ChildFund Indonesia

REACH
Narrative Report

Informal Interviews
2013

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1. Introduction

This paper presents findings from informal interviews conducted with village cadre and relevant staff of the *REACHing for Equal Access in Child Health (REACH) Project* in June 2013. The purposes of the interviews were to: 1. Evaluate the capacity of REACH cadres and the scope of the project among 5 villages in which it has been implemented; 2. Investigate the efficacy of ChildFund's partnerships with other REACH actors; and 3. Identify current shortcomings and future needs of REACH. This report accompanies formal qualitative and quantitative analyses of REACH being readied for publication by ChildFund and UNICEF.

2. Overall REACH Project

2.1. Background

REACH is a child survival project funded by UNICEF and the Canadian government (CIDA – Canadian International Development Agency) to address the issue of high mortality and morbidity of children under 5 years in the poorest quintile districts of Indonesia. Implementation is in the 4 province areas of Papua, Maluku, Central Java and East Nusa Tenggara (NTT), the latter for which ChildFund is responsible. Aimed to reduce the under 5 mortality rate (U5MR) by the end of 2012, the project in NTT began in June 2010 in partnership with *Sanggar Suara Perempuan* (SSP), a local community-based organization located in the city of SoE, and the University of Indonesia (Center for Biostatistics and Health Informatics). In the Timor Tengah Selatan District (TTS), the UM5R in 2007 was 57 per 1000 live births, higher than the national average today of 32 per 1000 live births.


A young mother breastfeeding her child

The project aims to implement improved service delivery of Community-Integrated Management of Childhood Illness (C-IMCI) through 5 interventions. REACH's interventions work to reduce rates of diarrhea, pneumonia and malaria among children through the promotion of hand washing, use of bed nets and application of appropriate medication and treatment as well as improved identification of symptoms. The project's messages also promote breastfeeding and the abstention from "sei" practice, a detrimental tradition of residing in a smoke-filled hut with no windows post-birth. A census conducted in July 2012 identified 7675 children under 5 supported and 175 professional health workers, 236 CCM cadres, 237 mother educators and 32 youths trained through REACH's implementation.

2.2. Interview Methodology

To conduct the interviews, key areas of interest were first identified by Dr. Brian Sriphastuti, MCH Specialist and REACH Program Manager. They are as follows:

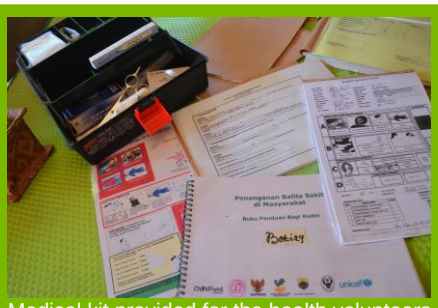
- Effectiveness of the project in facilitating community involvement in the decision making and problem solving processes of childhood illnesses;
- Effects to the enhancement of government capacities in the planning, coordination and implementation of the project;
- Impact on capacities of local NGOs and CBOs to be active in short and longer-term processes of the project;
- Impact on the visibility and character of ChildFund Indonesia among NGOs, INGOs, health sector government offices and potential donors or stakeholders.

Sophie Soares, REACH Intern (MPH Candidate, Columbia University), constructed pertinent questions in English for each area of interest – which were reviewed by Dr. Sriphastuti – and Nursia Eirene, REACH Project Officer, identified appropriate interview subjects and locations. The following 5 villages in West Timor, surrounding SoE, were selected: Noebesa, Kuannoel, Lasi, Meusin and Oni. Interviews with cadre were conducted either in their place of residence or the village *posyandu* (integrated village post). Additionally, interviews were scheduled with the staff of one *puskesmas* (government-mandated community health clinic), the BAPPEDA (local government) office and *Dinas Kesehatan* (DINKES/District Health Office). Interviews were conducted in their place of employment.

Interviews were conducted by Ms. Soares in English and facilitated by Anselmus Kase, a staff member of SPP who acted as translator. The first day of interviews were intended to test the initial draft of questions. Following this, questions were revised and expanded to be in a simpler and more efficient language to make for easier translation into Indonesian, and the local language of *Dawan.* If interview responses required follow-up questions, they were asked. Because use of verbatim quotations from project/research participants has become common practice in qualitative social research, Ms. Soares recorded each interview while taking notes and all interviews were later transcribed. The intention, seen later in this paper, is to ground future practice and recommendations to ChildFund in 'best practice and evidence'.

3. Findings

3.1. Major Themes


Medical kit provided for the health volunteers

Interviews with cadre and staff of various REACH partners generated common themes. Overwhelmingly, cadres feel that their capacity as volunteer health workers has expanded through the REACH project. In conversation with many of them, there were noted acknowledgements of knowingness and authority in the community. Mr. Maren Tahig of Meusin Village, a cadre since 2010 on behalf of REACH, noted "We are the real volunteers. We know everything about the client." Mr. Sorse Anin from Kuannoel Village mentioned how "especially for children 0 to 5, all the cadres feel [they] have a lot of influence over…health." As a cadre for over 20 years, Mr. Bruno of Noebesa village described how REACH had altered his role for the better: "Caring and helping comes from the heart. It has been rewarding to increase my capacity to help mother and children."

The shared experience of increased ability as a cadre among the men and women interviewed is in line with the positive feedback they provided their initial trainings in REACH, or *MTBSM* as it is known locally. Similarly, Matilda, Director of Puskesmas Niki-Niki and a government employee, noted that REACH facilitated government's work with puskesmas and surrounding communities, too expanding local government's capacity. The REACH Coordinator for SSP, Ms. Debby, also described the positive impact of the project on SSP's REACH: "REACH has been excellent. It has improved our relationship with the village."

Another oft-mentioned theme was that of increased utilization of services. Several cadres had observed more frequent visits to the posyandu: "A good thing is MTBSM is making clear that cadres are here for the community. I am seeing more people." Additionally, REACH has produced greater acceptance of puskesmas' services over self-care. Mr. Tahig notes, "You can see changes from people and children. When mother is pregnant, she goes to puskesmas now." With increased attendance to these health centers comes improved health. In an interview with Ms. Eirene herself, she also noted that the oft-absorbed message of REACH among parents was the

availability of C-IMCI cadre as primary responders to issues of health in the community. When asked if there is resistance at all, in her perspective as Program Officer, to REACH she said: "There is no resistance from parents, because actually the C-IMCI approach have helped the parents who lived in the village that have no public transportation, no health workers, and/or are far from the health center. So the parents can contact the C-IMCI cadre first before they refer to the health center."

Indeed, another common theme drawn from the interviews was a perceived retention of healthy behaviors by village women and children. Conversations revealed that in addition to increased use of medication and other services, villagers were sustaining healthy behaviors taught to them. Mr. Anin of the Koannoel Village says: "They understand well the importance of washing hands and ask many questions about that." Cadres mentioned, in passing, that breastfeeding too is becoming more common practice, while one mother in Oni Village said she now understood its importance because of MTBSM. Ms. Debby replies to cadre's observations in agreement: "REACH has helped raise children. Anyone involved with children is learning, whole communities are learning more. The mother support group and youth are learning to grown up and become good mothers themselves." Overall, the response has been very positive.

While the strengths of REACH were evident in conversation with cadre and REACH staff alike, there was additional inquiry into the relationship of ChildFund with the other REACH partners SSP, DINKES and the BAPPPEDA. Again, feedback was mostly reaffirming. Representatives of each of these offices described a strong working relationship with ChildFund, crediting ChildFund as effectively supportive and communicative. Head of DINKES local SoE office, Dr. Ani, said "There has been very good communication and involvement and inclusion in every step. That is very good thing." Furthermore, SPP expressed appreciation for the trust ChildFund placed in its office to implement REACH. Ms. Debby says "We have a good relationship with ChildFund because of this respect and trust." Mr. John, of SoE's local BAPPEDA said he had enjoyed the work with ChildFund and found coordination particularly effective at the beginning.

Despite positive reflections of REACH's impact, some weaknesses were cited as well. Program Officer Ms. Eirene cited persistent resistance to the REACH message discouraging "sei" practice. In conversation, she discussed the difficulty of counteracting a practice rooted in longstanding traditions and beliefs despite convincing evidence of it *not* promoting but actually undercutting good health. Indeed, any barriers that exist in her opinion revolve primarily around maintaining parents' awareness and internalization of health behavior.

3.2. Challenges

Conduct of interviews with REACH representatives was not without various hindrances. An obvious challenge was the language barrier. Questions had to be doubly translated by Mr. Kase; he personally needed to understand the question in Indonesian to then speak it in *Dawan*. On rare occasion, a question would be asked that would produce a response that did not correlate to the original question. Ms. Soares perceived this to be a result of the language barrier. Furthermore, because Mr. Kase was a staff member of SSP, it was unclear when questions were being asked on behalf of his agency's point of view rather than as Ms. Soares originally dictated them. Though a more than adequate translator, this too presented issues. Another challenge was in the potential restraint shown by interview subjects when in Ms. Soares' presence. Though there was no evidence that cadres and REACH staff were not honest with their answers, it is possible that interviews with a foreigner made them uncomfortable or shy. That said, interviews were well executed, especially in consideration of all that could have limited their success.

4. Conclusion

4.1. Future Needs and Recommendations

Needs and recommendations came from two sources, cadre and REACH partners. Among cadre, primarily, there was an express want for additional training. Though they felt their skills enhanced through MTBSM, several cadres seemed to desire more knowledge and inclusion, especially when asked what they would suggest to improve MTBSM in the future. Ms. Batseba, of Lasi Village said: "We, the cadre, need more training on how to teach others and answer the hopelessness from people here. I am very grateful for MTBSM but if MTBSM could give more training for *all* children, not just 1-2 or 0-5 years." It is important to note here that the need for more, in-depth exercises by cadre is motivated by the hope to establish greater accessibility to the care and information community members would otherwise receive from inaccessible, distant puskesmas.

Another recommendation made by a number of cadres was for government to 'officially' endorse visits to posyandu and role of the cadre. The aspiration of many cadres is to establish cadres as the "first line of defense" in instances of bad health within the community. Mr. Johannes, a father of one cadre in Lasi Village, depicted the challenge and potential solution: "I want the cadres to learn how to look after the mother after birth. The problem is that every time the mother gives birth here not in the puskesmas. The cadres are the first to help somebody, to get to the person first so they need training. In the future, it would be good to go to every posyandu and for it to be like a puskesmas. I also hope there is acknowledgement that my daughter was a cadre."


MTBSM cadre provides basic health service to a young child

DINKES would like to expand the scope of REACH to more puskesmas and villages in West Timor. Dr. Ani described that REACH's sustainability could be assured with more years of dedication to building the capacity of the community, promoting participation from not merely cadres but other heads of the community such as priests – "Every village in Timor has at least 1 church" – and teachers. Finally, in relation to partnership with ChildFund, some staff felt there was opportunity to make the relationship even stronger through more thorough communication, coordination and greater clarity of expectations during the planning stages: "I think the management in ChildFund is always changing so I hope that they can make their expectations clearer in the future."

With regard to awareness of the REACH messages, Program Officer Ms. Eirene recommended utilizing the community structure to communicate and increase understanding of REACH messages with the *tokoh adat*, community leader, husbands and mother-in-laws who typically have the power of decision-making within the community and home.

4.2. Conclusion

ChildFund intends to relinquish control of REACH to all local partners after Year 1 of implementation. With this in mind, it is the recommendation that the next step be to oversee requested training/refresher course to MTBSM cadre before terminating ChildFund's participation in REACH. This course would be best implemented following the formal analyses of REACH being conducted by UNICEF and ChildFund that can better elucidate its efficacy. Furthermore, after much discussion with local DINKES representatives, it is recommended that REACH actors, including ChildFund, consider expanding the current perception of what a "cadre" is to include not only volunteer community members but teachers and priests as well. There is ample opportunity to strengthen REACH and deepen its impact by utilizing community spaces such as the church, school and youth hang-outs.

4.3. Appendix

QUESTIONS VERSION 1.	**Interview w/**: Matilda, Director of Puskesmas Mona, Doctor (Did not speak) **Where**: Puskesmas Niki-Niki **When**: 13-6-13	**Interview w/**: Bruno (Cadre) **Where**: Noebesa Village **When**: 13-6-13
REACH Overall		
Hello, please state your name.	I am Matilda.	I am Bruno.
What is your position?	Head of the puskesmas since 2010.	I have been head of all cadre since 1982. I am special cadre for MTBSM. There are 5 cadre in this posyandu.
What is your role in the REACH project?		I am administration. I maintain pregnancy data and everything about the mother and children.
How has your role been in the REACH project? What has been most rewarding? What has been most difficult?	What has been rewarding is that more people are coming to the puskesmas now. The difficulty is that the cadre are not stocked with medicine.	Caring and helping comes from the heart. It has been rewarding to increase my capacity to help mother and children. What has been difficult is transportation to the puskesmas, especially when there is a big rain. If it is dark in the village, if the client comes, I might not be there to help. How to give them the medicine is a challenge. They don't always understand.
What, from your perspective, are the goals of REACH?	The goal is to help as many children as possible.	
Do you feel that overall, the project has been effective in REACHing its goals?		The community discusses everything with me. The people trust me and have confidence now that they won't get sick anymore. Children 0 to 5 years are remembering to wash their hands.
How is the partnership of ChildFund and UNICEF most effective?		

How is partnership of ChildFund and UNICEF least effective? or What are REACH's weaknesses?	REACH's weakness has been administration.	
Why do you think REACH has these weaknesses? What has caused them?		
What would you suggest to improve the efficacy of REACH or projects like REACH?	I hope that REACH can expand to all 10 villages of this district.	I need something for transportation.
Do you feel that REACH caused an expansion of government's capacities?	Yes, REACH has made it easy to work with puskesmas. It has expanded our capacities.	
REACH Impact		
How many cadres have been trained in the REACH program?		
How many parents have been trained in the REACH program?		
How many children have participated in the REACH program?		
Is there resistance to REACH from parents? From children?		
If so, why is there resistance?		
What is the REACH message?		
Which of REACH's messages do you think have had the greatest impact? With children? With parents?		
Which of REACH's messages do you think have had the least impact? With children? With parents?		
What are the barriers to REACH with children? With parents?		
Do you feel that these barriers can be overcome? How?		

Do the parents feel they can maintain the health behaviors they have learned? Do the children feel they can maintain the health behaviors they have learned?		
Do the parents feel they have benefited from the REACH program or not? Children?		
Do the cadres feel well-trained?		
Does the staff feel REACH has expanded the quantity of services offered at puskesmas?		
Does the staff feel REACH has expanded the quality of services offered at puskesmas?		
Does the staff feel these services can be sustained without assistance from UNICEF or ChildFund?		
What is the biggest challenge for them in dispensing REACH messages/services?		
What do they feel is largest benefit of the REACH program?		
How do community health workers feel REACH or other projects like it can be sustained?		
Relationship between Government and local NGO/CSO		
From your perspective, how has the relationship between government and ChildFund been in the REACH program?		
What are the biggest strengths in the relationship?		
How can ChildFund strengthen its relationship with local government in the future ?		

How can ChildFund become a more visible entity among health sector government offices?		
How can local NGOs such as ChildFund assist government in the planning, coordination and implementation of a project such as REACH? And vice versa? Would government like to be involved in all stages of the project?		
Where do you feel government would be most effective in facilitating the implementation of a project like REACH?		
What is local government's perception of ChildFund?		
How can we increase accountability between government and ChildFund?		
Do you have any other suggestions for what to do to improve the relationship between local government and local NGOs/CBOs?		

	Interview w/: Delphi Naben & Sorse Anin **Where**: Kuannoel Village **When**: 14-6-13	**Interview w/**: Batseba **Where**: Lasi Village **When**: 17-6-13	**Comments from**: Johannes (Batseba's Father) **Where**: Lasi Village **When**: 17-6-13	**Interview w/**: Daud **Where**: Lasi Village **When**: 17-6-13	**Interview w/**: Marten Tahig **Where**: Meusin Village **When**: 18-6-13	**Interview w/**: Antonia, Motivator, NMPL **Where**: Meusin Village **When**: 18-6-13	**Interview w/**: Ami (also interviewed 2 mothers; did not provide very much information but I highlighted their comments in purple). **Where**: Oni Village **When**: 19-6-13
QUESTIONS (CADRES)							
What is your position?	We are MTBSM cadre.	I have been a cadre since 2005.		I am cadre. Started in May, 2011.	I am a cadre. I have been with MTBSM since it began in this village in 2010.	I am a motivator since 2010 for NMPL.	I am MTBSM cadre in this village.
How many cadre are there in your village?	There are 5 cadres in the village. 1 per posyandu (5 posyandu). 4 cadre are for MTBSM.				There are 7 cadre total in this village.	In the village, there are 6 motivators, 1 posyandu.	
What is your role in the MTBSM?	People feel better because they can come to me for their medicine. They don't have to go all the way to the puskesmas.	I follow training from MTBSM and ChildFund.				Every month, I go to 2 meetings. I know how to keep children healthy especially 0 to 2 years and how to give the milk from mother to children. How to keep the place clean where children are living.	I have all information on pregnancies in the village. I keep schedule for when mother will give birth. Every month hwe have a meeting.

Have you liked your role in MTBSM? What has been hard? What has been good?	I like my role. Especially for children 0 to 5, all the cadres feel we have a lot of influence over their health. It has been hard to get enough medicine though. But, I am proud to be an MTBSM cadre.	I feel able to help children but the puskesmas is very far away so my ability to help is limited.		It is a good thing to have services so close. I am grateful because I believe God will give back to me for giving for nothing. Some parents believe the puskesmas more than the cadre, like me, though. It is a problem.	Big problem is that the medicine we get it only one dose. Not enough for the year round. In the past, puskesmas have refused to give additional medicine to cadre. Sometimes did not give the service to children around here in this village. A good thing is MTBSM is making clear that cadre are here for the community. Seeing more people.		When the mother come to me or other cadre and want to go to the puskesmas, I and other cadre to do not have the money to go with them. This is difficult.
Do you feel well-trained to give messages of MTBSM?	Yes, we have many exercises in past.				Yes, we are the real volunteers. We know everything about the client. We will always have the capacity.		

What are strengths of MTBSM?	Because of MTBSM, children are growing up healthy.				I'm so very proud to teeach the children to live healthy and protect themselves.	I am proud to have become a motivator. People are understanding from me how to keep their health and protect themselves.	We like being cadre. I feel I know a lot and people trust me, they like to ask me questions. I like MTBSM. I get all my information from Ibu Ami, DHO, puskesmas and my minister. It is helpful. I now understand the importance of breastfeeding.
What are weaknesses of MTBSM?	Children are learning to wash but with water only, no soap.	Weakness is human resources. Clients come and every time they think that the cadre will just give them medicine. Sometimes they are expending more than just medicine, more experience and information.				Some mothers are not going to the puskesmas, are not learning how to keep baby healthy after they are born.	
Which MTBSM message is MOST clear to the parents and children? Which MTBSM message is LEAST clear to the parents and children?	They understand well the importance of washing hands and ask many questions about that. But there is confusion about when				You can see changes from people and children. When mother is pregnant, she goes to puskesmas now. When children go to bathroom, they now have		We trust the magic here. If children are sick, we don't know if its magic or diarrhea + influenza. We are not sure.

	to breastfeed and how long.				room to do it and they always wash after.		
Do you think the parents and children will sustain good MTBSM behaviors?							
Do you think you can teach MTBSM messages without direction from ChildFund or UNICEF?	MTBSM cannot stop because it has become part of puskesmas.	I do not want it to finish. Before the program, we didn't have news or help from puskesmas. The MTBSM helped puskesmas feel motivated to come to my village and help people, provide services. The pregnancy services are especially helpful.		Yes but I think government can work together with cadre to improve and gain more trust of people. I want to know how to do better. We can do without direction from ChildFund but if someone could come to tell community to trust cadre, that would help. Or, create a rule, especially in this village.			

Do you have suggestions to improve MTBSM?	We need more trainings as cadres. And we would like to be included in trainings of puskesmas, or at least invited.	We, the cadre, need more trainings on how to teach others and answer the hopelessness from people here. I am very grateful for MTBSM but if MTBSM could give more trainings for all children, not just 1-2 or 0-5.	I want the cadres to learn how to look after the mother after birth. The problem is that every time the mother gives birth here not in the puskesmas. The cadre are the first to help somebody, to get to person first. So they need training. In the future, it would be good to go to every posyandu and it be like a puskesmas. I also hope there is acknowledgement that my daughter was a cadre.	In the future, when MTBSM is going alone, it would be good to have MTBSM be an institute.	I would suggest you make some sort of rule to puskesmas or government that there is some medicine set aside for the cadres. I want to refresh with trainings and for all the care to meet. In future, if REACH wants to do another training, they must include stakeholders in the village.		

	Interview w/: Mister John **Where**: Bappeda, SoE **When**: 15-6-13	**Interview w/**: Debby, REACH Coordinator **Where**: SSP, SoE **When**: 17-6-13	**Interview w/**: Dr. Ani, head of DHO (Berinice S. Valla) **Where**: DHO, SoE **When**: 19-6-13
QUESTIONS (BAPPEDA)			
Please state your name.	I am John.		
What is your role? How are you involved with REACH?	I am responsible for government commitments to NGO.		

How has REACH been effective?	Coordination went well at the beginning of implementation. We like to be involved in planning and coordination but trust others for implementation.		
What are the weaknesses?	Some staff were replaced and there was a lot of miscoordination. There is also little time in government to discuss. I have limited information of the project.		
How can ChildFund have relationship with BAPPEDA in the future?	We like to work with ChildFund. Data collecting is very good for us, very useful. We can know better what kind of service is giving by health facility.		
Where do you feel government would be most effective in facilitating the implementation of a project like REACH?			
QUESTIONS (SSP, LOCAL PARTNER)			
What is your position?		I have worked at SSP since 1999. I am a coordinator for REACH since end of September, 2010.	

Please tell me, what is happening with REACH right now?		Right now, we have an extension for 6 months, from April until this September, 2013, to prepare for handing over the project to government. We have 5 activities to finish by September. We have also creating report to give to ChildFund, UNICEF and DHO about all the activity we have completed in the puskesmas and with REACH team.	
From your perspective, has REACH been effective?		REACH has been excellent. It has improved our relationship with villages, has helped raise children. Anyone involved with children is learning, whole communities are learning more. The mother support group and youth are learning to grown up and become good mothers themselves.	
Do you have any suggestions for REACH in the future?		I hope that REACH, in the future, continues to teach children to protect themselves. ALL children. And I would like to expand REACH to all 280 villages in the future.	
Do you think REACH is sustainable without help from ChildFund?		Yes, it is sustainable. Government has a similar program.	
How is SSP's relationship with ChildFund?		ChildFund is a good partner because they trust SSP to do good job with implementation. We have good relationship.	
Do you have any suggestions to improve the relationship between ChildFund and SSP?		I think the administration of the system in ChildFund is always changing so I would hope that they could make more clear their expectations in the future.	
QUESTIONS (DHO)			
Hello, please state your name.			I am Dr. Ani.
What is your position.			I am head of DHO since 2010.

What, from your perspective, is REACH?			REACH or MTBSM is about capacity building of health staff.
Do you have any suggestions for REACH in the future?			REACH is sustainable. But I would like to see it expand to the 16 puskesmas left. I also feel that 3 years is not enough. We need to expand the capacity building of the community, make more people able to be cadres. For example, get teachers to act as health educators too. Every village in Timor has at least 1 church. We should talk to priests as well, make them informal cadres.
How is DHO's relationship with ChildFund?			DHO's relationship with ChildFund is good. There has been very good communication and involvement and inclusion in every step. That is very good thing.
Do you have any suggestions to improve the relationship between ChildFund and SSP?			No, it is very good.

2013