EVALUATION REPORT

NIAS COMMUNITY BASED HEALTH PROJECT

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Prepared by
Paulus H Santosa – Team Leader
Joedo Prihartono – Nias Specialist

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TABLE OF CONTENT

Acronyms 4

Executive Summary 7

1. Background 11

2. Methodology 14

2.1. Range of data collection activities 15

2.2. Challenges and Limitations 15

3. Timing of the Evaluation 16

4. Findings and Conclusions 16

4.1 Outcome 1: Relevance, effectiveness, efficiency and impact of the CBHP's approaches and activities. 16

4.1.1 The extent to which the CBHP has addressed, and plans to address the identified needs and priorities of target communities, including any specific needs of men, women, girls and boys. 16

4.1.2 The extent to which the CBHP has addressed, and plans to address the health priorities evidenced by the baseline survey and other available data sources 17

4.1.3 The extent to which the CBHP was originally, and has remained, aligned with national and sub-national government strategies, priorities and systems, and the New Zealand Aid Programme priorities 19

4.1.4 The extent to which the CBHP originally harmonized, and has continued to harmonize its interventions to complement, and avoid overlap with, the work of other development partners. 20

4.1.5 The extent to which the CBHPI met its planned goal, objectives and outcomes, including consideration of specific gender outcomes. 21

4.1.5.2.2 Health communication activities 22

4.1.5.2.8. The strengthening of Posyandu 25

4.1.6 The extent to which CBHPII year one has been focused upon strengthening community action and meeting the eight specific requirements set out by MFAT in September 2009 and March 2010. 26

4.1.7 The value for money provided by the CBHPI i.e., could activities have been implemented at less cost whilst retaining the same quality and quantity of benefits. 27

4.1.8 Any programme management issues (e.g. human resources, logistics, procurement and systems) which affected the efficiency of the CBHPI and CBHPII year one implementation. 28

4.1.9 The actual or likely impact (positive, negative, planned or unplanned) that the CBHPI has had, or will have, on project

stakeholders and the environment, where this can be identified from available evidence. *29*

4.2 Outcome 2: Sustainability of the CBHP's approaches and activities. 30

4.2.1 The extent to which the CBHP's target communities (including specific reference to men, women and children) have engaged in the design, implementation and monitoring of the project. *30*

4.2.2 The level of ownership that target communities have of the CBHP - its interventions, outcomes and shortfalls. *31*

4.2.3 The extent to which the CBHP has collaborated with government agencies at sub-national level, technical agencies and any CBOs in the design, implementation and monitoring of the project. *32*

4.2.4 The effectiveness of the CBHP's activities and/or approaches in strengthening links between communities and health services/facilities, building health governance and workforce capacity. *33*

4.2.5 The effectiveness of the local volunteering model and volunteering approaches that the CBHP has utilized. *33*

4.2.6 The extent to which volunteers' activities are likely to be sustained without further direct project intervention. *34*

4.2.7 The actual or likely sustainability of any observed or reported benefits which have arisen from the CBHPI, taking into consideration relevant institutional, gender-related, environmental and contextual factors that will impact upon these. *34*

5. Outcome 3: Recommendations for modifying the CBHPII to improve the relevance, effectiveness, efficiency, impact and sustainability of its interventions. 35

5.1 Ways in which the CBHPII could better address the health priorities of target communities, including any specific needs of men, women, boys and girls. *35*

5.2. Ways to enhance community participation in, and ownership of, CBHPII's implementation and outcomes. *35*

5.3. Opportunities for the CPHPII's closer alignment with government strategy and/or harmonisation with work of other development partners. *36*

5.4. Opportunities for the CBHPII to enhance its harmonisation with the work of other development partners to increase overall efficiency and effectiveness. *36*

5.5. Ways in which the CBHPII could maximise its effectiveness, with gender differentiation where relevant. *37*

5.6. Ways in which the CBHPII could improve monitoring of progress and demonstration of where development outcomes are being achieved and to allow for gender disaggregation where relevant. *37*

5.7. Areas where efficiencies could be made in the CBHPII without detracting from the project's effectiveness. *38*

5.8. Ways in which the CBHPII could increase the likely impact from its interventions. *38*

5.9 Ways in which the CBHPII could better ensure that the sustainability of its interventions and their results is achieved, with gender differentiation where relevant. *38*

Acronyms

AFM	Area Field Manager
ARI	Acute Respiratory Tract Infection
BAPPEDA	Badan Perencanaan Pembangunan Daerah/ Provincial or District Development Planning Agency
BAPPENAS	Badan Perencanaan Pembangunan Nasional/National Development Planning Agency
BD	Bidan Desa / Village Midwife
BPBN	Badan Penaggulangan Bencana Nasional / National Disaster Management Bureau
BPBD	Badan Penaggulangan Bencana Daerah / District Disaster Management Bureau
BPMD	Badan Pemberdayaan Masyarakat Daerah / District Community Development Bureau
CBHP	Community Based Health Programme
CBO	Community Based Organization
CD	Community development
CF	Community Facilitator
CG	Care Group
CLTS	Community Led Total Sanitation
Dinkes	Dinas Kesehatan,/ Provincial or District Health Services Bureau
DOM	Direct Observational Method
FGD	Focus Group Discussion
HH	House Hold
HPO	Health Promotion Officer
IEC	Information, education and communication
IMCI	Integrated Management of Childhood Illness
KAP	Knowledge, Attitudes and Practices Survey
Kemenkes	Kementerian Kesehatan/Ministry of Health
Kesga	Kesehatan Keluarga/ Family Health
MFAT	Ministry of Foreign Affairs and Trade
MOU	Memorandum of Understanding
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MNH	Maternal and Neonatal Health
MPS	Making Pregnancy Safer / Menuju Pesalinan Selamat

MTBS	Manajemen Terpadu Balita Sakit (=IMCI)
NGO	Non Governmental Organization
NZAID	New Zealand Aid Programme
PCG	Posyandu Care Group
PDI	Positive Deviance Initiatives
Polindes	Pondok Bersalin di Desa/ village birthing huts run by community midwives
Poskesdes	Pos Kesehatan Desa/ Village Health Post
Posyandu	Pos Pelayanan Terpadu / integrated services post located at village level
PNPM	Program Nasional Pembangunan Masyarakat,/Nasional Program for Community Development
PRA	Participatory Rapid Appraisal
Promkes	Promosi Kesehatan/ Health Promotion
Puskesmas	Pusat Kesehatan Masyarakat / community health centre
RVG	Representative Village Group
RG	Reference Group
RT	Review Team
SAI	Surf Aid International
TBA	Traditional Birth Attendant
TOR	Terms Of References
TOT	Training of trainers
UNDP	United Nation Development Program
UNICEF	United Nation Children Fund
VAT	Village Action Team
WATSAN	Water and Sanitation

G l o s s a r y

Bidan	Midwife
Bupati	Head of District
Camat	Head of Sub District
Desa	Village
Desa Siaga	Alert Village: a national community based health program initiated by Kemenkes

Dinas	Government Sectoral Services of Provincial or District levels
Ibu	Mother
Kabupaten	District
Kader	Volunteer
Kecamatan	Sub-district
Kepala Desa	Head of Village
Kesehatan	Health
Propinsi	Province
Sehat	Healthy
Selatan	South (e.g. Nias Selatah = South Nias)
Utara	North (e.g. Nias Utara = North Nias)

Executive Summary

The 2004 Tsunami and the ensuing major earthquake in 2005 propelled the island of Nias very quickly and suddenly into domestic and international attention. In effect, it ended Nias' isolation as the island was flooded with massive humanitarian response. The two disasters and the flooding of aid overwhelmed the population, and to some extent altered the attitude of the Nias people. Although the flow of humanitarian aid has improved the financial situation of certain segments of Nias' population, the health status of the mothers and children of Nias particularly those living in the rural areas, is still a major health issue.

Surfaid has been in contact with Nias since long before the Tsunami and the big earthquake happened. When the disasters struck, Surfaid responded with the Nias Community Based Health Programme; a program aimed to improve the health of the mothers and children of Nias, as the most vulnerable segments of population affected by the great disasters. The Nias Community Based Health Programme (CBHP) was implemented with MFAT funding through the New Zealand Aid Programme. The CBHP was developed in two stages: CBHP phase one, or CBHP I, was a child health promotion project, followed by CBHP II which is a maternal and child health promotion project.

The CBHP's proposal, which was submitted by Surfaid International (SAI) in October 2005, was formally approved by MFAT[1] in April 2006. The first funding covers the period from 1 October 2005 to 30 September 2008. The traumatic opening of Nias from isolation caused a range of negative impact on the traditional life and social behaviour of the Nias people. Humanitarian aid organizations involved in post disaster relief responses in Nias, CBHP included, reported negative behaviour by the people of Nias and difficulties encountered in program implementation. These problems led to delay in the implementation of CBHPI.

Due to the delay in implementation SAI submitted a request for "no cost extension" covering the period from October 2008 to June 2009. A series of contract variations was granted to extend CBHPI so as to allow more time for the design of CBHPII to meet the changing project environment. The extension was implemented from 1 October 2008 to 31 December 2009.

In March 2010, despite some residual concerns regarding the proposed design, MFAT approved funding for CHBP phase II, which covers the period from 1 January 2010 to 31 December 2012. MFAT requested that the first six months of CBHPII be focused upon strengthening community action; during which period SAI was requested to carry 8 points of actions that include the undertaking of an independent review of the project.

In August 2010 SAI submitted an "Overview of Proposed Modifications to CBHPII in Nias", which included a revised log-frame. However, the design did not address all of the residual concerns. MFAT commented on the design's shortfalls and proposed that an independent evaluation be commissioned to review CBHPI and year one of CBHPII.

[1] Operating at the time as NZAID.

The findings and recommendations from the evaluation were to be used to finalise the re-designing of years 2 and 3 of the CBHPII.

An Evaluation Team was appointed consisting of a team leader and a Nias specialist, and an evaluation Reference Group was formed to advise the evaluation team and MFAT at key stages of the evaluation process. MFAT, SAI and the Government of Indonesia are represented in the Reference Group. The scope of evaluation is the period between the approval of CBHPI (April 2006) and the end of the first year of implementation of CBHPII (December 2010). The field assessment was conducted from May 29 to June 21, 2011.

The evaluation adopted inclusiveness and participatory approaches in data collection. To ensure inclusiveness of all parties, the team met with 3 groups of stakeholders (government, community and volunteers) in both CBHPI and CBHPII target districts. All participants, particularly the program's beneficiaries, were encouraged to share their views. The participatory approach was conducted at the community level through the Focus Group Discussions, which brought all stakeholders of village/community level together to share their views on the project.

Participatory approach in data analysis and finding formulation was implemented through intensive and transparent group discussions with CBHP management and staff. The draft of evaluation tools that were used at the district, sub district and village levels were presented at the group discussions with CBHP staff for their comments and inputs.

The findings and conclusions of the field assessment are as follows:

a) Relevance

- CBHPI was developed based on a needs assessment conducted in randomly selected villages in Nias. Child morbidity and mortality were identified as a key health issue of the communities and CBHPI's goal is to reduce child morbidity and mortality. CBHPI's goal is aligned with national and sub-national government priorities.
- The design of CBHPI was based on a KAP survey to inform baseline evidences. However, the survey (1) was not customised to the specific needs of CBHPI; (2) was conducted in Nias and Mentawai, rather than in CBHPI's selected target areas; (3) was not designed to enable CBHPI to develop interventions that are aligned with the national MCH strategies and program; (4) was conducted without the involvement of the project staff and stakeholders; (5) was not designed to be gender-sensitive, and did not include husbands as survey informants. The weaknesses of the KAP survey method affect the quality of the project log-frame and the Monitoring &Evaluation framework.
- CBHPI's baseline assessments did not include an assessment of the state of local Posyandu and primary care services, or a participatory community assessment to complement the KAP survey. CBHPI did not conduct a gender analysis to assess the underlying gender issues that contribute to the local MCH situation.
- The weakness of the KAP survey method and the absence of the above assessments led to fundamental weaknesses in the CBHPI design. CBHP's strategies and

interventions were not aligned with the national strategies and programs for MCH development.

b) Effectiveness

- CBHPI's key intervention was the establishment of new community volunteer structures, i.e., CG and RVG, as key agents for program implementation. Despite reported achievements in program implementation, the CG model was considered ineffective and was discontinued in CBHPII. While the RVG formation was unsuccessful.
- CBHP II replaced CG with VAT, which emerged from CLTS program implementation. VAT was utilized as the key agent for program implementation and CLTS as point of entry to program development. CBHPII documents currently being used suggest that the project MCH goal could best be achieved through the implementation of CLTS. However, CLTS is not listed as a priority program in the national Maternal and Child Health strategy.
- CBHP conducted a range of interventions including water and sanitation and malnutrition rehabilitation programs. These were well accepted by the program beneficiaries. CBHPI adopted a Positive Deviance model, and a cost sharing strategy for its nutrition rehabilitation program aimed at strengthening the sense of ownership of the program. CBHP distributed impregnated bed nets to HH in the endemic areas and conducted HH level education for malaria prevention. CBHPI also implemented diarrhea prevention program through clean water and sanitation promotion. Meanwhile, CBHP immunization program was neither well planned nor implemented. However, CBHPI does not have any valid tool to measure the progress of its interventions, i.e., whether CBHPI has met its objectives and outcomes, including the gender outcome.

c) Efficiency

- CBHP has adopted and implemented a 'tight financial policy' and costs-sharing strategy for efficient program implementation. Budget was carefully developed based on costs assessments and a thorough understanding of Nias' living conditions. However, the influx of humanitarian funds and workers has altered Nias' situation and created difficulties to CBHP in maintaining its financial policies.

d) Impact

- The Evaluation Team was unable to measure the long-term impact of CBHPI during the field assessment. CBHPI has reported short-term impact of its activities, however the reports are difficult to ratify due to the weaknesses of the assessment methods for planning and monitoring. An analysis of the CBHPI program achievements is made and presented in the later part of this report (see 4.1.5.)

e) Sustainability

- CBHP's strategies and interventions were not aligned with the national strategies and programs for MCH development. Links between CBHP's village level activities and Bidan Desa was not established. The absence of a linkage between CBHP's village level activities with Bidan and primary health services will hamper project alignment with government health service system and MCH programs.

- CBHPI and CBHPII adopted the 'hamlet-based approach' in the selection of project areas. The adoption of a hamlet-based approach made it difficult for CBHP to coordinate its interventions with the health authorities' and to obtain support from these authorities hence to produce a meaningful impact in the improvement of primary services system in the target areas. In effect, the implemented programs were not sustainable.
- Posyandu is widely accepted as the most effective and sustainable local volunteering model for primary health care promotion, particularly MCH. The strengthening of Posyandu was considered an important program by CBHP; however, CBHP did not utilize Posyandu as the key agent for program implementation. Whilst revitalized Posyandus and their activities are sustained by Puskesmas and local communities.

Based on the afore-mentioned findings and conclusions it can be concluded that unless its strategies and interventions are radically revised, it is unlikely CBHPII will become an efficient and effective MCH promotion project, and its goals achieved. Also there will be some major challenges for sustaining the project's activities and their achievements beyond project duration. For the redesigning of CBHPII, the evaluation team makes the following recommendations:

1. In light of time constraints, it is recommended that CBHPII adopt a sub-district based approach and select all villages located within a sub-district as the project areas. CBHPII should select one sub-district as a pilot area for the development and implementation of a model of community-based approach to MCH promotion. It is recommended that CBHPII phase out its activities from areas that are not selected as their pilot area
2. Efforts should be focused on the development of a model Posyandu that meet the geographical and cultural specifics of Nias. This means the strengthening of the existing Posyandu as well as the establishment of a Posyandu system in all villages within the pilot sub-district, and this should be conducted as early as possible. CBHPII should facilitate the involvement of local Community Based Organizations (CBO) and Desa Siaga forum in the Posyandu strengthening program and utilize the Posyandu as the key agent in program implementation.
3. CBHPII programs should include the improvement of HH's knowledge and skills for MCH promotion, and the provision of technical assistance to Puskesmas in order to improve its capacity in providing primary health services at the village level and supporting Posyandu and relevant community actions for MCH promotion.
4. To better address the maternal and child health priorities of target communities, CBHPII should conduct the following assessments: a) KAP survey, b) participatory community assessment, and c) assessment of the state of Posyandu and primary care services. In addition, CBHP should also conduct a situation analysis on the state of implementation of national strategies and programs in the target areas. Detailed explanation of each of the assessment is provided in the later part of this report (see 4.1.2).

5. It is recommended that CBHP conduct a gender analysis of the MCH situation to identify underlying gender inequality issues that have contributed to the local MCH situation, such as high maternal and child mortality and morbidity rates.
6. It is recommended that the designing of project interventions be guided by the national MCH strategies adopted by Kemenkes, i.e. the MPS and the IMCI, and that the focus of the interventions be the non-clinical and preventative aspects of the programs. CBHPII should facilitate the formation of a District-level project coordination structure for the pilot program, chaired by BAPPEDA and including as members CBHPII Program Manager and district officials of relevant sections of Dinkes, BPMD, and Women Empowerment and Child Protection
7. It is recommended that CBHPII redesign its log-frame and develop an M&E framework based on the approved log-frame. The M&E framework should be made available to all staff and stakeholders involved in the monitoring activities, whose capacity for developing and implementing a monitoring plan based on the M&E framework should be built.
8. It is recommended that CBHPII facilitate the involvement of religious and adat/costumary institutions and their leaders in delivering health messages to HH and communities in the target areas.
9. It is recommended that CBHPII maintains its current capacity building program to strengthen its staff and management capacity, to enable them to effectively plan, implement and monitor the pilot programs.
10. To allow proper implementation of the above proposed pilot activities, it is recommended that CBHPII submit a request to MFAT an extension to allow two years implementation of the above recommended pilot activities, including the preparation and planning phase.
11. Subject to the approval of the requested extension, it is recommended that CBHPII schedule a midterm evaluation comprising of a subsequent assessment of baseline assessments, utilizing the same methods and tools, and that CBHPII consistently use the results of the monitoring and mid-term evaluation as management tools toward further design adjustment or revision whenever relevant.
12. To promote sustainability of programs, it is recommended that CBHPII gradually reduce Surfaid identity and the foreign image of the project. A new project identity using Bahasa Indonesia or Bahasa Nias and a new logo should be developed and used. Surfaid’s and NZMFAT’s identities in the project should be sustained as ‘supporters’ instead of ‘owners’ of the project.

1. Background

Geographical remoteness has caused the island of Nias to become isolated from the recent progresses that took place in Western Indonesia. Development indicators, particularly of health, show Nias’ level of development to be more similar to that of Eastern Indonesia. This isolation ended when the Tsunami hit in 2004, followed by a major earthquake in 2005. Nias was suddenly the centre of attention of domestic and international Aid agencies, and the island was flooded with massive humanitarian

response. The influx of aid has improved the financial situation of certain segments of Nias' population, nevertheless, the health status of the mothers and children of Nias, particularly those living in the rural areas, is still a major health issue[2].

Surfaid members and functionaries have been in contact with Nias since long before the Tsunami and the big earthquake. When the disasters struck, Surfaid responded with a project plan -- the Nias Community Based Health Programme (CBHP) – that has a long-term goal focusing on child health which happens to be a national, as well as Nias', health development priority. The Nias Community Based Health Programme is implemented with MFAT funding through the New Zealand Aid Programme[3].

The CBHP was developed in two stages, with an initial approval for a three-year implementation from 1 October 2005 to 30 September 2008. The programme's goal was ***"to improve the health of vulnerable persons in partner communities along the coastal areas of Nias Island and reduce mortality in children under five years of age by improving clean water availability, hygiene, sanitation, malaria reduction, nutrition and improved health services".*** To achieve its goal, CBHPI established 6 strategic objectives which focused on 4 areas: (1) Community Engagement; (2) Water and Sanitation rehabilitation; (3) Child Health promotion; and (4) Capacity Building of Health Centre [4].

The traumatic opening of Nias caused a range of negative impact on the traditional life and social behaviour of its people. Humanitarian aid organizations working in post disaster relief responses reported negative behaviour by the people of Nias, and difficulties encountered in program implementation[5]. A similar situation was experienced by CBHP, and reports of negative attitude coming from program beneficiaries and community level stakeholders that hampered program implementation appeared in CBHP report[6] and proposal.[7] The reported problems include such issues as lack of community enthusiasm toward unpaid program activities, hostilities in the communities that the NGO staff found disconcerting, and vandalism of reconstructed public facilities by certain community groups.[8]

The problems were experienced and reported more often in the western coastal areas that were hit by the tsunami and earthquake, and where the influx of aid was higher than in other areas of Nias. CBHPI was committed to the coastal area population and decided to implement the activities in the western coastal sub-districts. The problems caused delays in program implementation, and because of the delays, CBHPI requested a 9-month extension.

Responding to SAI's request for a 9-month extension of CBHPI implementation, in May 2008, MFAT invited SAI to submit a proposal for the extended period and to

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[2]. This situation was reported by National, Provincial and Nias health authorities during the interview.

[3] Operating at the time as NZAID.

[4] Surf Aid International; *Community Based Health Program, Nias Island, Indonesia, A Funding Proposal to NEW ZEALAND AID, By Surf Aid International*; October 2005

[5] Expressed by AusAID, UNDP and BAPPENAS officials during the interview.

[6] Final report; Community Based Health Program; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island; October 2006 to September 2009; pages 6 and 8

[7] Overview of Proposed Modifications to CBHPII Nias, August 2010, page 5.

[8] The Evaluation Team encountered and witnessed these problems during the field assessment in Nias.

consider working on a proposal for an additional three-year project. The second phase was intended to build upon the progress made during CBHPI, and to undertake further work towards the objectives originally envisaged for the CBHPI. The intention was to enhance the sustainability of project outcomes so that support for target communities could be phased out during the project. The 9-month extension of CBHPI was formally started in October 2008 and completed at the end of 2009.

Several versions of CBHP II design were developed and discussed over 22 months. In March 2010, despite some residual concerns regarding the proposed design, MFAT approved funding for CHBP phase II that covers the period of 1 January 2010 to 31 December 2012. The goal of the proposed CBHPII is ***"to reduce maternal and under-5 child mortality and morbidity in Nias"***. MFAT requested that the first six months of CBHPII be focused on strengthening community action; during which period SAI was requested[9] to carry 8 points of actions, including the undertaking of an independent review of the project.

In August 2010, SAI submitted an "Overview of Proposed Modifications to CBHPII in Nias" which included a revised log-frame. The design, however, did not address all of the residual concerns. MFAT commented on the design shortfalls and proposed that an independent evaluation be commissioned to review CBHPI and year one of CBHPII. The findings and recommendations from the evaluation will be used to finalise the re-designing of years 2 and 3 of CBHPII.

1.1. National Strategy for Maternal and Perinatal Health: The Making Pregnancy Safer/Menuju Pesalinan Selamat (MPS)

Indonesia was one of the 10 countries selected for the pilot implementation of WHO's initiative for reducing maternal and perinatal mortality and morbidity: The Making Pregnancy Safer (MPS)[10]. Since then, the MPS has become the national strategy for reducing maternal and perinatal health in Indonesia.

The MPS consists of clinical and non-clinical strategies aim to contribute to the empowerment of women, families and communities to improve and increase their control over maternal and newborn health, as well as to increase the access and utilization of quality health services, particularly those provided by the skilled attendants. Interventions are organized into four priority areas: (1) developing capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies; (2) increasing awareness of the rights, needs and potential problems related to maternal and newborn health; (3) strengthening linkages for social support between women, men, families and communities and with the health care delivery system; and (4) improving quality of care and health services and of their interactions with women, men, families and communities[11].

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[9] NZAID comments for SurfAid on the revised proposal for CBHPII, dated 11 September 2009

[10] World Health Organization, Making Pregnancy Safer, Report by the Secretariat, EB 107/26, 5 December 2000

[11] World Health Organization; Making Pregnancy Safer Initiative: Working with individuals, families and communities to improve maternal and newborn health, WHO/FCH/RHR/03/11, Geneva 2003

In Indonesia, the MPS strategy is focused to the establishment of clinical services at village level, including the allocation of Bidan Desa and the construction of Poskesdes[12] in all villages; and the organizing of community engagement initiatives such as the Desa Siaga program. Bidan Desa holds a central role in the implementation of MPS strategy at village level. The MPS has become a key strategy for the achievement of MDG goals. A set of health information system indicators has been selected by Kemenkes for the monitoring of MPS progresses.

1.2. District Health System, Priorities and Programmes

The health system in Indonesia is 'district-based'. The District Health Services or District Dinkes is responsible for the coordination of all health service activities and for the planning of a public health services system in the district, except the District Public Hospital. Puskesmas is the Dinkes extension at the sub-district level. Puskesmas has dual roles: (1) the provision of clinical services and (2) the coordination of public health program and services at the sub-district level. In its operation, Puskesmas is supported by the Satellite Health Centres or Pustu (Puskesmas Pembantu) and Poskesdes at the village level.

Bidan Desa or the village's midwife is the spearhead of the Public Health services system, as she brings the services closer to where the people work and live. In her work, the Bidan Desa is equipped with a Poskesdes, a facility for the bidan to deliver clinical services and attend maternal deliveries.

Posyandu is a community-based movement for health promotion. Although its formation was originally facilitated by the public health sector, currently the coordination of Posyandu is placed under the District Community Development Bureau (BMPD). Posyandu organizes monthly meetings that are utilized as an extension of services for the Puskesmas' maternal and child health programs. In Nias, Posyandu is established at the village level, where a linkage between communities and health services/facilities exists through the interaction of Bidan Desa and Posyandu volunteers in village level health promotion.

In Nias' context, the availability of Bidan is a major constraint in the delivery of services. One Bidan may be assigned to cover more than one village and stationed at the Puskesmas, not at the village level. The distance between Puskesmas and the village is another constraint. The link between community action for MCH promotion (Posyandu) and Bidan needs to be established and strengthened. Without the Bidan's support, Posyandu will fail.

2. Methodology

The Evaluation was implemented by a team consisting of a team leader and a Nias' specialist. An evaluation Reference Group was formed to advise the evaluation team and MFAT at key stages of the evaluation process. MFAT, SAI and the Government of Indonesia are represented in the Reference Group. The evaluation process was managed by the Development Programme Coordinator (DPC), based in Jakarta. The

[12] Formerly it was a Polindes or Pondok Pesalinan Desa (Village Birthing Hut)

scope of this evaluation covers the period from the approval of the CBHPI (April 2006) to the end of the first year of implementation of CBHPII (December 2010).

The evaluation involved a variety of stakeholders. The groups and individuals involved in the interviews are listed in Appendix 2.b. of this report. Meetings with national stakeholders were arranged by the Development Program Coordinator of the NZ Embassy in Jakarta, while meetings with provincial and lower-level stakeholders were arranged by SAI and the CBHP team.

The evaluation adopted inclusiveness and participatory approaches in data collection where all participants, particularly the program's beneficiaries, were encouraged to share their views. Due to time constraint, the Evaluation Team did not meet with each and every representative of the stakeholders in the 3 target districts. Nevertheless, to ensure inclusiveness of all parties, the team met with 3 groups of stakeholders (government, community and volunteers) in both CBHPI and CBHPII target districts.

The participatory approach was conducted at the community level through the Focus Group Discussions, which brought all stakeholders of village/community level together, both primary (households/mothers and their husband) and secondary beneficiaries (volunteers and community leaders), to share their views on the project. Participatory approach in data analysis and finding formulation was implemented through intensive and transparent group discussions with CBHP management and staff. The draft of evaluation tools that were used at the district, sub district and village levels were presented at the group discussions with CBHP staff for their comments and inputs. The involvement of the staff in refining and finalizing the tools was meant to provide the staff with a chance to better understand the evaluation method and process, as well as to build a sense of ownership of the evaluation.

2.1. Range of data collection activities

Both quantitative and qualitative data were collected through the following methods:

- Briefing, interviews and discussions with project stakeholders (see list in Appendix 3.b)
- FGD with community level stakeholders
- Other means of information gathering including review of project reports/documents and management tools such as proposal, M&E framework, Log-frame, annual plans/reports, KAP survey, progress reports, monitoring reports, manuals, policies, communication/IEC materials, MOU and other agreements and SK Bupati, and minutes of meetings. The full list of the reference documents is available in annex 2.a of this report.

2.2. Challenges and Limitations

With regard to CBHPI activities, the data collected by the evaluation team were mostly secondary data and this is due to the fact that with the exception of the community level stakeholder participants of the Focus Group Discussion in Afulu and three community level staff of CBHP, all other informants were relatively new to CBHP and were not involved in the implementation of CBHPI. This situation was caused by the following reasons:

- During project life time Nias' administration was expanded from 2 to 5 district level administrations. Although CBHP is still operating at the same district CBHPII is currently dealing with new district and sub-district level officials, as former district level stakeholders have been reallocated or promoted to new positions. While the new officials have no knowledge on CBHPI at all.
- Many International NGOs and donor organisation have permanently closed their office in Nias and most of the staff of those still operating are newly-recruited. For instance, World Relief that implemented the Care Group model has ceased its operation in Nias, therefore, the RT could not obtain more detailed information on CG model implementation in Nias.
- With the exception of three former Community Facilitators, all CBHPII staff are newly-recruited, mostly after CHBPII has started. In addition, CBHPII is operating in new hamlets. Activities in sixty six (out of 77) hamlets covered by CBHPI were discontinued in CBHPII without proper phasing out process, partly was due to safety reasons. The current project team has very limited knowledge on the old hamlets and could not arrange any meeting in the old hamlets, partly was due to safety reason.

3. Timing of the Evaluation

The implementation of the evaluation process was done in three phases:

3.1 Preparation (21 April to 14 May) consisting of team formation, MFAT/IDG briefing, submission of draft of evaluation plan, and finalization and approval of the evaluation plan.

3.2 Field assessment, temporary findings presentation and report drafting (29 May – 21 June), which consists of the following activities: field assessments in Jakarta, Medan and Nias; presentation of temporary findings in Nias and Jakarta; and submission of draft of evaluation report.

3.3 Submission of report draft for peer review, finalization and submission of final evaluation report (21 June to 24 August).

4. Findings and Conclusions

4.1 Outcome 1: Relevance, effectiveness, efficiency and impact of the CBHP's approaches and activities.

4.1.1 The extent to which the CBHP has addressed, and plans to address the identified needs and priorities of target communities, including any specific needs of men, women, girls and boys.

Finding: SAI carried out a needs assessment at five randomly-selected villages in two districts[13], focusing on their main health problems and health treatment behaviour. Primary community diseases and child health problems were identified as the two key

[13] This was conducted prior to the expansion of Nias island administration

priorities of the communities[14]. To address the identified needs, SAI developed a project plan: the Nias CBHP that aims to reduce child morbidity and mortality, and established 6 strategic objectives (SO) to achieve its goal. CBHPI adopted community engagement as a key strategy for program implementation, and its interventions were focused on 4 areas: (1) Community Engagement (SO1); (2) Water and Sanitation rehabilitation (SO2); (3) Child Health promotion (SO3, SO4 and SO5); and (4) Capacity Building of Health Centre (SO6) [15]. In developing the CBHP proposal, SAI did not conduct any gender analysis.

Conclusion: Child morbidity and mortality were identified as a key health issue and CBHPI was developed to address the identified needs and priorities. CBHPI's goal is to reduce child morbidity and mortality through the achievement of its 6 Strategic Objectives. CBHPI consistently intended to address health priorities of the target communities. Gender analysis was not conducted to support the project design; therefore specific needs of men and women were not properly identified and addressed.

4.1.2 *The extent to which the CBHP has addressed, and plans to address the health priorities evidenced by the baseline survey and other available data sources*

Finding: In 2007, CBHPI conducted a Knowledge, Attitude and Practice (KAP) survey.[16] CBHP's plans and reports[17] indicate that CBHP consistently intended to address health priorities evidenced by the KAP survey. However, the evaluation team found the baseline KAP survey as having the following weaknesses:

- The survey was contracted to a nutrition research and teaching institute and implemented with limited or minimal involvement by project staff and stakeholders. No training was conducted for project staff and stakeholders, to enable them to implement subsequent mid-term and end-of-project surveys.
- The selection of variables did not include the national Maternal and Child Health (MCH) programs' indicators[18].
- The selected respondents were mothers of under-fives, whereas the best respondents for MCH program are mothers of under-two years old child[19] and their husbands.

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[14] This was reported in detailed in the CBHP proposal.

[15] Surf Aid International; *Community Based Health Program, Nias Island, Indonesia, A Funding Proposal to NEW ZEALAND AID, By Surf Aid International;* October 2005

[16] SEAMEO Tropmed RCCN; University of Indonesia; *Final Report; Health and Nutritional Status Among Under Five Children in selected sub-districts in Nias and Mentawai Islands; A Baseline Survey for Community Based Health Programme (CBHP)*; by Surf Aid International; 2007

[17] Listed in Appendix 2a

[18] Kemenkes has established Health Information System for the national MCH programs containing basic program indicators to be used nationally for the monitoring of progresses of program implementation.

[19] Considered best for provision of information regarding mother's pregnancy and delivery and infant and child health history, including their immunization situation.

- The survey was conducted in Nias and Mentawai (as one survey) and not in the hamlets selected by CBHPI.
- There was no questionnaire for the men/husbands, and data on the children was not sex-segregated.

Review on CBHPI proposal and reports indicate that CBHPI set its targets based on the KAP survey findings. At a later stage of program implementation, CBHPI identified the weaknesses of the KAP survey and use Direct Observational Monitoring (DOM) method as a mean for monitoring. This was reported in the CBHPI final report without detailed information on when this happened. However, the Report acknowledges that the field staff that carried out the DOM were not trained, and the results were not validated by other monitoring activities. The Report reported CBHPI progresses in addressing the health priorities, which were determined by comparing evidences produced by the 2007 KAP survey and the DOM findings. Since results of the 2 surveys were not compatible and comparable to each other then the reported progress were actually invalid.[20]

A review on CBHPI reports[21] indicates that the baseline assessment conducted by CBHPI did not include assessment of (1) the state of implementation of the national child health strategy and programs[22] in the target areas; (2) the state of Posyandu in the target villages; and (3) the state of primary service system for child health promotion in the target areas[23]. CBHPI did not carry out a gender analysis of local MCH issues, to identify gender issues which have become the underlying causes of maternal and child morbidities and mortalities.

A participatory community assessment in the target areas to complement the KAP survey has not been conducted as well. This assessment is needed to provide qualitative evidences on household and community attitude toward MCH promotion; relevant local traditions and beliefs related to health and cross-cutting issues; decision making process at HH and community level; and social and leadership structures. These evidences are needed to guide the development of community participation and gender strategy, and in planning culture- and gender-sensitive behaviour change communication programs.

Conclusion: CBHPI conducted a KAP survey in 2007. However, the KAP survey does not provide valid baseline evidences for CBHPI intervention designing, as there are some weaknesses of the KAP survey method and the findings do not represent the situation of the target areas. The weaknesses of the KAP survey design affect the quality of the project log-frame and the M&E framework, which means CBHPI does not have valid evidences for monitoring the progress of its interventions.

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[20] SurfAid International; Final Report; COMMUNITY BASED HEALTH PROGRAM; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island; October 2006 – September 2009; pages 34.

[21] Listed in Appendix 2a

[22] The national strategy for maternal health promotion is the Making Pregnancy Safer (MPS) and for child health is the Integrated Management of Childhood Illnesses (IMCI)

[23] The Primary health services system consists of Bidan Desa/Poskesdes at village level and Puskesmas services system at sub-district level.

This weakness was recognized by CBHPI and therefore CBHPI used DOM as a tool for monitoring. However, the DOM was not properly implemented and the findings of the KAP survey and the DOM were not comparable. In result, CBHPI still lacked evidences to measure progress of its achievements and it is uncertain whether CBHPI has addressed the health priorities of its target areas.

CBHPI lacked qualitative evidences needed for the designing of culture- and gender-sensitive community engagement and behaviour change communication strategies. The absence of these evidences implies that CBHPI's communication and community participation strategy was not developed based on valid evidences.

CBHPI also lacked evidence to properly address: (1) the needs to strengthen primary health services for child health promotion, (2) specific local child heath development issues related to geographical and cultural constraints, (3) the needs to contribute to the achievement of national MCH targets for child health development, and (4) child health issues emerging from gender inequality.

CBHPI's intention to address health priorities of the target communities was not supported by adequate baseline assessments and CBHPI also lacked evidences to measure progress of its achievements. Thus it is uncertain whether CBHPI has addressed the health priorities of its target areas.

4.1.3 The extent to which the CBHP was originally, and has remained, aligned with national and sub-national government strategies, priorities and systems, and the New Zealand Aid Programme priorities

4.1.3.1.

Finding: CBHPI's goal, "to reduce mortality in children under five years of age", and CBHPII's goal, "to reduce maternal and child health mortality rate", are both the goals of the Millennium Development Goal (MDG), and aligned with the national and Nias' health development priorities. To achieve its goal, CBHPI established a logical framework for its interventions. An analysis of CBHP's log-frame indicates that in developing its intervention strategies, CBHP did not use the national strategies and programs for maternal and child health development as a key reference[24].

Discussions and interviews with project staff and health officials at the national and district levels and analysis of CBHP reports indicate that Bidan Desa was not involved in CBHP's village level activities. The two community groups established by CBHP, i.e. Care Group (CG) and Village Action Team (VAT) were not linked with village level health services (Poskedes or Bidan), and there was no reference made on the management role of Bidan Desa in the planning and monitoring of CG and VAT activities.

Conclusion: CBHP's goal was originally, and has remained, aligned with national and sub-national government priorities. However, CBHP's strategies and interventions were not aligned with the national strategies and programs for MCH development. Links between CBHP's village level activities and Bidan Desa was not established:

[24] Also based on discussions and interviews with project staff and health officials of national and district levels.

even though Bidan Desa is the key provider of maternal and child health services at the village level, and the first contact point for alignment with government health service system and MCH programs. The absence of a linkage between CBHP's village level activities with Bidan and primary health services will hamper project alignment with government health service system and MCH programs.

4.1.3.2.

Finding: CBHPII year one adopted Community Lead Total Sanitation (CLTS) as its backbone and as the point of entry to community empowerment and program development[25]. Latrine and sanitation programs are not listed as a priority in the national Making Pregnancy Safer (MPS) strategy and Integrated Management of Childhood Illnesses (IMCI) program.

Conclusion: The adoption of CLTS will not support project alignment with the national and sub-national strategy and system for MCH development, since CLTS is not an effective lead program for maternal and child health promotion. In fact, it will reduce CBHP's effectiveness in achieving its overall MCH goal.

4.1.3.3.

Finding: MFAT's bilateral program is currently preparing a new strategic plan, which includes a stronger geographic focus on eastern Indonesia and on supporting sustainable economic development. The strategy will also focus on human development outcomes that may include education, health, and local economic development opportunities.

Conclusion: Due to its geographic location, Nias CBHP will not be a priority in the new MFAT's strategic plan.

4.1.4 The extent to which the CBHP originally harmonized, and has continued to harmonize its interventions to complement, and avoid overlap with, the work of other development partners.

Finding: Evidences collected during interviews with district and sub-district stakeholders indicate that CBHP was actively involved in the communication networks of agencies working in Nias, and attended meetings with relevant stakeholders.

CBHPI implemented both post disaster rehabilitation of water and sanitation facilities and a program of long term goal, i.e., the maternal and child health program. CBHPI has completed the Water and Sanitation (WATSAN) activities. Currently CBHPII plans to implement MCH programs and the project team works in close coordination with District Dinkes and local Puskesmas. No overlap has been reported on the implementation of CBHP MCH activities.

Conclusion: There was a strong indication that CBHP has continuously intended to harmonize its activities, and avoid overlap, with the work of other development partners. With the completion of the WATSAN programs and the close coordination

[25] Overview of Proposed Modifications to CBHPII Nias, Augus 2010, page 8; as well as stated by the CBHP project team during the field assessment.

with Dinkes and Puskesmas in the implementation of MCH program, CBHP is in a better position to successfully harmonize its interventions with the work of other development partners.

4.1.5 The extent to which the CBHPI met its planned goal, objectives and outcomes, including consideration of specific gender outcomes.

4.1.5.1.

Finding: To achieve its project goals, CBHPI established six strategic objectives and developed a project log-frame describing the project activities, outputs and outcomes for the achievement of each strategic objective[26]. An analysis of the intervention logic as described in the CBHPI's log-frame indicates the following weaknesses:

(1) *Utilization of mortality rates at Strategic Objectives level (SO5).* CBHPI operates at the hamlet level in sparsely populated areas[27]. The utilization of mortality rate in this setting is technically inappropriate and not practical.

(2) *Inconsistency of the vertical hierarchy of intervention logic.* For example, one of the program outputs of community empowerment program (SO1), "On-going community participation in planning, implementing, monitoring and evaluating SurfAid project activities at the village level", is not complemented with activity plan (key task) and expected outcome. The importance of Posyandu services for MCH promotion has been identified in the CBHPI proposal; however, Posyandu strengthening activities were not included in SO1.

(3) Due to the weaknesses of the baseline KAP survey, log-frame targets were set arbitrarily, rather than evidence-based (see 4.1.2)

(4) The log-frame indicates that CBHPI's intervention logic does not include gender consideration.

Conclusion: The weaknesses of the project log-frame along with the weaknesses of the baseline KAP survey imply that CBHPI utilized weak management tools for planning and monitoring activities. It also means CBHPI does not have any valid tool to measure the progress of its interventions, i.e., whether CBHPI has met its objectives and outcomes, including the gender outcome.

4.1.5.2.

Finding: For four years CBHPI had implemented a range of activities with partner communities. Many positive outcomes have been reported and briefly witnessed by the Evaluation Team during the field visit. However, due to the absence of evidences measured by valid monitoring activities and the limited availability of informants who have knowledge on CBHPI, the Evaluation Team could not properly ratify the reported

[26] Surf Aid International; Community Based Health Program, Nias Island, Indonesia, A Funding Proposal to NEW ZEALAND AID, By Surf Aid International; October 2005, page 19-27

[27] Population of the CBHPI selected hamlets was between 20 to 80 HHs or 60 to 500 people.

achievements of CBHPI in meeting its planned objectives and outcomes. As such, it is not possible for the Evaluation Team to report fully on the extent of CBHPI's achievements. The following report on CBHPI activities is taken mostly from CBHPI's progress reports.

4.1.5.2.1 CBHPI Community Engagement program

Finding: CBHPI established and supported the functioning of 72 CG in 77 hamlets, involving around 600 volunteers as the key agents in program implementation. The latter included promotion of hand washing practice, rehabilitation of malnourished children, distribution of impregnated bed nets and communication activities to increase HH knowledge of ARI, Hygiene, nutrition/breast feeding, malaria prevention, and diarrhea management. In four years of project implementation, CG had reached 4560 households. It has also been reported that CG members were actively involved in the revitalization of Posyandu.[28] CG was the key strategy for community empowerment of CBHPI and key agent of many achievements reported by the CBHPI.

In May 2010, the SAI New Zealand Programme Committee undertook a formal assessment of all CBHP activities in Nias, including the CG approach and recommended that the CG approach should be modified in order to engender greater community support and participation in program activities[29]. Therefore, the CG approach was discontinued and replaced it with VAT.[30]

Conclusion: Although it is difficult to ratify, there is a strong indication that CG volunteers produced positive outputs for the benefit of their communities. However the discontinuation of the model by CBHPII implies that the CG model is in fact unsustainable.

4.1.5.2.2 Health communication activities

Finding: CBHPI's communication activities were implemented by CG volunteers and CF (staff) through household level visits and Posyandu sessions. Achievements made by the program have been discussed in 4.1.5.2.1 above. CBHPI reports indicate that CG volunteers encountered difficulties in implementing the house visit program and considered the approach culturally unacceptable, and the program was discontinued[31]. CBHPII has not established a new strategy to replace the discontinued house visit.

Conclusion: CBHPI's household visit program was considered unacceptable and was discontinued. In actuality, the unacceptability of the house visit approach is still subject for further investigation, as this approach has been successfully utilised by various community-based health programs in other parts of Indonesia[32]. Regardless, the program has been discontinued and CBHPII has not established a new strategy.

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[28] Ibid., pages 16 and 31

[29] Information was provided by SAI as a feed back to the Evaluation Report draft.

[30] Overview of Proposed Modifications to CBHPII Nias, Augus 2010, pages 68-69.

[31] 2008 – 2009 Annual Report; Nias Community Based Health Programme; Surf Aid International; October 2008 – September 2009, page 5.

[32] The Evaluation Team members were involved in a range of community based programs in other parts of Indonesia, which all adopted the house visit communication strategy.

4.1.5.2.3 Nutrition Program

Finding: Child malnutrition is a major health problem in Nias[33]. CBHPI's nutrition program utilized the Positive Deviance approach (described as PDI or PD Hearth in CBHP reports) and engaged CG volunteers in program implementation. 524 malnourished children had been rehabilitated to the normal status. In malnutrition rehabilitation programs, the PDI model incorporates food already found in the community that provides important nutrients[34]. It was reported by project staff during team discussion that the PDI model was not consistently implemented in the later period of CBHPI, during which non-indigenous food products, such as carrots and vegetables imported from Sumatra were introduced through supplementary feeding sessions. In general, project team and stakeholders indicated that the PDI model was well implemented and accepted by CG volunteers and partner communities, although achievement was reported as under the target: i.e., 24% instead of the targeted 50% reduction of rehabilitated mal-nourished children[35].

The noted constraint of the program's implementation was the process-oriented nature of the approach, which absorbed time, attention and resources. In effect, the approach is more suitable for an exclusive nutrition project rather than as part of a complex MCH program. The approach is also more oriented toward rehabilitation instead of prevention of malnutrition. CBHPII has allocated budget for nutrition improvement program, however CBHPII has no plan to implement the PDI program and no nutrition improvement program has been implemented in year one[36].

Currently, there is an NGO, the Obor Bahtera Indonesia (OBI), that operates an institution for the rehabilitation of severely malnourished children. OBI has invited CBHP and other NGOs to refer any malnourished child to the institution[37].

Conclusion: Malnutrition is common among Nias children and CBHPI responded with malnutrition rehabilitation program utilizing the PDI approach. The program engaged CG volunteers in its implementation and was well accepted by the partner communities. The CBHPII allocates budget for nutrition program; however, the program has not yet been implemented.

4.1.5.2.4 Water and Sanitation Program

Finding: Water and Sanitation Program is a key program in a post disaster situation. The program was implemented by many multi-lateral, bi-lateral and international NGO humanitarian responses, including CBHP. CBHPI's Water and Sanitation rehabilitation program has been completed and its achievement was reported as over

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[33] As reported by District Bappeda and Dinkes Officials interviewed by the Evaluation Team.

[34] Surf Aid International; *Final Report; COMMUNITY BASED HEALTH PROGRAM; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island*; October 2006 – September 2009, pages 21–26.

[35] Ibid page 25

[36] Reported by project staff involved in CBHPI during field assessment.

[37] Expressed by an OBI staff during interview with the Evaluation Team.

the target.[38] CBHPI's Water and Sanitation activities had been augmented with UNICEF-funded Watsan activities, which were implemented mainly during the 9-month extension period.

Conclusion: The Water and Sanitation program was well implemented and accepted by the target communities. CBHPI also implemented UNICEF's Watsan program and the Watsan program achievement was over the target. The implementation of UNICEF's Watsan program generated additional workload to CBHP management and was likely to be one of the causes of CBHPI delay in program implementation.

4.1.5.2.5 Malaria Program

Finding: Malaria is a major health problem in Nias, and in the context of malaria programs, pregnant mothers and children are considered as high-risk. The malaria in Nias is of the drug-resistant type, which is life threatening.[39] The CBHPI Malaria program focused on impregnated nets distribution and HH level education on malaria prevention. 2683 impregnated bed nets had been distributed to 1044 HHs located in Sirombu, Afulu and Alasa, which are considered endemic areas[40]. Currently, malaria program is a key priority in Global Fund interventions in Nias, in which net distribution is a key activity. Global fund officer indicated that, in the future, net distribution would be sufficiently addressed while program addressing vector eradication is still lacking.[41] A review of the impact of the net distribution has not been conducted by CBHP.

Conclusion: The CBHPI's malaria program was appropriate, as the Global Fund's malaria initiative for Nias was still in the planning stage when CBHPI implemented the net distribution and HH malaria education. However, a review of the impact of the net distribution has not been conducted.

4.1.5.2.6 Immunization program

Finding: Coverage of immunization is one of the key maternal and child problems in Nias.[42] Normally, immunization program is conducted by the Puskesmas staff during a Posyandu session. The low coverage of immunization was a result of the state of the Posyandu; i.e. many Posyandu are inactive, or worse, many villages do not have a Posyandu, while the attendance rate at Posyandu sessions is very low. A 2007 KAP survey reported that only 21% of Nias' children were fully immunized[43]. CBHPI

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[38] Surf Aid International; Final Report; COMMUNITY BASED HEALTH PROGRAM; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island; October 2006 – September 2009, pages 19 -20.

[39] http://www.malariajournal.com/content/6/1/116

[40] Surf Aid International; Final Report; COMMUNITY BASED HEALTH PROGRAM; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island; October 2006 – September 2009, pages 26-27.

[41] Information provided by Provincial Dinkes staff who was also a Global Fund Officer for North Sumatra.

[42] Reported by Dinkes and Puskesmas staff to the Evaluation Team during interviews. It was estimated that less than 40% of children were fully immunized.

[43] SEAMEO Tropmed RCCN; Final Report; Health and Nutritional Status Among Under Five Children in selected sub-districts in Nias and Mentawai Islands; A Baseline Survey for Community Based Health Programme (CBHP); by Sur Aid International; University of Indonesia; 2007.

established plans to address the problem, which include providing support for immunization session at the Posyandu and provision of cold chain materials to health centres.[44] The Evaluation Team could not find any report that indicates the plan has been implemented, and could not obtain any information on CBHPI's immunization program from the project team during the interview or group discussion. Meanwhile, although budget has been allocated, CBHPII has not established any plan to support the immunization program[45].

Conclusion: CBHPI's baseline assessments did not include assessment on the state of Posyandu and the primary services that include the state of immunization program in project areas (see 4.1.2). Thus the planning of an immunization program was not adequately supported by the needed evidence. It is likely that CBHPI's immunization program was not properly planned and the plan was difficult to implement.

4.1.5.2.7 Diarrhoea program

Finding: The CBHPI diarrhoea program was focused more on hygiene promotion as a mean to reduce incidence of diarrhoea. The program was linked with WATSAN programs (SO2). The effectiveness of WATSAN program in reducing incidence of diarrhoea was reported in the project report, i.e., from 84% to 51% of diarrhoea incidence.[46] The report was based on monitoring activities using DOM method.

Conclusion: The positive effect of clean water, sanitation and personal hygiene programs on diarrhoea reduction has been widely reported and accepted.[47] However, the reduction of incidence of diarrhoea due to implemented hygiene and sanitation program in the project areas as reported in the CBHPI Final report is difficult to ratify, as DOM is not an appropriate method for making estimates on diarrhoea reduction[48].

4.1.5.2.8. The strengthening of Posyandu

Finding: Posyandu has been proven as the only community movement for health promotion that is sustainable, having been accepted by the communities across Indonesia as well as the government at the national and sub-national levels, and supported by a range of legislations and policies established at the national and sub-national levels. However, in many remote and poor areas such as Nias, the state of Posyandu is deteriorating. CBHPI recognises the importance of strengthening Posyandu in MCH promotion. CBHPI's key program of community engagement is CG, and CBHPI's approach to Posyandu strengthening is through the CG program.

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[44] Surf Aid International; Community Based Health Program, Nias Island, Indonesia, A Funding Proposal to NEW ZEALAND AID, By Surf Aid International; October 2005, pages 21-22.

[45] Based on discussions and interviews with project team

[46] Surf Aid International; Final Report; COMMUNITY BASED HEALTH PROGRAM; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island; October 2006 – September 2009, page 29.

[47] Esrey SA, Feachem RG, Hughes JM. Interventions for the control of diarrheal diseases among young children: improving water supplies and excreta disposal facilities. WHO Bulletin, 1985; 63:757-72 .

[48] An epidemiological research is needed to estimate the effect of CBHPI sanitation program on diarrhea reduction, while DOM is a real-time monitoring system.

CBHPI's report indicated that achievement of Posyandu strengthening activities is over the target[49]. The reported achievement occurred in Sirombu and Teluk Dalam sub-districts.

Conclusion: Although CBHPI did not utilize Posyandu as a key agent for program implementation, Posyandu strengthening activities were considered an important program. CBHPI has reported over the target achievements for its Posyandu revitalization activities. However, the impact of the achievement became less significant during the implementation of CBHPII due to the changes made in the selected target villages. The revitalized Posyandus are located in Sirombu and Teluk Dalam sub-district, which are not covered by CBHPII.

4.1.6 The extent to which CBHPII year one has been focused upon strengthening community action and meeting the eight specific requirements set out by MFAT in September 2009 and March 2010.

4.1.6.1. The strengthening of community action

Finding: CBHPII carried out 2 programs aimed at strengthening community action: (1) the establishment of VAT, and (2) the strengthening of Posyandu. VAT is a newly established community action group that replaces the discontinued CG. VAT emerged from CLTS program implementation and became a key agent for CBHPII's program development and implementation. CBHPII's strategy towards Posyandu strengthening was achieved through the automatic membership of Posyandu volunteers in VAT. CBHPII provided training on hygiene and sanitation to VAT volunteers[50].

Conclusion: The strengthening of community actions for health development has been a key program of CBHPII, which focuses on the establishment of VAT and the strengthening of Posyandu. The strategy used in Posyandu strengthening was an automatic membership of Posyandu volunteers in VAT. Such a strategy will produce impact only in villages that already have a Posyandu. The new skills obtained by Posyandu volunteers from their involvement in VAT will not effectively improve their contribution to MCH program implemented by the Posyandu. Moreover, the automatic membership of Posyandu volunteers in VAT is basically against self-determination principles.

4.1.6.2 Progress of the implementation of the 8 Tasks as requested by MFAT

4.1.6.2.1 CBHP has formalized its relationship with government health institutions at the national, provincial, and district levels through letter of agreements and MOUs. However, the agreements and MOUs have not been focused specifically to programs alignment, coordination, and handover[51]. It is more important for CBHP to draw an agreement or MOU with the BAPPEDA, involving the Dinkes, BPM, Women Empowerment and Child Protection Bureau and the Family Planning Agency for program alignment, coordination and handover.

[49] The target was 50% improvement of Posyandu, but 120% achieved, as reported in the 2008-2009 annual report and final report of CBHPI.

[50] Overview of Proposed Modifications to CBHPII Nias, Augus 2010, pages 64 -69.

[51] Review of the currently available MOU.

4.1.6.2.2 Mapping of other interventions in the health sector delivered by other agencies and the existing government frameworks and structures including Desa Siaga, Dasa Wisma, Posyandu Polindes, Polkedes, and Puskesmas activities is currently conducted by the project team[52]. The results will be used in the planning of CBHPII interventions.

4.1.6.2.3 The set up of an advisory board is still in progress. To coordinate program implementation and all collaborative activities with Puskesmas, Camat and village administrations, the project will require a greater support from a task force group or a project coordination committee established at the district level. This task force should engage all district level stakeholders.

4.1.6.2.4 Development of a more comprehensive monitoring and evaluation plan will be conducted after the refined CBHPII design and its log-frame is approved by MFAT/IDG.

4.1.6.2.5 An independent review of CBHPI and CBHPII year one is currently being conducted.

4.1.6.2.6 Revision of CBHPII log-frame will be conducted with inputs provided by the independent evaluation team.

4.1.6.2.7 A strategy for a gradual increase towards greater local management and ownership of the programme will be developed as part of the refined CBHPII design.

4.1.6.2.8 A revised project document that incorporates all key findings from the evaluation will be drafted and submitted in the near future for MFAT/IDG approval.

4.1.7 The value for money provided by the CBHPI i.e., could activities have been implemented at less cost whilst retaining the same quality and quantity of benefits.

4.1.7.1.

Finding: CBHP has adopted a 'tight financial policy' by avoiding payment of subsidy to program implementation and implementing cost-sharing strategy. Surfaid implemented a similar program in Mentawai. What this means is that costs of development of materials and other resources were shared between the Nias and the Mentawai programs. The cost-sharing strategy was also utilized in the nutrition program. Budget was developed based on careful cost assessments. Surfaid has been in Nias long before the tsunami, and as such possess an in-depth knowledge on Nias' standard of living. However, the influx of funding and foreigners as a result of the disasters dramatically changed the market situation and living standard, and created difficulties to CBHP in maintaining its financial policies.

The implementation of a cost-sharing strategy in the context of a joint Nias and Mentawai KAP survey implementation is in fact technically not feasible. And it has made the survey findings unusable as CBHP baseline evidence and caused weaknesses

[52] Reported by the project team

in the program design. The weakness of the program design led to failure in program implementation, including its financial efficiency policies.

Conclusion: CBHP has adopted and implemented a 'tight financial policy' and costs-sharing strategy for efficient program implementation. Budget was carefully developed based on costs assessments and a thorough understanding of Nias' living conditions. However, the influx of humanitarian funds and workers has altered Nias' situation and created difficulties to CBHP in maintaining its financial policies.

The inappropriate application of the efficiency policy in the context of a joint Nias and Mentawai KAP survey has detrimental effects on program implementation and led to the failure in program implementation and its financial efficiency policies.

4.1.7.2

Finding: CBHP worked in close coordination with BAPPEDA and Dinkes for program harmonization to avoid program overlaps.

Conclusion: CBHP's program harmonization through coordination with district stakeholders will lead to an efficient implementation of programs.

4.1.8 Any programme management issues (e.g. human resources, logistics, procurement and systems) which affected the efficiency of the CBHPI and CBHPII year one implementation.

4.1.8.1.

Finding: The most detrimental management issue was the high turnover of project staff across all levels, particularly those of program coordination and management. The current professional team members, consisting of Program Manager, M&E officer, Training Officer, and Area Field Managers, are relatively new, recruited after CBHPII has started. None was involved in the implementation of CBHPI. During group discussions with the project team, the Evaluation Team found current project team members to have limited knowledge of CBHPI program concepts and implemented activities. The Evaluation team found that relevant project documents on CBHPI, such as annual reports and plans were of limited availability, and the staff were not adequately briefed about the overall CBHP I and II program context.

Conclusion: CBHP recruitment process did not properly address the need to adequately brief and guide new staff for a smooth program handover thereby ensuring consistency in program implementation. This situation caused a weak program linkage between CBHPI and II.

4.1.8.2.

Finding: For over a year, the current project team implemented the project without being equipped with proper management tools such as an approved log-frame and evidences from valid and updated baseline assessments. Meanwhile, CBHPII design is still subject for review and design refining. CBHPII documents that were currently

available and utilized implied a "new"[53] CBHP with a strong emphasis to latrine and hygiene promotion; and adopted CLTS as a lead program to achieve the project's MCH goal[54]. However, some project team members expressed that in actuality, they do not agree with what has been suggested in the document. Nonetheless, they felt they were obliged to implement the suggestion[55].

Conclusion: CBHPII year one implemented mainly hygiene and sanitation promotion programs, i.e, CLTS and the establishment of VAT that emerged from CLTS implementation. The current CBHPII's strategy and programs imply that CBHP has become a latrine-and-hygiene-based program, although the project goal remains MCH promotion. The observed situation also indicates that the new project team has limited knowledge of CBHPI concepts and programs (see 4.1.8.1). In effect, the team has faced difficulties in keeping CBHPII on the right track toward the achievement of the overall CBHP MCH goal, and to keep its activities consistent with CBHPI. The absence of valid (approved) project documents and management tools has exacerbated the negative impacts of the situation on CBHPII project management.

4.1.8.3.

Finding: CBHPI has engaged project field staff, i.e., CF, in both program coordination and direct activities implementation at the household level.[56]

Conclusion: The involvement of project staff in program implementation at the household level will have a negative impact on program sustainability.

4.1.8.4.

Finding: Evidences indicate that the project lacks manuals and guidelines for program implementation[57].

Conclusion: The absence of program manuals and guidelines will affect the quality and consistency of program implementation.

4.1.9 The actual or likely impact (positive, negative, planned or unplanned) that the CBHPI has had, or will have, on project stakeholders and the environment, where this can be identified from available evidence.

4.1.9.1.

Finding: The Evaluation Team was unable to measure the long-term impact of CBHPI during the field assessment. CBHPI has reported short-term impact of its activities, however the reports are difficult to ratify due to the weaknesses of the assessment

[53] here "new" means that CBHPII is not programmatically linked to CBHPI with the two having different goal, target areas, strategies and program emphasis.

[54] Surfaid International; *Overview of Proposed Modifications to CBHPII Nias*, August 2010

[55] Anonymously expressed.

[56] The field staff were assigned to carry out communication activities at the household level.

[57] For example, the PDI nutrition rehabilitation program, which is a complex program and not widely implemented by other NGOs. The new project team suggested that they would not be able to implement the program without the manual or guidelines for implementation.

methods for planning and monitoring. Likewise due to the following reasons: (1) Most of the target areas of CBHPI are no longer covered by CBHPII and no follow-up was made in the former target areas; (2) The current project team members are new and have limited knowledge of CBHPI concepts and implemented activities; (3) Key activities of CBHPI, i.e., CG, WATSAN and PDI, have been discontinued; and (4) Detailed program reports and manuals are of limited availability.

Conclusion: In light of the problems mentioned above, the Evaluation Team is unable to report with confidence or to confirm the validity of reports of the detailed impact of CBHPI activities on project stakeholders. An analysis of the CBHPI program achievements has been presented in 4.1.5 above.

4.2 Outcome 2: Sustainability of the CBHP's approaches and activities.

4.2.1 The extent to which the CBHP's target communities (including specific reference to men, women and children) have engaged in the design, implementation and monitoring of the project.

4.2.1.1.

Finding: For the designing of CBHP, SAI carried out needs assessment in five villages in the districts of Nias and South Nias. During the planning stage, CBHPI conducted a KAP survey using mothers from randomly selected communities as informants. However, the villages selected by CBHPI for the needs assessment and KAP survey were located outside of CBHPI's target areas.

CBHPI adopted community engagement strategy and established CG, which comprised of both male and female volunteers, as key agents for implementation of its communication activities and Posyandu revitalization. Posyandu volunteers were involved in the implementation of CBHPI nutrition rehabilitation program.

CBHPII established VAT as a key agent in CLTS program implementation. The VAT comprises of male and female volunteers, including Posyandu volunteers who are members of the target communities.

Conclusion: CBHP adopts community engagement as key strategy for program implementation and has consistently intended to involve the target communities in the design and implementation of its interventions. With the exception of the KAP survey, in which target communities have not engaged in the KAP survey implementation, both men and women of the target communities who are members of CG, RVG, Posyandu and VAT have consistently engaged in the implementation of CBHP programs.

4.2.1.2.

Finding: CBHPI monitoring activities (DOM) were carried out by the project staff. Discussions and interviews with project staff and stakeholders reveal that the Monitoring and Evaluation (M&E) framework has not been developed to accommodate involvement of community volunteers in program monitoring.

Conclusion: Members of the target communities have not engaged in CBHPI monitoring activities, which was conducted by project staff. The current M&E framework does not accommodate involvement of members of target communities in program monitoring.

4.2.2 *The level of ownership that target communities have of the CBHP - its interventions, outcomes and shortfalls.*

4.2.2.1.

Finding: CBHP consistently promotes community ownership through the adoption of community engagement and cost sharing strategies.

CBHPI established 72 CG in 77 hamlets involving around 600 CG volunteers. CG was involved in the implementation of Posyandu strengthening, PDI nutrition rehabilitation and house visit communication program. CBHPI's nutrition rehabilitation program involved cost-sharing, in which CG volunteers and HH members contributed local food products such as vegetables to the program. Discussions and interviews with projects staff reveal that the cost sharing strategy was well accepted by the volunteers and program beneficiaries.

CBHPII year one adopted CLTS as a lead program and established VAT as key agent for program implementation. Latrine constructions within the CLTS program were fully funded by the household recipients. During team discussion, the project staff reported that HHs' commitment to the program was based on an expectation that the project will provide water facility at a later stage of implementation. The latrines built were of the wet type which requires water for utilization, while the dry type latrine was not popular. Without provision of water facility, the latrine is unusable. Some field staff expressed that they had implicitly informed HH beneficiaries that CBHP will assist in bringing water programs to the community.

In a group discussion with the project staff, it was reported that SAI management has advised the staff that CBHPII will be focused more on sanitation promotion. As such, in year one, the team only implemented CLTS. The staff had assumed that CBHPII would allocate budget for additional WATSAN activities to support the expanded CLTS program. In fact, CBHPII allocates a small budget for hygiene and sanitation programs (2%)[58] and no budget for water facilities construction.

The Evaluation Team was informed that SAI has received donation of WATSAN facilities from an NGO that closed their activity in Nias. The donated facilities will be used to support the CLTS program. However, SAI acknowledged that the donated WATSAN facilities would only be sufficient to provide water facilities at the community level and not at the HH level. Provision of water facilities to the HH level will be very costly.

Conclusion: In CBHPI, the high number of members of target communities who have engaged in the implementation of Posyandu strengthening, nutrition rehabilitation and communication program; as well as the cost-sharing strategy utilized in the nutrition

[58] Overview of Proposed Modifications to CBHPII Nias, Augus 2010, page 79.

rehabilitation program would have built a strong sense of ownership of the programs[59]. While in CBHPII year one, latrines built by the program were definitely owned by the household recipients and not the community.

To ensure CLTS program sustainability, a sense of program ownership should be established at the community level, or with the VAT group, which has not been assessed yet. The CLTS program depends on the availability of water facilities. CBHPII planned to expand the CLTS program and support the expansion with the donated water facilities. CBHPII only allocated 2% of its budget to hygiene and sanitation program, and no budget was allocated to implement WATSAN activities. The implementation of the CLTS program is at risk, as the donated water facilities are limited to the community level only. The inability to provide the needed water facility to HH beneficiaries will damage the sense of ownership by the household recipients and local community of CLTS and other CBHP programs.

4.2.3 The extent to which the CBHP has collaborated with government agencies at sub-national level, technical agencies and any CBOs in the design, implementation and monitoring of the project.

Table 1[60]

Agencies and Organizations with which the CBHP has collaborated

Agencies/Organizations	Design	Implementation	Monitoring
MOH/Kemenkes	No	No	No
Provincial Dinkes	No	No	No
District Dinkes	No	Yes	No
Puskesmas	No	Yes	Yes
Bidan/Village level	No	No	No
District WECP Bureau	No	No	No
District Education Services	No	Yes	Yes
Schools	No	Yes	No
District BAPPEDA	No	No	No
Camat	No	No	No
Village head	No	No	No

[59]This conclusion is based on the assumption that community participation in and contribution to a program will build community's ownership of the program. However, this assumption has not been ratified by any assessment.

[60] The Table was developed in a group discussion with project staff. The timeframe of the Table is CBHPI and CBHPII year one. Thus it does not reflect the most current situation of CBHPII

4.2.4 The effectiveness of the CBHP's activities and/or approaches in strengthening links between communities and health services/facilities, building health governance and workforce capacity.

Finding: CBHP adopted a hamlet-based approach for its implementation and established new community structures, the CG and VAT, at the hamlet level. Review of project reports as well as discussions and interviews with project staff and district stakeholders reveal that CBHP did not establish any link between the CG and VAT that operate at the hamlet level and the Bidan Desa who operates at the village level. CBHP recognizes the importance of Posyandu strengthening and efforts were made during CBHPI and II to strengthen Posyandu services in the project areas. CBHPI reported achievement in increasing the number of active Posyandus; however the reports do not indicate that a link between Posyandu and Bidan has been established[61].

CBHPII utilized Puskesmas (sub-district) trainers in the implementation of CLTS program at the hamlet and household levels, but did not involve Bidan Desa and Posyandu volunteers in the program[62].

Conclusion: CBHP does not have any activity to strengthen the link between community actions and primary services, i.e., the Bidan Desa and/or Poskedes at the village level. No activity has been established for the purpose of strengthening the link between Posyandu and Bidan services at the village level. However, links between communities and the Puskesmas were established by CBHPII in the implementation of CLTS training.

4.2.5 The effectiveness of the local volunteering model and volunteering approaches that the CBHP has utilized.

4.2.5.1.

Finding: CBHP established new community volunteering models, i.e. CG, RVG and VAT, and utilized them as its key implementation agents. An assessment of the CG model conducted by the SAI New Zealand Programme Committee recommended modification of the CG approach in order to engender greater community support and participation in program activities, which leads to discontinuation of the model. While the formation of RVG was not successful and the model was also discontinued (see also 4.1.5)

The effectiveness of the VAT model has not been assessed as well. However, a review on the model indicates that the VAT volunteering model will not be an effective model for the achievement of CBHPII's MCH goal (see 4.1.6.1 and 4.1.8.2).

Posyandu is widely accepted as the most effective local volunteering model for primary health care promotion, particularly MCH[63]. CBHP recognizes the importance of Posyandu and implemented the Posyandu strengthening program. However,

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[61] From the review of CBHPI reports as listed in Appendix 2.a

[62] The CBHPII's maternal health activities were started in March 2011.

[63] Expressed by all Health and Planning officials in the field assessment interviews.

CBHPI and CBHPII year one did not utilize Posyandu as its key agent for program implementation[64].

Conclusion: Posyandu is the widely accepted local volunteering model for MCH. Although CBHP recognizes the importance of Posyandu, CBHPI and CBHPII year one did not use Posyandu as the key agent for its implementation.

The CG model was considered ineffective and discontinued, while the VAT model is not an effective model for MCH promotion.

4.2.6 The extent to which volunteers' activities are likely to be sustained without further direct project intervention.

4.2.6.1.

Finding: The discontinuation of CG and RVG implies that the volunteering models established by CBHPI were not sustainable. While the sustainability of the VAT model depends on the sustainability of the CLTS program and the sustainability of CLTS program depends on the availability of a Watsan program.

CBHPI's Posyandu strengthening activities have revitalized 12 Posyandus in Sirombu and Teluk Dalam sub-districts. Currently, CBHPII no longer operate in these two sub-districts. The revitalised Posyandus are being sustained by local communities and the Puskesmases, who utilize the Posyandus as an extension of their MCH promotion programs.

Conclusion: Experiences in Indonesia indicate that the sustainability of new volunteering activities or community structures established by NGOs to meet their program needs depends on the sustainability of the program and/or sustainability of the implementing NGOs. Posyandu has been accepted and included in the national primary health care system and utilized by Puskesmas as its services extension. The revitalized Posyandus are sustained by local communities and Puskesmas without further direct project intervention.

4.2.7 The actual or likely sustainability of any observed or reported benefits which have arisen from the CBHPI, taking into consideration relevant institutional, gender-related, environmental and contextual factors that will impact upon these.

4.2.7.1.

Finding: CBHPI adopted a hamlet-based approach where individual hamlets were selected as a unit area for program implementation. The wide distribution of the project areas that resulted from the hamlet-based approach made it difficult to link and align project interventions with the government primary care system. The distribution of programs and their benefits to many individual hamlets created difficulties in engaging the Puskesmas in program coordination and management support provision, and in sustaining the programs after project completion.

[64] The scope of this evaluation is CBHPI and CBHPII year one. It is important to note that currently CBHP has adopted a new strategy that utilizes Posyandu as its key implementing agent.

Conclusion: The hamlet-based approach is not suitable for health programs with a long-term goal, such as MCH promotion, that needs to be linked and aligned with the district health system. In effect, the implemented programs were not sustainable.

5. Outcome 3: Recommendations for modifying the CBHPII to improve the relevance, effectiveness, efficiency, impact and sustainability of its interventions.

5.1 Ways in which the CBHPII could better address the health priorities of target communities, including any specific needs of men, women, boys and girls.

5.1.1 It is recommended that CBHPII consistently focus its intervention on the promotion of maternal and child health, which is a national as well as Nias' priority. To better address the maternal and child health priorities of target communities, CBHPII should conduct assessments aimed at identifying and prioritising key maternal and child health issues, and problems specific to the target areas. These assessments include an assessment on the state of Posyandu and primary health services, a KAP survey, and a participatory community assessment[65]. As a community-based health program for MCH development, it is recommended that CBHPII include the following interventions in its programs: (1) the strengthening of Posyandu structures and activities in all target villages, (2) improvement of HH's knowledge and practices (KAP) of MCH promotion; and (3) aiding the Puskesmas so as to improve the quality and coverage of primary services, including provision of support for Posyandu activities.

5.1.2 It is recommended that CBHP conduct a gender analysis of the MCH situation. CBHP's intervention approaches and planned activities should be developed to address the underlying gender issues.

5.2. Ways to enhance community participation in, and ownership of, CBHPII's implementation and outcomes.

5.2.1 The level of ownership that the target communities have of CBHPII should be enhanced by increasing the level of community participation in program planning, implementation and monitoring, and their contribution to the program.

5.2.2 It is recommended that CBHPII utilize Posyandu volunteers as a key change agent for project implementation, and to focus its community empowerment activities on strengthening Posyandu structure and activities in all target villages.

[65] The assessment is to provide qualitative evidences for household and community attitude toward MCH promotion, relevant local traditions and beliefs related to health and cross-cutting issues, decision making process at the HH and community level, and social and leadership structures.

5.2.3 The strengthening of Posyandu should have 100% target coverage in projects villages and be conducted as early as possible, so as to enable Posyandu volunteers to be involved in program preparation, implementation and monitoring.

5.2.4 It is recommended that CBHPII facilitate the involvement of local CBOs, including religious groups and desa siaga forum, in the planning, implementation and monitoring of the Posyandu strengthening program[66].

5.2.5 It is recommended that CBHP employ an approach that allows local contribution to cover costs of activities, such as the contribution of food products in nutrition demonstration activities.

5.3. Opportunities for the CPHPII's closer alignment with government strategy and/or harmonisation with work of other development partners.

5.3.1. It is recommended that CBHPII adopt a subdistrict-based approach in selecting target areas, i.e., the inclusion of all villages located in the sub-district.

5.3.2. It is recommended that CBHPII work in close cooperation with District level BAPPEDA, DINKES and BPM for program harmonization and coordination.

5.3.3. In the designing of its interventions, CBHP should use national MCH strategies adopted by Kemenkes, i.e. the MPS strategy and the IMCI program, as key references. CBHP should emphasize the non-clinical and preventative aspects of the program; i.e., to include malnutrition prevention, support to Posyandu immunization program, and HH education on fever and diarrhoea management in the child health promotion programs[67]. Maternal health interventions should be focused on assisting both the community and the health services system in solving the problems of Bidan (in)availability, and accessibility to and affordability of Bidan services.

5.3.4. It is recommended that CBHP strengthen the links between community actions and primary services for MCH, which involve strengthening Puskesmas' and Bidan's supports to Posyandu and facilitating the implementation of Kemenkes' Bidan and TBA partnership initiatives.

5.3.5. It is recommended that CBHPII phase out those activities that are not aligned with government MCH strategy, priorities and system, such as the CLTS program.

5.4. Opportunities for the CBHPII to enhance its harmonisation with the work of other development partners to increase overall efficiency and effectiveness.

5.4.1. It is recommended that CBHPII facilitate the formation of a District-level project coordination structure, chaired by BAPPEDA and including as members the

[66] As recommended by Kemenkes and District Health Officials.

[67] As the non-clinical aspects of IMCI.

CBHP Program Manager, relevant sections of District Dinkes, BPMD and Women Empowerment and Child Protection.

5.5. *Ways in which the CBHPII could maximise its effectiveness, with gender differentiation where relevant.*

5.5.1. In light of time and budget constraints, it is recommended that CBHPII select one sub-district as a pilot area for the development and implementation of a community-based approach to MCH promotion. Such an approach will include the establishment of a Posyandu model.

5.5.2. It is recommended that CBHPII undertake qualitative and quantitative assessments as listed in 5.1.1, and conduct a thorough gender analysis to identify the underlying gender issues of maternal and child morbidity and mortality.

5.5.3. It is recommended that CBHPII establish a strategy for prioritization of problem solving including the project phasing strategy, i.e., scheduling of program implementation and village coverage.

5.5.4. It is recommended that CBHPII develop and implement a strategy for early phasing out of hamlets that are not included in the pilot sub-district.

5.5.5. It is recommended that CBHPII restructure its management system to align with the new sub-district based strategy and program focus.

5.5.6. It is recommended that CBHPII strengthen its staff and management capacity so as to enable them to effectively plan, implement, and monitor the planned interventions.

5.6. *Ways in which the CBHPII could improve monitoring of progress and demonstration of where development outcomes are being achieved and to allow for gender disaggregation where relevant.*

5.6.1. It is recommended that CBHP utilise only academically sound methods in conducting the assessments listed in 5.1.1.

5.6.2. It is recommended that CBHP redevelop its log-frame, to align its structure with CBHP's roles as a community based health program for MCH promotion, and to align its interventions with government MCH strategies and programs. It is recommended that CBHP develop an M&E framework based on the approved log-frame. The M&E framework should be made available to all staff and stakeholders involved in the monitoring activities, and their capacity for developing and implementing monitoring plans based on the M&E framework should be developed.

5.6.3. Subject to the approval of the recommended project extension (5.8.2), it is recommended that CBHP schedules a midterm evaluation that comprises of subsequent assessment of baseline assessments, utilizing the same methods and tools. It is recommended that CBHPII consistently use the results of the monitoring and mid-term evaluation as management tools for design adjustment or revision as deemed necessary.

5.7. Areas where efficiencies could be made in the CBHPII without detracting from the project's effectiveness.

5.7.1. It is recommended that CBHPII carefully design its approach and interventions, and regularly test program hypothesis using evidence provided by timely monitoring activities, so as to ensure that its approaches and interventions will lead to the achievement of project objectives and goal.

5.7.2. It is recommended that CBHP utilize materials for training and health communication interventions that are produced by reliable sources or organizations and which have been tested and utilized in other areas. It is recommended that CBHP adapt these materials to the Nias' situation.

5.7.3. It is recommended that CBHP work in close coordination with BAPPEDA, Dinkes and BPM for program harmonization, and facilitate cost, information and other resources-sharing practices between development partners and government institutions working in MCH promotion in project areas and in Nias.

5.8. Ways in which the CBHPII could increase the likely impact from its interventions.

5.8.1 It is recommended that CBHP develop and implement a pilot model for Posyandu development, which addresses the specific geographical and cultural constraints of Nias (see 5.5.1). A successful model of Posyandu will be sustained by the communities and the government, and further replicated in other villages in the sub-district and other sub-districts in the pilot district[68]. The established Posyandu will sustain programs initiated by CBHP and replication of the Posyandu model will include replication of the programs.

5.8.2 To allow proper implementation of the proposed pilot activities, it is recommended that CBHPII submit a request to MFAT for an extension of project implementation[69].

5.9 Ways in which the CBHPII could better ensure that the sustainability of its interventions and their results is achieved, with gender differentiation where relevant.

5.9.1 It is recommended that CBHP develop and implement health communication activities that are culturally sensitive to Nias' situation. CBHP should involve religious and adapt institutions and their leaders in delivering health messages to the communities. Programs should include activities that address the identified gender issues.

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[68] This was expressed by the Head of BAPPEDA of Central Nias District and agreed by all participants attended the feedback meeting in Nias and debriefing in Jakarta.

[69] It is estimated that CBHPII will need 24 months of program implementation in order to properly implement the recommended pilot activities, considering that currently the project is lacking in basic project management tools, i.e. baseline data of the pilot area, project logframe and activity plan.

5.9.2 It is recommended that CBHPII gradually reduce and eventually discard Surfaid identity as the sole owner of the project, as well as the interchangeable use of Surfaid and CBHP in project reports and other project documents and communications. CBHPII should develop and use its own logo using Bahasa Indonesia or Bahasa Nias. Surfaid and MFAT's identity in the project should be established as 'supporters' instead of 'owners' of the project.

5.9.2 It is recommended that CBHP engage only stakeholders in program implementation and to limit its staff's roles to the provision of technical support and process facilitation.

5.9.3 It is recommended that CBHP facilitate advocacy activities to District Government through the BAPPEDA, Dinkes and BPM, and to promote awareness of MCH development issues among District Executive and Legislative members so that MCH development in the district is supported by relevant policies and bud and local legislation.

APPENDICES

Appendix 1 Terms of Reference

Terms of Reference for the Nias Community Based Health Programme Evaluation

Final 21 March 2011

Prepared by: Helen Bradford, Development Programme Manager, Indonesia, Kirk Yates, Counsellor Development, Indonesia and Gloriani Panjaitan, Development Programme Coordinator, Indonesia.

Overview

This document specifies the terms of reference for the Nias Community Based Health Programme (CBHP) Evaluation.

It is intended for use by contractors, staff managing contractors for the New Zealand Aid Programme, and other stakeholders associated with the assignment.

Contents

Overview 41
Contents 41
Purpose 42
Details of the Assignment 42
Outcome 1: 42
Outcome 2: 43
Outcome 3: 43
Methodology 44
Outputs 47
Background 48
Approval 51

Purpose

The purpose of this evaluation is to determine the extent to which the CBHPI has achieved its intended results and to identify any areas for improving the design and implementation of the CBHPII.

Details of the Assignment

Outcome 1:

An assessment of the relevance, effectiveness, efficiency and impact[70] of the CBHP's approaches and activities is made.

To achieve outcome 1, the evaluation should consider:

(1) The extent to which the CBHP has addressed, and plans to address the identified needs and priorities of target communities, including any specific needs of men, women, girls and boys.

(2) The extent to which the CBHP has addressed, and plans to address the health priorities evidenced by the baseline survey and other available data sources.

(3) The extent to which the CBHP was originally, and has remained, aligned with national and sub-national government strategies, priorities and systems, and the New Zealand Aid Programme priorities.

(4) The extent to which the CBHP originally harmonised, and has continued to harmonise its interventions to complement, and avoid overlap with, the work of other development partners.

(5) The extent to which the CBHPI met its planned goal, objectives and outcomes, including consideration of specific gender outcomes.

(6) The extent to which CBHPII year one has been focused upon strengthening community action and meeting the eight specific requirements set out by MFAT in September 2009 and March 2010 (refer to background section).

(7) The value for money provided by the CBHPI i.e. could activities have been implemented at less cost whilst retaining the same quality and quantity of benefits[71].

(8) Any programme management issues (e.g. human resources, logistics, procurement and systems) which affected the efficiency of the CBHPI and CBHPII year one implementation.

(9) The actual or likely impact (positive, negative, planned or unplanned) that the CBHPI has had, or will have, on project stakeholders and the environment, where this can be identified from available evidence.

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[70] Impact is defined here as positive and negative long term effect(s) produced by a development intervention, directly or indirectly, intended or unintended

[71] Value for money should be assessed by (1) comparison with experience in other activities where similar outcomes or impacts have been aimed for/achieved and (2) by analysing the activity's own cost structures analysed to identify cost effectiveness issues e.g. could savings have been made without compromising outcomes through different methods, management, procurement, prioritisation , design etc.

Outcome 2:

An assessment of the sustainability of the CBHP's approaches and activities is made.

To achieve outcome 2, the evaluation should consider:

(1) The extent to which the CBHP's target communities (including specific reference to men, women and children) have engaged in the design, implementation and monitoring of the project.

(2) The level of ownership that target communities have of the CBHP - its interventions, outcomes and shortfalls.

(3) The extent to which the CBHP has collaborated with government agencies at sub-national level (predominantly health office and planning agency/bappeda), technical agencies and any CBOs in the design, implementation and monitoring of the project.

(4) The effectiveness of the CBHP's activities and/or approaches in strengthening links between communities and health services/facilities, building health governance and workforce capacity.

(5) The effectiveness of the local volunteering model and volunteering approaches that the CBHP has utilised.

(6) The extent to which volunteers' activities are likely to be sustained without further direct project intervention.

(7) The actual or likely sustainability of any observed or reported benefits which have arisen from the CBHPI, taking into consideration relevant institutional, gender-related, environmental and contextual factors that will impact upon these.

Outcome 3:

Evidence and findings from the CBHPI is used to inform recommendations for modifying the CBHPII to improve the relevance, effectiveness, efficiency, impact and sustainability of its interventions.

To achieve outcome 3, the evaluation should consider recommendations in relation to:

(1) Ways in which the CBHPII could better address the health priorities of target communities, including any specific needs of men, women, boys and girls.

(2) Ways to enhance community participation in, and ownership of, CBHPII's implementation and outcomes.

(3) Opportunities for the CPHPII's closer alignment with government strategy and/or harmonisation with work of other development partners.

(4) Opportunities for the CBHPII to enhance its harmonisation with the work of other development partners to increase overall efficiency and effectiveness.

(5) Ways in which the CBHPII could maximise its effectiveness, with gender differentiation where relevant.

(6) Ways in which the CBHPII could improve monitoring of progress and demonstration of where development outcomes are being achieved and to allow for gender disaggregation where relevant.

(7) Areas where efficiencies could be made in the CBHPII without detracting from the project's effectiveness.

(8) Ways in which the CBHPII could increase the likely impact from its interventions.

(9) Ways in which the CBHPII could better ensure that the sustainability of its interventions and their results is achieved, with gender differentiation where relevant.

Methodology

An evaluation Reference Group will be formed to advise the evaluation team and MFAT at key stages of the evaluation process, in particular on the evaluation plan and the draft evaluation report. Any other issues related to the evaluation that cannot be resolved by the evaluation task manage may also be brought to the Reference Group for their consideration. MFAT, SAI and the Government of Indonesia will be represented on the Reference Group. The evaluation process will be managed by the Indonesia Development Programme Manager, based in Wellington. Whilst in Indonesia, day-to-day support for the evaluation team will be provided by the Development Programme Coordinator based in Jakarta.

The team which undertakes this evaluation will be expected to complete all tasks outlined above, or offer justification as why these cannot be satisfactorily completed. For example, where data required to undertake a task(s) is unavailable or cannot be reasonably gathered within the time available. The team will be required to prepare a written evaluation plan for MFAT's approval. This should detail the team's proposed approach to carrying out the specified tasks and to achieving the desired assignment outcomes. The plan should clearly identify the evaluation's information requirements, noting where there are gaps/constraints so that these may be mitigated to help ensure a robust final report.

The scope of this evaluation is the period from the approval of the CBHPI (April 2006) to the end of the first year of implementation of CBHPII (December 2010). Where relevant, it may be useful to provide reference to other SAI projects, other government/NGO initiatives in Nias and/or examples of similar projects operating elsewhere in Indonesia or other countries.

The evaluation will involve a variety of stakeholders including the target communities and local leaders; local, district, province and national level health authorities including local health service providers (Posyandu); district and provincial planning agency (Bappeda); project volunteers; SAI project staff and management; local NGOs/CBOs/CSOs working in the health sector; other relevant development actors operating in Nias (IFRC, PMI, BDPB, INGOs etc); lead health technical agencies working in Indonesia (e.g. UNICEF, WHO, UNFPA); and the New Zealand Aid

Programme team. This evaluation should adopt approaches throughout which empower and encourage all relevant parties, particularly the project's beneficiaries, to share their views. Opportunities to consult, and share observations and preliminary findings with, key stakeholders should seek to be participatory and where possible bring key groups of stakeholders together.

The evaluation team should adopt a focus and approach which emphasises the learning opportunities which exist to improve the second phase of the CBHP, and which identifies and encourages opportunities for greater ownership and participation in the project by its key stakeholders.

The results of the evaluation will be available to all stakeholders but will primarily be reported to project beneficiaries, project volunteers and SAI staff, local government and MFAT who are the main parties which need to be informed of project progress and learning, and engaged in decisions on taking forward the findings and recommendations during the remainder of the CBHPII.

It is expected that a presentation, discussion and testing of preliminary findings and recommendations with key stakeholders be undertaken in Nias towards the end of the field work. A member of the New Zealand Aid Programme team will travel to Nias to attend this presentation on behalf of MFAT.

The report and presentation of findings should demonstrate rigour of approach, relevance, a comprehensive coverage of the outlined tasks, and an interpretation of the findings and **should clearly substantiate** judgements and recommendations made, drawing upon relevant quantitative and qualitative evidence. Parties should be made aware that it is expected that the evaluation report will be widely shared with all relevant parties and as such should be concise and readable.

The evaluation Reference Group and key stakeholders, including MFAT and SurfAid International (SAI), will provide written comments on the draft report within three weeks of receipt. The final draft report will be peer reviewed and MFAT will advise the Team Leader in writing if further work and/or further revision of the report is required if the report does not meet the TOR or the quality is not of an acceptable standard. The final report will be appraised before being considered for public release by MFAT's International Development Assistance Evaluation and Research Committee (ERC).

MFAT policy provides for part or all of the final report to be made publically available and allows for the release of full reports upon request, unless prior agreement has been reached not to do so. Any information that could prevent the release of the final report under the Official Information or Privacy Acts, or would be in breach of evaluation ethical standards must be placed in a confidential annex.

Reports are expected to conform to MFAT's International Development Assistance Guideline on the Structure of Review and Evaluation Reports and DAC Evaluation Quality Standards.

The Review Report should be presented according to the format below and should be concise and to the point (maximum length of 25 pages plus appendices with a font size no smaller than Arial 11 point).

1. Title Page

2. Executive Summary (6 pages maximum)
3. Main body of the report which includes:
   - a Background
   - b Methodology used
   - c Timing of the assignment
   - d Findings and conclusions
   - e Recommendations
4. Appendices which should include:
   - a Glossary of acronyms
   - b Terms of Reference
   - c List of data sources including literature and persons/groups interviewed
   - d Summary of CBHP budget and expenditure to date

It is anticipated that this assignment will involve up to 32 days, including up to 15 days spent in Nias. Confirmation of actual dates, milestones and payment arrangements will be subject to discussion between MFAT and the contracted team/individuals and will follow approval of a submitted budget(s). It is anticipated that the final report will be approved by MFAT by 30 June 2011.

During this assignment the team will be expected to work in close collaboration with the SurfAid International project staff based in Nias, and the New Zealand Aid Programme team based at the New Zealand Embassy in Jakarta. SurfAid International and MFAT will make available all relevant documentation to the team in advance of the field work and will assist with the scheduling of initial consultation meetings in consultation with the team. The team will be expected to lead on arranging follow-up meetings, presentations and feedback sessions although both SurfAid International and the New Zealand Aid Programme team will assist.

For this assignment a team of two people is being sought. The team will consist of the team leader who is the lead evaluator and a health specialist; and an Indonesian development specialist with significant knowledge of Nias. The team is required to have the following skills, knowledge, experience and personal attributes;

<u>Experience</u>

(1) Proven team leader experience

(2) Significant previous experience of conducting evaluations of community development programmes, including in South-East Asia and ideally in Indonesia

(3) Significant previous experience of community based health programme implementation, including in South-East Asia and ideally in Indonesia

(4) Broad knowledge of, and experience of working with, a range of relevant government, multilateral, bilateral and non-governmental agencies

(5) Development programming and policy experience, gained in South-East Asia and Indonesia specifically

Skills

(1) People management (Team Leader only required)

(2) Ability to work as part of a team

(3) Excellent written and cross-cultural communication

(4) Strategic thinking

(5) Gender analysis

(6) Research and analysis

(7) Report writing

(8) Presentation and facilitation

(9) Excellent spoken and written English

(10) Excellent spoken and written Bahasa Indonesia

(11) Local Nias language skills preferable

Personal attributes

(1) Commitment to participation of key stakeholders

(2) Understanding of, and commitment to, crosscutting issues (human rights, gender and environment)

(3) Commitment to ensuring the independence and transparency of the evaluation

Outputs

No.	*Milestone /Output*	*Description*	*Inputs*	*Due date*	*Payment*
1	*Acceptance of Evaluation Plan*	*Team to prepare Evaluation Plan (max 10 pages) incorporating, Reference Group and MFAT/SAI comments*	*Team Leader up to 5 days* *Nias Specialist up to 5 days*	*Mar/Apr*	*Nil*
2	*Delivery of Draft Report*	*Desk-research and data analysis; briefing in Wellington and Jakarta; meetings in Jakarta; field-visit to Nias; presentation of initial findings and recommendations to key stakeholders in Nias, Jakarta and Wellington. Leading to a draft report of up to 25 pages (plus appendices)*	*Team Leader up to 20 days* *Nias Specialist up to 15 days*	*Apr/May*	*75%*
3	*Delivery of Final Draft Report for Peer Review*	*Completion of a final draft report including all revisions requested (by Reference Group, MFAT and SAI) and delivery to MFAT*	*Team Leader up to 5 days* *Nias Specialist up to 2 days*	*May*	*Nil*
4	*Acceptance of Final Report by MFAT*	*Completion of a final report addressing comments raised by peer review and delivery to MFAT*	*Team Leader up to 2 days*	*June*	*25%*

Where reasonably requested, the evaluation team will be expected to provide MFAT with brief verbal or written progress updates in between milestone/outputs.

Background

In April 2006 MFAT, through the New Zealand Aid Programme[72], approved IDR 11,887M (NZD 1.7M at January 2011 rates) funding for SurfAid International (SAI) to implement a three-year Community Based Health Programme (CHBPI) in Nias, Indonesia (1 October 2005 – 30 September 2008). The programme goal was "to improve the health of vulnerable persons in partner communities along the coastal areas of Nias Island and reduce mortality in children under five years of age by improving clean water availability, hygiene, sanitation, malaria reduction, nutrition and improved health services". The programme objectives were:

1. To establish a good working relationship with partner communities and government agencies in order to effectively implement project activities and promote community ownership and programme sustainability.

2. To facilitate the improvement of water provision and sanitation damaged in the March 05 earthquake and promote good hygiene practice in partner communities.

3. To improve the immunisation and nutritional status of children under five.

4. To reduce the incidence of malaria in partner communities.

5. To decrease morbidity and mortality due to acute respiratory infections (ARI) and diarrhoea in children under five years old.

6. To increase the capacity of health centres to service Surf Aid's target communities.

A baseline health and nutritional status of under fives, conducted in selected sub-districts of Mentawai and Nias Islands by SEAMEO – Tropmed RCCN in April and May 2007 provided useful data for monitoring the project's impact against key health indicators.

Routine project reports demonstrated that considerable progress was being made in some areas but also highlighted a number of issues resulting from working in a difficult post-disaster environment; challenges engaging communities in project activities; capacity and commitment of local health offices involved in project implementation; staff and volunteer turnover and some staff-management conflict; and managing a community volunteering approach without the use of financial incentives. These issues were reported to be hampering the effectiveness of the project. It was evident, and acknowledged by SAI, that the CBHPI was overly ambitious in its scope for the given three-year timeframe and that more time would be required to embed health-related behaviour changes and to be confident in the ability of communities and health service providers to sustain progress.

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[72] Operating at the time as NZAID.

In its comments to SAI, MFAT particularly encouraged SAI to foster greater collaboration with health and other relevant government agencies, improve its monitoring and evaluation frameworks (e.g. provide a clearer definition of outcomes and indicators which related to the baseline survey) initiate and strengthen partnerships with other development actors and to give greater consideration to gender. At the time SAI was a young organisation with limited development experience. Its commitment to researching and using evidenced-based approaches applied elsewhere, and to take on board MFAT's advice and suggestions, is commendable. Mid-2008 SAI recruited a M&E Officer to respond to the identified need to improve the monitoring of its projects.

Given the over-ambitious planning of what could be achieved by the CBHPI, SAI requested a nine-month no-cost extension to the project. In May 2008 MFAT invited SAI to both submit a proposal for this extended period and to consider working on proposal for a further three-year project. The second phase would be intended to build upon progress made and undertake further work towards the objectives originally envisaged for the CBHPI with the intention of enhancing the sustainability of project outcomes so that support to the target communities could be phased out during the project. SAI responded favourably to this suggestion and expressed its intention to use the second phase to consolidate work in the CBHPI target communities rather than an earlier intention it had of widening the project scope. SAI also stated it would place more emphasis on sustainability through working through existing government structures and building capacity and through empowering communities; and giving greater emphasis to gender – especially by gaining men's' support to the project interventions.

Several versions of a design for the CBHPII were developed and discussed over the next 22 months. Prior to approving the project, MFAT requested further work be undertaken in a number of areas which included increasing stakeholder involvement in design, implementation and monitoring; increasing the alignment of the project with local, regional and national priorities; strengthening the project's approach to building health governance and workforce capacity as a means to ensure sustainability and to provide an exit strategy; contextualising the project by improving its links to the baseline survey and other relevant data sources; increasing the focus on gender and other crosscutting issues (namely human rights and environment) and the monitoring of relevant indicators; and improving the monitoring and evaluation framework and measurement of effectiveness.

A series of contract variations was granted to extend the CBHPI to allow more time for the design of the CBHPII and to alter the logical framework to meet the changing environment. MFAT provided an additional IDR 600M to CBHPI for additional activities related to project design, staff recruitment and orientation to transition to this second programme phase.

In March 2010 MFAT approved IDR 17,673M (NZD 2.5M at January 2011 rates) funding for SurfAid International to implement CHBPII over the period of 1 January 2010 – 31 December 2012. The goal of the CBHPII is "to reduce maternal and under-5 child mortality and morbidity in Nias". The programme objectives are:

1. Communities are leading and managing their own village health programmes.

2. Improved nutritional status and immunisation of children under five years old.

3. To improve hygiene and sanitation practices in partner communities.

4. To decrease morbidity and mortality in children under five years due to acute respiratory infection, diarrhoea and malaria in partner communities.

5. Improved maternal and neonatal health outcomes in partner communities.

6. Communities and partnering health providers are delivering improved quality health services.

Given some residual concerns regarding project design, MFAT requested that the first six months of the CBHPII be focused upon strengthening community action during which period SAI was requested[73], and agreed, to carry the following actions:

1. Obtain agreement and endorsement from the Bupati, the head of Bappeda and the head of health Dinas on the set of objectives to be achieved;

2. Map out other interventions of the health sector delivered by other agencies and outline the relationship and alignment of the project those interventions as well as the existing government frameworks and structures such as Desa Siaga, Desa Wisma, PKK, Puskesmas, Posyandu, PNPM activities etc;

3. Set up an advisory board consisting of relevant government officials, CBOs/NGOs working in the health sector, academia, churches/religious leaders and NZAID to meet every 12 months to review progress and assist in revising annual plans;

4. Develop a more comprehensive monitoring and evaluation plan;

5. Conduct a short/small independent review of CBHPI and incorporate the findings into the revised project document for the remainder of CBHPII;

6. Revise the log-frame to more logically outline the project targets and how these will be reached;

7. Introduce a gradual increase towards more local management and ownership of the programme over the three years rather than concentrate this in the final 12 months;

8. Submit a revised project document that incorporates all key findings from the first six month phase II implementation and the independent review of phase I. This point was stressed in a later communication where "a significantly revised project

[73] NZAID comments for SurfAid on the revised proposal for CBHPII, dated 11 September 2009

document – one that is coherent, straightforward and clear on the programme goals and objectives (5 – 10 pages)"[74] was requested.

Whilst SAI strongly supported an independent review of CBHPI, and to incorporating the findings of the review into the revised project document for the remainder of CBHPII, the review has yet to take place.

In August 2010 SAI submitted an "Overview of Proposed Modifications to CBHPII in Nias" which included a revised log-frame. The design, however, fails to address all of residual concerns and further comments, including on the design shortfalls, were provided by MFAT[75]. In these comments MFAT proposed that the independent evaluation now be commissioned to review the CBHPI and year one of CBHPII. The findings and recommendations should be used to finalise the re-design of years 2 and 3 of the CBHPII.

Approval

Approved by:

.... Date:

(*signature*)

Steve Dowall
Deputy Director, Asia team

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[74] 31 March 2010 letter from Merinda-Lee Hassall to Andrew Judge

[75] SurfAid International: Overview of Proposed Modifications to CBHPII in Nias, MFAT, International Development Group Comments, dated 8 December 2010

Appendix 2 List of data

Appendix 2.a Literature

(1) 2006 – 2007 Annual Report; Nias Community Based Health Programme; Surf Aid International; October 2006 – September 2007.

(2) 2007 – 2008 Annual Report; Nias Community Based Health Programme; Surf Aid International; October 2007 – September 2008.

(3) 2008 – 2009 Annual Report; Nias Community Based Health Programme; Surf Aid International; October 2008 – September 2009.

(4) A Proposal for a No Cost Extension for The Community Based Health Program; Nias Indonesia; June 2009; Surf Aid International

(5) Community Based Health Programme Nias Island, Indonesia; A Funding Proposal to New Zealand AID by Surf Aid International; October 2005

(6) Community Based Health Programme Nias; Progress Report Againts Output Indicators; January 2011

(7) DAC Guidelines and Reference Series; Quality Standards for Development Evaluation

(8) Final Report; Health and Nutritional Status Among Under Five Children in selected sub-districts in Nias and Mentawai Islands; A Baseline Survey for Community Based Health Programme (CBHP); by Sur Aid International. SEAMEO Tropmed RCCN; University of Indonesia; 2007.

(9) Final Report; COMMUNITY BASED HEALTH PROGRAM; To improve the health of vulnerable persons in partner communities along the coastal communities of Nias Island; October 2006 – September 2009; Surf Aid International.

(10) Grant Funding Arrangement; Indonesia Programme, Surf Aid International Community Based Health Programme II; Ministry of Foreign Affair & Trade; March 2010

(11) Interim Report, Community Based Health Program, To improve the health of vulnerable persons among partner communities along the coastal communities in Nias island, July to December 2009

(12) Interim Progress Report CBHP II Nias; 1 July 2010 – 31 March 2011.

(13) NZAID Guideline on the Structure of Evaluation and Review Reports

(14) Overview of Proposed Modifications to CBHPII in Nias; Surf Aid International; August 2010.

(15) Report of the KOHA and HAF Organizational Review of SurfAid International Incorporated New Zealand (SurfAid NZ); Draft 14/06/09

Agenda 2b. Field Assessment Agenda and List of People met and interviewed

Agenda of Field Assessment: 29 May – 17 June 2011

Date	Program	Places	Note
Sunday, 29/05	Arrival in Jakarta	Arrival time: 11.30 am	Hotel: Century Park, Senayan
Monday, 30/05	09:00 - 11.30 Briefing with IDG team	NZ Embassy	
	13:00 – 14:00 Meeting with AusAID	AusAID office Menara MNC 26th Fl Jl Raya Kebon Sirih Jakarta	Mr. Andrew Dollimore and Mr. Sigit Pratigno
	14:30 – 16:00: Meeting with Officials from Ministry of Women Empowerment and Child Protection	KEM PP & PA Office Lt. 5 Jl. Merdeka Barat No. 15 - Jakarta Telp:38005542, nesya: 0813-1115816	Mr. Jonhar; Assistant Deputy III (Women Protection)
Tuesday, 31/05	09:30 – 10:30: meeting with Crisis Prevention & Recovery Unit UNDP	UNDP office Menara Thamrin 8th Fl. Jl. MH Thamrin	Kristanto Sinandang and Bambang Malika (CPRU)
	13:30 - 14:30 Meeting with Multi Donor Trust Fund for Aceh , Nias and Java Reconstruction Fund	World Bank Office Indonesia Stock Exchange Bldng Tower 1, 9th Floor	Ms. Sarosh Khan, Acting Programme Manager Mr. Akil

		Jend. Sudirman – Jakarta	
	17:00: depart for SH airport 19:45: depart for medan	GA196 JKT ETD 19:45pm MES ETA 21:55 pm	Hotel in Medan: Pardede Int
Wednesday, 01/06	7am Pick up from Hotel Pardede 7.30 - 8.30 Meeting with Head of Bappeda and other relevant stakeholders 11.30 - 12.30 SurfAid office (confirmed) 12.30 - 01.30 lunch (confirmed) 02.30 - 03.30 Kepala BPBD propinsi (confirmed) 04.00 return to Pardede Hotel	Pick up by SurfAid Meeting in Bappeda office	Mr. Allan Reguson, Country Program Director Mr. Asriyal, CBHP Program Manager Mr. Riyadil, Head of Provincial BAPPEDA Officials from: Provincial Women Empowerment and Child protection Bureau Provincial Dinkes Planning Section Provincial Dinkes Health Promotion Provincial Dinkes Communicable Diseases Control – Global Fund Provincial Agriculture Services BPBD: Head of Financial Department
Thursday 02/06 (public holidays)	06.55 – 08.00 Depart for Gunung Sitoli Nias	MZ5424 MES ETD 06:55 am GNS ETA 08:00 am	
	15.00 – 19.00 Briefing with the Project Manager and Professional Staff	CBHP office	Endah – M&E Officer Erwan Ginting – Training Officer Asriyal – Program Manager
Friday, 03/06	09:00 – 12:00 Meeting with Project Staff	CBHP office	3 Area Field Managers; HPO; M&E Officer; Training Officer; Program Manager
	14:00 – 16.00 Meeting with INGOs	CBHP office	MAP Int: Japari Ginting

	operating in Nias: MAP International and OBI		Obor Berkat Indonesia: John
Saturday, 04/06	10:00 – 16:00 Meeting with Project Staff	CBHP office	Name in the attached list
Sunday, 05/06	Finding analysis and report drafting		
Monday, 06/06	09.00 – 12.00 Bupati/Wakil Bupati and other relevant stakeholders (Bappeda, Dinkes, Kesga, etc) 14.00 – 15.00 Meeting with District Dinkes officials	Meeting in the Bappeda Office in Gunung Sitoli Dinkes Office in Gunung Sitoli	Name in the attached list Name in the attached list
Tuesday, 07/06	09.00 Meeting with Puskesmas Head of Bawolato Visit to Bawolato and Siofaewali • Camat of Bawolato At Siofaewali: FGD with: • Kepala Desa/Kepala dusun • Village Volunteers • Religious Leader • Community leaders • CBO functionaries • Households beneficiaries of CBHP Depart to Nias Selatan, overnight in Sorake	CBHP office Community Church at Siofaewali Keyhole Hotel Sorake	Name in the attached list
Wednesday, 08/06	08.30 Depart to Teluk Dalam At District level: • Meet & discussion with Officials of	District Dinkes Office	Names in the attached list

	Dinkes Nias Selatan At kecamatan level: • Meet Puskesmas Head and staff Teluk Dalam At community level: • Community visit in Hilitobara 13.00 Depart to Lahusa 14.30 – 16.00 visit to Puskesmas Lahusa, Meeting with Puskesmas Head and staff 16.00 back to Gunung Sitoli	Puskesmas Teluk Dalam Hilitobara village Puskesmas Lahusa, Nias Selatan District	
Thursday, 09/06	09.00 Depart to Lotu, Afulu: At district level meet with: 10.00-12.00 Meeting with Dinkes Kabupaten Nias Utara 12.00-13.00 lunch At kecamatan level: 13.00-14.00 Meeting with Camat of Afulu and Puskesmas Head and staff of Afulu 14.00- 17.00 at community level: Lauku Fadoro village Meet with school children beneficiaries **FGD** • Kepala Desa/Kepala dusun • Village volunteers • Religious Leader	Dinkes office, Lotu Camat office, Afulu Puskesmas Office, Afulu Community Church Lauku Fadoro	Names in the attached List

	• Teachers • Community leaders • Traditional Birth Attendants • Households/mothers beneficiaries 17.00 depart back to Gunung Sitoli		
Friday, 13/06	09.00 Depart to Alasa 10.00 At kecamatan level meet with: • Camat • Puskesmas Head and staff Back to Gunung Sitoli 14.00 – 16.00 meeting with CBHP management and staff		Names in the attached lists
Saturday, 11/06	9.00-13.00 Presentation of preliminary findings and group discussion with CBHP staff including area field managers and HP Officers	CBHP office in Gunung Sitoli	Names in the attached list
Sunday, 12/06	Finding analysis and report drafting		
Monday, 13/06	09:00 – 16.00 Findings analysis, report finetuning and preparation for stakeholders meeting	CBHP office	
Tuesday, 14/06	09:00 – 12.00 Presentation of findings to multi stakeholders 14.00 – 16.00 Discussion with Program Manager	Nias Palace Hotel CBHP office	Attended by stakeholders from Nias Induk, Nias Dalam and Nias Utara Districts. Names in the attached list
Wednesday,	Gunung Sitoli – Medan – Jakarta	ETD 14:50pm – ETA 15:55pm	

15/06		(MZ 5429 GNS MNS) ETD 18:30pm – ETA 20.45pm (GA147 MNS CGK)	
Thursday, 16/06	14.00 – 16.00 Presentation and debriefing with IDG team and HOM	NZ Embassy, Senayan	
Friday, 17/06	08:00 – 09:00 Debriefing with Ibu Lili Sulistyowati, Head of Promkes (kemenkes) 13:00 – 14:00 debriefing with pak yoga, bappenas 14.00 – 15.30 Debriefing with Kemenkes 16:00: depart for SH airport 19:05: depart for Oz	Kemenkes Office Bappenas Office Kemenkes Office JKT – ADL 19:05pm – 08:10 +1am	

List of names attended discussions and interviewed:

SAI management and CBHP staff:

	Names	M/F	Position	Institution
1	Mr. Alan Rogerson	M	Country Program Director	SAI
2	Asrial	M	CBHP Program Manager	CBHP
3	Endah	F	CBHP M&E Officer	CBHP
4	Wira Ginting	M	Training Officer	CBHP
5	Zaimah	F	Area Field Manager Nias Selatan	CBHP
6	Yuliana	F	Area Field Manager Nias Induk	CBHP
7	Respati	M	Area Field Manager Nias Utara	CBHP
8	Nurita K Mendrofa	F	Health Promotion Officer Nias Utara	CBHP
9	Posko Siregar	M	Health Promotion Officer Nias Selatan	CBHP
10	Arsyadi Simanjuntak	M	Health Promotion Officer Nias Utara	CBHP
11	Harpendi Simamarta	M	Health Promotion Officer Nias Utara	CBHP
12	Wahyu	F	Health Promotion Officer Afulu	CBHP
13	Yanulis Gulo	M	Health Promotion Officer Alasa	CBHP
14	Rita M Turnip	F	Health Promotion Officer Bawolato	CBHP
15	Syukur	M	Health Promotion Officer Nias Selatan	CBHP
16	Marhaban Abdulah	M	Health Promotion Officer Nias Induk	CBHP
17	Sonti Manik	F	Health Promotion Officer Nias Selatan	CBHP
18	Wilda Sihombing	F	Health Promotion Officer Nias Selatan	CBHP
19	Christina L Napitupulu	F	Health Promotion Officer Nias Selatan	CBHP
20	Buteli Nazara	M	Health Promotion Officer Afulu	CBHP
21	Dolok Siregar	M	Health Promotion Officer	CBHP
22	Richard	M	Technical Engineer	CBHP
23	Wapanya Yudha	M	Technical Officer	CBHP
National level				
1	Gloriani Panjaitan	F	Development Program Officer	IDG
2	Kirk Yates	M	Development Counselor	NZ Embassy
3	Andrew Dollimore	M		AusAID
4	Sigit Pratigno	M		AusAID
5	Jonhar Johan	M	Deputy for Women Protection	MWE&CP
6	Kristanto Sinandang	M	Head of Crisis Prevention and Recovery Unit	UNDP
7	Bambang Malika	M	Staff of CPRU	UNDP
8	Sarosh Khan	F	Deputy Program Manager	MDF
9	Akil Abduljalil	M	M&E Consultant	MDF
10	Dr. Lili S. Sulistyowati	F	Head of the Center; Center of Health Promotion	MOH
11	Dr. Kodrat Pramudo	M	Head, Division of Community Empowerment & Participation, Center of Health Promotion	MOH
12	Marzuki	M	Center of Health Promotion	MOH
13	Dr. Ir. Suprayoga Hadi	M	Director For Special Area and	BAPPENAS

			Disadvantaged Region	
Provincial Level – North Sumatra Province – Medan				
1	Riyadil	M	Head	BAPPEDA
2	Dinkes Officials		Planning Section	
3	Dinkes Officials		Communicable Diseases Section	
4	Dinkes Officials		Nutrition Section	
5	Dinkes Officials		MCH Section	
6	Officials Women Empowerment & Child Protection		Staff	
7	Officials		Agriculture Bureau	
8	BPMD Officials		Financial Manager	
	Name list could not be obtained			

NGO working in Nias

1	Joni Nazara	M	Project Officer, Obor Bahtera Indonesia	OBI
2	Jamari Darius Ginting	M	Project Officer, MAP International	MAP International

District level – Nias Induk

	Names	M/F	Position	Institution
1	Agustinus Zey	M	Head	BAPPEDA
2	Dorothea E. Tel.	F	Secretary	BAPPEDA
3	Ros Okti Harefa	F	Division Head	Population & FP
4	H Hosun Alrafar	M	Services Division Head	G.Sitoli Hospital
5	Agus Halim Isigayo	M	Division Head	BAPPEDA
6	Afolos Tel	M	Deputy Social Welfare	District Secretariat
7	Agus Zebua	M	Head - Health Promotion Division	Dinkes
8	Herlina T	F	Staff – Health Promotion Division	Dinkes
9	Firimina Halawa	F	Division Head – PSDA & TTE	BAPPEDA
10	Yoniel Temali Hulu	M	Staff	BAPPEDA
11	Alvien C Lase	M	Staff	BAPPEDA
12	Ridwan Lala	M	Staff	BAPPEDA
13	Enisari Halawa	F	Head Economic Dev Subdivision	BAPPEDA
14	Agustinus Hulu	M	Staff	BAPPEDA
15	Israfan Mar	M	Staff	BAPPEDA
16	Ir Oimolala	M	Head of M&E	BAPPEDA
17	Fapi K Z	F	Staff	BAPPEDA
18	Dr. Idaman Zega	M	Head	Dinkes

District level – Nias Selatan

1	Nurlinda Siregar	F	Head – MCH Division	Dinkes
2	Adifiat Sarumaha	F	Head – Puskesmas Lagundri	Puskesmas
3	Dr. Wilser Napitupulu	M	Head – Human Resource Div	Dinkes
4	Surimahati Gowasa	F	Head of Pustu	Pustu
5	Marinus Gowasa	M	Head of Puskesmas Hilisofari	Puskesmas
6	Octavianus Dakhie	M	Head of Puskesmas Teluk Dalam	Puskesmas

7	Arfanuto Dakhie	M	Head – Program Development Subdivision	Dinkes
8	Intansani Haria	F	Head of Health Security Section	Dinkes
9	Ufati Fanir	M	Head of Division	Dinkes
10	Taratulo Terskan	M	Head	Dinkes
District level – Nias Utara				
1	Dr. Yafeti Nazara	M	Head	Dinkes
2	Emos Zendrato	M	Head of Health Services Division	Dinkes
Sub district level – Lahusa Sub-district				
1	Tawaonosohulu	M	Staff	Puskesmas
2	Noveriang Sar	F	Staff	Puskesmas
3	O'Ozisokhi Tel	M	Staff	Puskesmas
4	Syukur Slamet Amz	M	Staff	Puskesmas
5	Chaerul I	M	Staff	Puskesmas

Sub district level – Teluk Dalam Sub-district				
1	Octavianus Dakhie	M	Head	Puskesmas
2	Swasti e Duha	F	Head of Nursing Section	Puskesmas
3	Tiuk Nihati Laina	F	Staff	Puskesmas
4	Kristin YB Sarumaha	F	Staff	Puskesmas
5	Rifyan Wanur	M	Head of Administration	Puskesmas
Sub district level – Afulu Sub-district				
1		M	Secretary	Camat Office
2	Kurniawan Harefa	M	Staff	Puskesmas
3		F	Staff	Puskesmas
Sub district level – Alasa Sub district				
1	Sekhiaro Zebua	M	Head/Camat	Camat Office
2	Johnbarnes Hutahuruk	M	Puskesmas doctor	Puskesmas
3	Madeline	F	Puskesmas Staff	Puskesmas
4	Suzana	F	Dental Technician	Puskesmas

FGD Participants

Lauru Fadoro Village, Afulu Sub-district, Nias Utara

1	Noferius Hulu	M	Health Volunteer
2	Bazaro Harefa	M	Health Volunteer
3	Adisana Halawa	M	Health Volunteer
4	Duhusokhi	M	Health Volunteer
5	Yasa fati	M	Hamlet Chief
6	Niati Lase	F	Traditional Birth Attendant
7	Nusima Wasuru	F	Health Volunteer
8	Tukari Zali	M	Teacher
9	Satira Zebua	F	Traditional Birth Attendant
10	Iriani Gea	F	Health Volunteer
11	Faomasih War	F	Mother of underfive
12	Suhelvi	F	Village volunteer

13	Oliria Gulo	F	Mother of underfive
14	Etini Waruwu	M	Teacher
15	Yulifao L	M	Teacher

Siofoewali Village, Bawulato Sub district, Nias Induk

1	Tati Bate'e	F	Mother
2	Yakiami Laoli	F	Mother
3	Isahati Nduru	F	Mother
4	Ina Yesi	F	Mother
5	Ina Muri	F	Mother
6	Kasiati N	F	Mother
7	Yusman Ndruru	F	Mother
8	Ama Benard	M	Father
9	Ina Peri Ndruru	F	Mother
10	Risi Ndruru	F	Mother
11	Asali Ndruru	M	Health volunteer
12	Sokiato Ndruru	M	Religious Leader
13	Mita Ndruru	F	Mother
14	Melia Ndruru	F	Mother
15	Fauluazisokhi	M	Father
16	Hiruharo Ndruru	M	Health Volunteer
17	Waozidhuhu Ndruru	M	Father
18	Fatizokho Ndruru	M	Religious Leader
19	Faosiaro Zebua	M	Hamlet Chief
20	Mastria Waruwu	F	Mother
21	Gatinia Lase	F	Health volunteer
22	Yunisa Ndraha	F	Mother
23	Agustina Gulo	F	Mother
24	Fatima Harefa	F	Health volunteer
25	Warli Ndruru	M	Health volunteer
26	Muniaro Ndruru	M	BPD
27	Ta'aro'o Ndruru	M	Health volunteer
28	Saliaro Lawolo	M	Health volunteer
29	Yadro Ndruru	M	Health volunteer
30	Nasiba Ndruru	F	Mother
31	Yurunima Waruwu	F	Mother
32	Jaato Ndruru	M	Religious Leader
33	Faosiaro Zebua	M	Adat Leader
34	Taliami Gulo	M	Religious Leader
35	Darius Ndruru	M	Health volunteer
36	Atiria Ndruru	F	Health volunteer

Stakeholders Attending Presentation of Findings in Gunung Sitoli, Nias

	Name	M/F	Position	Organizations
1	F. Agus Halim Wijaya	M	Division Head	Bappeda-Nias Induk

2	H. AHD Agus Zebua	M	Head of Health Promotion	Dinkes, Nias Induk
3	Herlina Telaumbanua	F	Division Head	Dinkes, Nias Induk
4	Ziarah Zendrato	F	Head	District Family Planning and Population Services, Nias
5	Idaman Zega	M	Head	Dinkes, Nias Induk District
6	Dermawani Gea	F	Division Head	Dinkes, Nias Induk
7	Kasinudin Mendrofa	M	Division Head	Dinkes, Nias Induk
8	Nuriana Hia, SKM	F	Chairperson	Midwives Association, Nias
9	Firmina Halawa	F	Head	BPMD, Gunung Sitoli
10	Sozanolo Zendrato	M	Staff	Puskesmas-Bawalato
11	Idaman Laoli	M	Staff	Puskesmas- Bawalato
12	Mahyudin T	M	Staff	District Family Planning and Population Services, Nias
13	Murni Riang Wao	F	Staff	Dinkes, Nias Selatan
14	Tawaonasokhi Nduru	M	Head	Puskesmas plus Lahusa
15	Dr. Avanifasa Laia	M	Head	Puskesmas , Gomo
16	Megawati You, SKM, MPH	F	Head, Family Planning Division	Dinkes Nias Selatan
17	Forniwati Mendrofa, SE	F	Staff	Dinkes, Nias Selatan

APPENDIX 3 Questionnaires

Questionnaire for District BAPPEDA

List of Questions
Government MCH priorities, program and system 1) What are the main health problems of Nias, is MCH among key priorities and needs? 2) How is the Puskesmas and Bidan situation in Nias area, after the district expansion? Do you think that the number is sufficient? 3) How is the quality of the Polindes/Poskedes facilities 4) Do you think that the Poskedes system sufficiently supporting the MCH program? 5) If TBA delivery is the major concern – what has made mothers use TBA instead of Bidan 6) What is the cost of child delivery with bidan? 7) What is the current underfive years health situation in Nias? 8) What is the major cause of child morbidity and mortality. 9) Which of the following health issues are more important to address in Nias: diarrhoea, mal nutrition, ARI, malaria, immunization coverage, hygiene **Knowledge on CBHP** 1) Are you familiar with the CBHP? 2) Do you know the purpose and goal of the project. 3) What activities have been conducted by the project in your area? 4) Do you know, how long the project has been operating in your area 5) Do you meet with CBHP management regularly. **Program coordination** 1) Were you involved in the planning and monitoring of CBHP activities? 2) How do you coordinate non-government organization health initiatives at provincial level? Is there any coordination concern or issue in the case of CBHP implementation? 3) Do you see or experience any overlap with regard to NGO health project implementation? 4) How this overlap can be avoided or managed? 5) Do you meet regularly with NGO representatives, including CBHP's? 6) What will be the best way to improve your coordination roles to produce a better outcomes in MCH development and achievement of MDG goals **Program sustainability** 1) What will be the best way to make NGO initiatives such as CBHP sustainable after project completion? 2) What difficulties are faced by District Governments in sustaining or providing management support to the activities? **Gender issues** 1) What is the key gender issues that have affected maternal and child health situation in Nias. 2) What is the Government policy to address gender issues. **CBHP II** CBHPII will be implemented in 3 Districts in Nias. What is your suggestion or advice to the project, as to make the activities more fruitful and contribute to the improvement of MCH situation in Nias?

Questionnaire for Dinkes Kab

List of Questions
Government MCH priorities, program and system 1) What are the main health problems of your area, is MCH among key priorities and needs in your area? 2) What has became the main cause of martenal morbidity and dealth 3) How many Puskesmas and Bidan servicing your area? Do you think that the number is sufficient? 4) How many Polindes/Polkedes located in your area. Do you think that the number is sufficient? 5) How is the quality of the Polindes/Polkedes facilities 6) Do you think that the Polkedes system sufficiently supporting the MPS program? 7) How do you implement "MPS" strategy in your area 8) How is the ANC situation? Do you know, how many % of pregnant mothers has attended the ANC with Bidan 9) How many percent of delivery attended by health workers and how many by TBA 10) How is the Post natal care situation 11) What are the major concerns/issues faced in MPS program implementation 12) If TBA delivery is the major concern – what has made mothers use TBA instead of Bidan 13) Do you think that cost of delivery with health workers become a reason fo delivery with TBA 14) What is the current underfive years health situation in your area? 15) What is the major cause of child morbidity and mortality. 16) Do you or did you implement IMCI initiative in your area. 17) Do you receive training of IMCI? 18) Do you think that the program is helpful and will become appropriate solution for high child mortality rate? 19) What community actions are needed to support IMCI intervention 20) Which of the following health issues are more important to address in your area: diarrhoea, mal nutrition, ARI, malaria, immunization coverage, hygiene **Knowledge on CBHP** 1) Are you familiar with the CBHP? 2) Do you know the purpose and goal of the project. 3) What activities have been conducted by the project in your area? 4) Do you know, how long the project has been operating in your area 5) Do you meet with CBHP management and field staff regularly 6) Are you familiar with maternal and child health component of CBHP. 7) Are you familiar with PDI nutrition model 8) Are you familiar with the CG or VAT models and their activities 9) Do you think that the CBHP intervention aligned with your MCH priorities, program and service system 10) How has the project helped in strengthening you MCH services 11) How do you think that the project can be more helpful in improving the MCH situation and supporting you MCH development program.

Community actions

1) What community actions are needed to support the implementation of MPS and neonatal health initiatives in your area?
2) What actions have been organized so far?
3) How many Posyandu are active in your area
4) Do you think that the number is enough?
5) Did you implement any Posyandu revitalization activities?
6) Does you Puskesmas facilitated any community actions? How is the MCH community action such as Sayang ibu initiative or Desa Siaga program situation in your area?
7) How is the health volunteer situation?
8) Are they motivated?
9) Are you familiar with the CG or VAT
10) Do you think that the established new community groups can be helpful and supportive to your MCH program and Posyandu revitalization
11) Do you think that these groups need to be sustained after the project complete
12) Will you provide management support to the groups and their activities

Health Communication/Promotion activities

1) Are you familiar with CBHP health communication programs implemented at HH level?
2) Are you familiar with the PDI nutrition rehabilitation program? If yes.
3) Do you think that this approach is effective in address child malnutrition?
4) Are you familiar with the CLTS and WATSAN programs
5) Do you think that the programs are aligned with your program priotities
6) In your opinion, what is the best way to sustain the project activities beyond the project life

Program coordination

1) Were you involved in the planning, implementation and monitoring of CBHP activities in your area?
2) How do you coordinate non-government organization MCH initiatives and community health actions in your area? Is there any coordination concern or issue in the case of CBHP implementation?
3) Do you see or experience any overlap with regard to NGO health project implementation in your area?
4) How this overlap can be avoided or managed?
5) Do you meet regularly with NGO representatives, including CBHP's?
6) What will be the best way to improve your coordination roles to produce a better outcomes in MCH development and achievement of MDG goals

Program sustainability

What will be the best way to make NGO initiatives such as CBHP sustainable after project completion?
What difficulties are faced by Dinkes in sustaining or providing management support to the activities?

Gender issues

What is the key gender issues that have affected neonatal and child situation in your area.
Do you received any training or attended any workshop on gender issues.

CBHP II

CBHPII will be implemented in your area. What is your suggestion or advice to the project, as to make the activities more fruitful and contribute to the improvement of MCH situation in your area?

Questionnaire for Puskesmas head and MCH staff/Bidan

List of Questions
Government MCH priorities, program and system 1) What are the main health problems of your area, is MCH among key priorities and needs in your area? 2) What has became the main cause of martenal morbidity and dealth 3) How many Bidan servicing your area? Do you think that the number is sufficient? 4) How many Polindes/Polkedes located in your area. Do you think that the number is sufficient? 5) How is the quality of the Polindes/Polkedes facilities 6) Do you think that the Polkedes system sufficiently supporting the MPS program? 7) How do you implement "MPS" strategy in your area 8) How is the ANC situation? Do you know, how many % of pregnant mothers has attended the ANC with Bidan 9) How many percent of delivery attended by health workers and how many by TBA 10) How is the Post natal care situation 11) What are the major concerns/issues faced in MPS program implementation 12) If TBA delivery is the major concern – what has made mothers use TBA instead of Bidan 13) What is the cost of child delivery with bidan? 14) Do you think that cost of delivery with health workers become a reason fo delivery with TBA 15) What is the current underfive years health situation in your area? 16) What is the major cause of child morbidity and mortality. 17) Do you or did you implement IMCI initiative in your area. 18) Do you receive training of IMCI? 19) Do you think that the program is helpful and will become appropriate solution for high child mortality rate? 20) What community actions are needed to support IMCI intervention 21) Which of the following health issues are more important to address in your area: diarrhoea, mal nutrition, ARI, malaria, immunization coverage, hygiene **Knowledge on CBHP** 1) Are you familiar with the CBHP? 2) Do you know the purpose and goal of the project. 3) What activities have been conducted by the project in your area? 4) Do you know, how long the project has been operating in your area 5) Do you meet with CBHP management and field staff regularly 6) Are you familiar with maternal and child health component of CBHP. 7) Are you familiar with PDI nutrition model 8) Are you familiar with the CG or VAT models and their activities 9) Do you think that the CBHP intervention aligned with your MCH priorities, program and service system 10) How has the project helped in strengthening you MCH services 11) How do you think that the project can be more helpful in improving the MCH situation and supporting you MCH development program. **Community actions** 1) What community actions are needed to support the implementation of MPS and neonatal health

initiatives in your area?
2) What actions have been organized so far?
3) How many Posyandu are active in your area
4) Do you think that the number is enough?
5) Did you implement any Posyandu revitalization activities?
6) Does you Puskesmas facilitated any community actions? How is the MCH community action such as Sayang ibu initiative or Desa Siaga program situation in your area?
7) How is the health volunteer situation?
8) Are they motivated?
9) Are you familiar with the CG or VAT
10) Do you think that the established new community groups can be helpful and supportive to your MCH program and revitalize Posyandu
11) Do you think that these groups need to be sustained after the project complete
12) Will you provide management support to the groups and their activities

Health Communication/Promotion activities
1) Are you familiar with CBHP health communication programs implemented at HH level?
2) Are you familiar with the PDI nutrition rehabilitation program? If yes.
3) Do you think that this approach is effective in address child malnutrition?
4) Are you familiar with the CLTS and WATSAN programs
5) Do you think that the programs are aligned with your program priotities
6) In your opinion, what is the best way to sustain the project activities beyond the project life

Training
1) Did you attend any training conducted by CBHP? What kind of training?
2) Do you think that the training is helpful for you to carry out you duties?
3) Do you think that the training is helpful for you to provide management support to CBHP activities
4) Do you think that the training is helpful for your to provide management support to community actions or Posyandu
5) Do you need such training at all?
6) What kind of training that you really need?

Program coordination
1) Were you involved in the planning, implementation and monitoring of CBHP activities in your area?
2) How do you coordinate non-government organization MCH initiatives and community health actions in your area? Is there any coordination concern or issue in the case of CBHP implementation?
3) Do you see or experience any overlap with regard to NGO health project implementation in your area?
4) How this overlap can be avoided or managed?
5) Do you meet regularly with NGO representatives, including CBHP's?
6) What will be the best way to improve your coordination roles to produce a better outcomes in MCH development and achievement of MDG goals

Program sustainability
1) What will be the best way to make NGO initiatives such as CBHP sustainable after project completion?
2) What difficulties are faced by Puskesmas in sustaining or providing management support to the activities?

Gender issues

1) What is the key gender issues that have affected neonatal and child situation in your area.
2) Do you received any training or attended any workshop on gender issues.

CBHP II

CBHPII will be implemented in your area. What is your suggestion or advice to the project, as to make the activities more fruitful and contribute to the improvement of MCH situation in your area?

Instrument Title: Focus Group Discussion Guide

Total Participant time required: **1 hour 30 minutes – 1 hour + 50 minutes**
Break: **15 minutes**

The purpose of the discussion is:

- To gather evidences from CBHP primary beneficiaries and community level stakeholders, that will be used to support the overall assessment on the relevance, effectiveness, impact and sustainability of CBHP I interventions and to provide recommendations for the refining of the CBHPII design and activities plan
- To provide a chance for the primary beneficiaries and community level stakeholders to learn about the project approach and activities and to contribute to the improvement of the CBHPII approach and methodology.

The discussion is facilitated by Evaluation Team member.

Before the group begins, conduct the informed consent process, including compensation discussion.

I. Introduction (10 m)

- Welcome and introduction
- Explain the general purpose of the discussion and why the participants were chosen.
- Discuss the purpose and process of focus groups
- Explain the presence and purpose of recording equipment and introduce observers.
- Outline general ground rules and discussion guidelines such as the importance of everyone speaking up, talking one at a time, and being prepared for the moderator to interrupt to assure that all the topics can be covered.
- Review schedule and break.
- Address the issue of confidentiality.
- Inform the group that information discussed is going to be analyzed as a whole and that participants' names will not be used in any analysis of the discussion.
- Read a protocol summary to the participants.

<u>Discussion Guidelines</u>:

- *The discussion to be informal. Encourage participants to respond directly to the comments other people make. If participants don't understand a question, encourage to let facilitators know.*
- *Facilitators are present to ask questions, listen, and make sure everyone has a chance to share.*

- *If discussion seems to be stuck on a topic, facilitator may interrupt and if some participants aren't saying much, facilitator may call on individuals directly. Explain that this just a way of making sure facilitators obtain everyone's perspective and opinion is included.*
- *Ask that participants keep each other's identities, participation and remarks private. We hope you'll feel free to speak openly and honestly.*
- *Begin with introduction. .*

II. Discussion Topics

II.1 Maternal and child health needs of the community.

The objective of the discussion is to find out:
(1) whether maternal and child health is a felt need and priority of the community;
(2) what maternal and child health problems are encountered by the community,
(3) what programs and services are needed by the community to address the problem

II.2 Existing community actions for maternal health, the importance of Posyandu in maternal and child health and Posyandu situation

The objective of the discussion is to find out:
(1) Knowledge of participants about existing community actions for maternal and child health development and the range of community actions and structures available within the community
(2) Community's understanding on the role of Posyandu for maternal and child health development
(3) The current situation of the local Posyandus

II.3 Knowledge on CBHP and its activities

The objective of the discussion is to find out:
(1) Participants knowledge about CBHP and its interventions
(2) Benefits of the project interventions to individual participant and their family
(3) Benefits of the project to the community

II.4 Involvement in project implementation and monitoring

The objective of the discussion is to find out:
(1) whether any member of the participants involved in CBHP implementation
(2) range of activities involving participants
(3) in what roles were their involvement
(4) what activities performed by participants

II.5 Level of ownership

The objective of the discussion is to find out:
(1) participants understanding on health project ownership and on "who own CBHP?"

(2) participants commitments to sustain CBHP activities
(3) participants willingness to contribute to the project costs

II.6 Links between communities and health services/facilities,

The objective of the discussion is to find out:
(1) the Bidan/Polindes/Polkedes situation
(2) whether the relationship with Bidan and the above facilities is better?

II.7 The effectiveness of CG and VAT

The objective of the discussion is to find out:
(1) Participants' knowledge on CG and VAT activities?
(2) Participants' knowledge on the objectives of CG and VAT activities
(3) Participants knowledge on any achievements made by CG and VATs
(4) Participants' knowledge on the current situation of the groups

II.8 Sustainability of CBHPI benefit and or future sustainability of CBHPII

The objective of the discussion is to find out:
(1) Participants knowledge on CBHPI and II interventions (provide list) and their benefits
(2) The current situation of CBHPI And II interventions
(3) Participants involvement in CBHPII activities
(4) Participants willingness to sustain their involvement and or contribution to the activities

V. Closing (10 m)

- Closing remarks
- Thank the participant