas of activity in the project :

- Development of formal health sector resources such as construction of buildings, provision of equipment (e.g. for immunization) training of personnel, development of case management protocols and a computerized health information.
- Health education which included training of village cadres and members of PKK (family welfare movement) and other community groups (schools, churches, yayasans, etc).
- Community development which included the formation of community development groups, income generation, gender awareness, agriculture (LEISA), animal husbandry (rabbits), small infrastructure (water supply, bridges), cooperatives, and appropriate technology development.

A diagrammatic model of WATCH interventions is shown below :

This model is an abstract representation of the essential characteristics of phenomena of interest and the arrows show causal relationships between the variables in the boxes. As can be seen in the model, health interventions are not the only variables for health and nutritional improvement.

The model views health interventions as a foundation but they must be supplemented by other features. Medical approaches must be accompanied with other approaches which address poverty. Added to these two approaches were the activities in other sectors (multi-sector approach) which addressed the root causes of poor health. An exclusive reliance on medical approaches bring down death rates but will not ensure improvement

of health and welfare. Since the beginning, the project tried to implement a comprehensive or integrated PHC model and not a selective or partial PHC approach.

The WATCH model is in accordance with the Alma Ata definition of PHC which combined basic health services with a community development movement of self help.

The WATCH PHC model is more comprehensive than the Posyandu (integrated service post) model which is the current government PHC model. It is more in line with the PKMD (Village Community Health Development) model developed in the 1970s in Banjarnegara.

In a region like Jayawijaya where most people are subsistence agriculturists or hunter gatherers living in rugged and isolated areas, PHC (in the Alma Ata spirit) is an ideal approach for improving quality of life.

WATCH's multi-pronged approach to attack health problems tried to overcome the causes of disease and not just the symptoms. For instance, activities to control pneumonia (the main cause of death in the highlands) followed problem linkages that worked on improving the quality of medical care (early diagnosis and prompt treatment), reducing malnutrition, decreasing indoor air pollution, preventing hypothermia of infants, supporting the immunization program and alleviating poverty through community development activities. The project focused on health problems at multiple levels : social, economic, institutional and biochemical.

A unique and innovative approach of WATCH was the attempt to address gender inequalities. The communities in Jayawijaya have a clear sexual division of labor between men and women. Women do almost all of the work that leads to food production from hoeing and planting to cooking, raising pigs, selling produce and raising children. Ironically, development has meant that men lose many of their traditional roles (warfare, tribal religious ceremonies). As children now go to school and polygamy is discouraged, women have fewer people to help in the gardens. From the time she gets up to the time she goes to sleep, a Jayawijaya woman may have been busy for 16 hours. The improvement of gender relationships by WATCH is expected to ultimately lead to improved health of women and children. This of course will need a long time to change. But the WATCH project has certainly increased the awareness of the importance of gender in development.

While health care is service oriented, community development is process oriented, thus creating a possible cause of tension.

The downside to using an integrated PHC approach is that it increases the complexity of project activities and requires coordination across sectors. WATCH staff spent a great deal of time and effort communicating and coordinating with many government agencies and NGOs. Related to this is the problem that as this PHC approach can cover a wide range of things it is easy to become side tracked. Project staff felt that there was always tension from working on activities that were not directly health related but at the same time were not unrelated. Approaches of community development which emphasize a learning process are more suited to sustainability than simply providing more health

services.

PHC in Jayawijaya is particularly challenging because of the cross-cultural context in which it is embedded.

There are four fallacies which commonly afflict intercultural health programs (Polgar, 1963) : (a) the fallacy of the empty vessels : that people do not have established health beliefs and customs of their own and are empty vessels waiting to be filled with new health information; (b) the fallacy of the separate capsule :that health beliefs and practices comprise a domain of behavior and cognition separate from the culture as a whole; (c) the fallacy of the single pyramid : that societies are structured as single pyramids such that information and practices poured at the top will trickle down to all levels; (d) the fallacy of the interchangeable faces: that all clients and health professionals are alike.

When the WATCH project started it was not clear what interventions would be appropriate in the Jayawijaya physical and social-cultural environment. Participatory Rural Appraisal (PRA) was used by WATCH to ensure community participation and promote communication. This technique is useful but not sufficient to really understand a culture. This has meant that the project unavoidably operated to a large degree by trial and error. The consultancy of Dr Barbara Dix Grimes, an anthropologist with experience in Eastern Indonesia provided better understanding about Melanesian culture and designing health education messages which are relevant and clear for the target communities. Dr Grimes also gave a better insight about gender relations in the Melanesian context. Some changes in the gender awareness module need to be made to make it more relevant with the local culture. The need to modify project strategies, targets and interventions should not be seen as failures, but as successes and significant steps in the on-going process of adapting health care to the context of the highlands of Irian Jaya.

A major problem confronting the WATCH project was how to go about collecting data for monitoring and evaluating the impact of the program on the health status of target communities. The nation-wide health information system (HIS) requires all health centers to complete a total of 36 forms with a total of 1000 questions per month. In the highlands of Irian Jaya where shortages of human and material resources are more acute than in other districts this meant that the data generated was completely unreliable. Much of the data collected were also locally irrelevant.

In response to these problems WATCH tried to establish an alternative HIS which would be locally relevant. In collaboration with staff of the DHO/DHS the HIS was simplified. Monthly reporting requirements were reduced from 36 forms with over 1000 questions to six forms covering 200 questions. WATCH also created a computerized HIS.

HIS data base and training activities were undertaken to introduce the new simplified HIS. This was also linked with the training in the use of case management protocols (CMP) as the two systems support each other. But the goal of collecting reliable health

data for planning and evaluation remains elusive given the staffing and resource shortages in most health centers and their low level of numeracy and literacy skills. Inadequate supervision, logistical problems (shortages of forms), lack of feedback and low motivation were important obstacles for the HIS. The HIS consultants in WATCH III (Drs Abdul Wahab and Dr Haripurnomo Kushadiwijaya from Gadjah Mada University) gave some recommendations for the improvement of HIS but these are difficult to implement in the present situation. It is clear that the sustainability of these activities depends on the DHS. There is definitely a need for a locally functioning HIS to face the coming decentralization. The HIS developed by WATCH is an important achievement as it provided an invaluable experience. Given the current move towards greater regional autonomy the Jayawijaya HIS experiment is of considerable interest for health administrators across Indonesia who are trying to develop HIS's for planning, implementing and evaluating local community health services. The lessons learned from the Jayawijaya HIS experiment are useful and attempts should be made to develop similar HIS's, in districts where the availability of better human and material resources provides a greater chance of success.

6. Lessons learned from the WATCH Project

The foregoing chapters have examined the several aspects of PHC and the experience of the WATCH project over almost a decade. They may point to lessons that may benefit future strategies and activities to develop PHC in Irian Jaya specifically and Indonesia generally. Some of the lessons learned are the following :

6.1 Integrated approach in PHC

This approach combined essential health care with community development activities. The WATCH project has demonstrated that this integrated approach is feasible in poor communities of the Jayawijaya highlands. With this approach WATCH helped overcome the causes of ill-health and not just the symptoms. The delivery of clinical services and preventive technologies alone is not sufficient to improve the welfare of the people in the highlands of Irian Jaya. An integrated approach of health services and community development is needed.

6.2 Community participation

The use of PRA/PLA (Participatory Rural Appraisal/Participatory Learning Approach) are useful to know the needs and demands of communities. People feel that they have input into decisions and "ownership" of project activities, and then are more likely to contribute to the project. The WATCH experience also supports the idea that development projects should work along locally meaningful divisions, like people who share the same "silimo" - that is the same hamlet or compound. It is much more difficult to negotiate group action in Jayawijaya than in Java, because of the high degree of individualism, fluid hierarchies and consensual decision making systems in most communities in Irian Jaya.

6.3 Cross-cultural sensitivity

WATCH staff became more aware of the importance of cross-cultural communication as the project unfolded. Anthropology consultants were employed to help staff better understand local culture, especially related to health belief systems. Better understanding of the local culture has enabled WATCH to produce materials for health education which make sense to the local communities and ensure better community participation.

6.4 Gender sensitivity

The imbalance in gender relationships in Jayawijaya communities is a significant contribution to the poor health of women and children. The WATCH project has highlighted the importance of gender role imbalance as a barrier to the community development process. A special Women in Development Coordinator was appointed and modules for gender sensitivity training were developed which were widely used by PKK, churches and local government. A special module using pictures was developed for the community. These materials and modules can be used in Jayawijaya to raise the awareness about gender inequalities and provide better services for women and children.

6.5 Project management and coordination

The WATCH project demonstrated that an NGO can provide flexible management for an integrated PHC project in close cooperation with the government. The goal was not to replace government services but to make them more effective by stimulating micro-policy changes, training staff of government agencies in new skills and influencing their approach to working in the community. The project manager had the role of coordinating the various resources needed to improve community health. The project manager must act as a bridge between the community and government services.

A Project Coordinating Board (PCB) was established to provide direction and coordination for the project. The PCB was a valuable tool in establishing the project in the eyes of the government and establishing profile within the Ministry of Health. The PCB meetings were an essential element of the relationship developed between the government, the NGO contractors and the donor (AusAID).

A local Social-economic Development Area Committee consisting of government agencies and representatives of NGOs/churches was useful to provide direction and coordination at the district level.

6.6 Project staffing and use of consultants

It was an advantage to select nationals to work for the project as this has kept funds, expertise and skills within the recipient country. But employment of expatriate staff should not be excluded if the expertise is not available in the country. This person/s could act as a kind of “cultural broker” having both strong English language skills and a better understanding of the donor’s mindset.

The employment of predominantly female staff may have caused some problems in

establishing effective communication, but seemed the obvious choice as the project focused on women and their children's health. More-over, placing women in responsible positions in the project sends a strong message to the community. Showing that women are capable of holding positions of power is another example of how WATCH helped change gender attitudes in the community.

It was difficult to recruit suitably qualified Irianese. The project should have prepared a plan of Irianisation from the start, at least for field level positions.

The project used a variety of consultants during WATCH II. Ideally, as the need for consultants is greatest at the beginning, the project should have utilized consultants earlier on.

Three lessons emerged from these experiences :

- It is fruitful to employ consultants who are not only expert in their field but also know the highlands of Irian Jaya. Otherwise it is questionable whether they are able to give relevant advice which is implementable. The short time that consultants spend in the field is not sufficient to understand the dynamics of the situation. Exception to this are consultancies to advise on particular technical problems like improving HIS computer programs.
- A project review should preferably be done by more than a single consultant in order to get a more comprehensive review and to respect the multi-disciplinary nature of the project.
- The Project found it worthwhile to employ consultants from the same source as it allowed for the cross-fertilization of ideas and from a logistic viewpoint, going to the same place to find consultants was easier.
- The establishment of a group of experts (government, university and NGO) at provincial level) to provide consultants in PHC for the for the district would have been useful to overcome problems in the field.

6.7 Government-NGO collaboration

As a bilateral project WATCH had an obligation to work with and through the DHO and DHS and other government institutions. But the government infrastructure was still in the early phase of development and agencies like LKMD and PKK are not yet functioning. Using NGOs and missions to deliver health care and undertake community development activities was the best way to reach the population in the district. This presented the project with a dilemma. To only work with government structures and institutions would compromise the project's ability to effectively engage with the community, while to work with NGOs and missions could be seen as undermining government authority.

The WATCH project partially succeeded in solving this dilemma. As a bilateral project with the DHO/DHS, WATCH provided an appropriate vehicle for an NGO (WVII) to conduct activities grounded in the communities yet also linked to government structures.

6.8 Flexible design and funding arrangements

The WATCH project has experienced difficulties in these areas. The classical planning approach implied in AusAID project log frames assumes that the expected outputs from a set of inputs can be predicted with a high degree of certainty and that these can be measured by predetermined indicators. These assumptions work well with established technologies. However, when bringing new health technologies to communities it can be hard to predict which technologies will be acceptable. In these circumstances a process documentation and learning approach is more appropriate as a model for managing projects. This management method monitors activities and client responses to determine which activities work, how to modify activities to make them more effective and how to reallocate resources based on this information. This approach can be accommodated in a log frame provided there is a willingness to accept periodic changes.

When developing a service delivery model the project design must include adequate resources for technical inputs, monitoring and evaluation of project activities.

The funding arrangements of the WATCH project were more flexible than with many other development projects especially those that have to go through the government bureaucracy. This allowed the project to adopt new ideas and approaches without excessive bureaucratic procedures.

6.9 Appropriate technology

An important factor for the success of PHC was the use of appropriate technology. The word “technology” here means an association of methods, techniques and equipment which, together with the people using them, could contribute significantly to solving a health problem. “Appropriate” means that besides being scientifically sound the technology is also acceptable and affordable to those who apply it and affordable to those for whom it is used. This implies that technology should be in keeping with the local culture. In addition, it should preferably be understood by community health workers and by individuals in the community; although different forms of technology are appropriate at different stages of development, their simplicity is always desirable. The WATCH project attempted to select, develop and introduce appropriate technologies which were relevant to local conditions and resources such as standard case management protocols, temperature measurement of newborns, small technologies for village midwives, cultivation of mushrooms, traditional birthing positions, sweet potato based rehydration, making sweet potato flour, improved farming methods (low external input sloping agriculture or LEISA), solar batteries (for cold storage of vaccines), etc.

6.10 Sustainability

Sustainability can be defined as the capacity of the health system to function effectively over time with minimal external input (La Fond). The WATCH project has contributed to increase the capacity of the DHO by assisting the training of health personnel at the

SPK or Health Nursing School in Wamena and upgrading courses for health center staff of Jayawijaya district. By involving NGOs in the community development activities WATCH has also contributed to increase capacity of local NGOs to undertake community development activities. These NGOs may be able to continue some of the community development activities. The involvement of DHO staff in the WATCH project was also a valuable contribution to increase capacity for PHC development in the district. Although difficult to measure, WATCH did succeed in altering attitudes in the target communities as well as government personnel. Spending time, money and efforts to change people's mindset is a worthwhile investment as only through changes in the ways people feel, think and behave towards certain issues can a project have lasting impacts. Concentrating on people rather than "things" or infrastructure was the correct approach to develop sustainable PHC.

7. Summary and Conclusions

The Jayawijaya WATCH Project funded by AusAID and administered under the umbrella of the bilateral program had the goal to improve the health and nutritional status of women and children in the highlands of Jayawijaya, Irian Jaya.

The purpose of the project was to develop and implement an integrated and appropriate primary health care (PHC) model for the highlands of Irian Jaya.

The project started in 1991 (WATCH I) and was extended in 1995 (WATCH II) and continued as Kanggime extension (WATCH III) between 1998-2000. The aim of the extension was to consolidate previous interventions and further evaluate and comprehensively document the model.

The WATCH project can be considered as a pilot project for PHC according to the concept of integrated PHC in the highlands of Irian Jaya. The project is in line with the Alma Ata declaration described earlier in section 3. An integrated PHC approach is based upon a combination of basic health services and community development of self help. This is also in line with the Village Community Health Development Program or PKMD, (based on the Banjarnegara experience) developed in the early 1970s. It was a setback that the PKMD concept was abandoned by the government and replaced by a more selective PHC approach, the Posyandu or Integrated Health Service Post). The WATCH project has attempted to revitalize the PKMD concept and applied it in the context of the highlands of Irian Jaya.

Considering the difficult operating environment, the project was able to achieve increase in: raising gender sensitivity; training and support for midwives, mantris, health cadres, traditional birth attendants (TBAs); innovative nutrition activities; development of appropriate IEC materials for health staff and cadres; development of a local health information system; introduction of appropriate technologies; support of local NGOs and strengthening of community development initiatives were impressive.

There are many lessons to be learned from the project and these include project management, project staffing, community participation, gender and cross-cultural sensitivity, use of consultants, NGO-government collaboration, and use of appropriate technology.

The WATCH project has extended health services to remote villages, improved nutrition through agricultural innovations and managed isolated community development projects in difficult circumstances. Future sustainability is threatened by security disturbances, weakness of the DHO and limited resources of existing NGOs. AusAID should consider funding extension of the UNICEF Irian Jaya Safe Motherhood program, support NGOs to implement community development in Jayawijaya and strengthen the District Health Service in the frame of decentralization.

The WATCH project leaves a legacy of an innovative experiment by the Indonesian and Australian government working collaboratively with the health services and NGOs to improve the health and social conditions of remote communities. Decentralization and flexible planning - using unconventional approaches to maximize the human and material resources of communities, government services and NGOs - is an appropriate strategy for expanding coverage of a PHC program in a poor and isolated area. Even in countries such as Indonesia, where the national social-political climate is not yet favorable for widespread community participation in development, PHC programs can be established, provided some community-supportive backing is available at an intermediate level of government administration. Like the Solo and Banjarnegara experience, the Jayawijaya experience should serve as an inspiration for implementing comprehensive primary health care in the spirit of Alma Ata.

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Jayawijaya WATCH Project
Project Documentation Consultancy
Primary Health Care Model
15 Dec. 2000 - 15 January 2001

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Note : These books are available in the libraries of NIHRD (Badan Litbang Kesehatan) and the British Council in Jakarta.