Nabire Health and Disaster Management Project

Independent Completion Report

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Contents

Acronyms and Glossary

ANC	Ante Natal Care
AusAID	Australian Agency for International Development
BAPPEDA	Badan Perencanaan Pembagunan Daerah (district planning body)
BCC	Behaviour Change Communication
Bupati	Head of district government
Camat	Head of Sub-district Government
CBDRM	Community Based Disaster Risk Management
CBO	Community Based Organisation
C-IMCI	Community - Integrated Management of Childhood Illnesses
CLTS	Community-Led Total Sanitation ("no open defecation")
CS	Child Survival
Desa SIAGA	Village Ready/Transport/Stand-by (for medically supervised deliveries)
DM	Disaster Management
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
DHO	District Health Office
EOP	End of project
ECCD	Early Childhood Care and Development
FGD	Focus Group Discussions
GoI	Government of Indonesia
HH/C-IMCI	Household and Community Integrated Management of Childhood Illnesses
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Childhood Illnesses
IPCC	Interpersonal Communication and Counselling
KMS	Kartu Menuju Sehat (Road to Health Card)
Kabupaten	District
KAPC	Knowledge, Attitudes, Practice and Coverage
Kecamatan	Subdistrict
LKMD	Lembaga Ketahanan Masyarakat Desa (Institution for Village Resilience)
LPPM	Lembaga Pengembangan dan Pemberdayaan Masyarakat (Local Community Development Institute)
LSS	Life Saving Skills
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MPA	Methodology for Participatory Assessments
MPS	Making Pregnancy Safer
NGO	Non-Governmental Organization
NHDM	Nabire Health and Disaster Management Project
P4K	Program Perencanaan Persalinan & Pencegahan Komplikasi (Birth Preparedness and Complication Readiness) previously known as Desa SIAGA
PCI	Project Concern International
PD	Positive Deviance

PDAM	Perusahaan Daerah Air Minum (State water authority)
PKBI	Perkumpulan Keluarga Berencana Indonesia (family planning NGO
PLA	Participatory Learning and Action
Polindes	Pondok Bersalin Desa (Village Midwife's Clinic)
Posyandu	Pusat Pelayanan Terpadu (Community Health Posts)
PRA	Participatory Rural Appraisal
Puskesmas	Pusat Kesehatan Masyarakat (Subdistrict Health Center)
Pustu	Puskesmas Pembantu (Sub-health center)
RT	Household neighbourhood
RW	Hamlet (within village)
SATLAK	Satuan Pelaksana (district disaster management agency)
SKDN	Monitoring system used to measure Posyandu performance
TB	Tuberculosis
TBA	Traditional Birth Attendant
ToT	Training of Trainers
VC	Village Committee
WatSan	Water Supply and Sanitation

Report Summary

In 2006, following two significant earthquakes affecting Nabire District, Papua Province, in February and November 2004, AusAID contracted the US NGO Project Concern International (PCI) to implement a three-year trial project in Community-Based Disaster Risk Management (CBDRM) in the District. The project was funded from the Australia-Indonesia Partnership for Reconstruction and Development (AIPRD) established in the wake of the Aceh earthquake and tsunami of December 2004.

Both AusAID and PCI had limited experience of CBDRM at the time but PCI had worked in Nabire District for almost 10 years, mainly in health and water supply and sanitation. AusAID's prior disaster management work had focused mainly on preparedness and emergency response. The Nabire Health and Disaster Management Project (NHDM) comprised three components in Maternal and Child Health (MCH); Water Supply and Sanitation (WatSan); and CBDRM. The project had two distinct goals – the first related to reduced mortality and morbidity for women and children in the target villages and the second to reduced vulnerability to future disasters. The MCH and WatSan components were specifically linked to the health goal and the CBDRM component to the disaster vulnerability goal. Eventually, AusAID's intention was for the three components to be integrated in NHDM's work in each village. Initially however, this was not made clear to PCI and, as a result, the nature of this integration was not clearly articulated in the project design or in subsequent implementation management support. As a result, the intent was only partially resolved up to the time of the ICR Review. There was also misunderstanding about the nature of NHDM, AusAID seeing it as a trial or exploration of integrated CBDRM and PCI perhaps more as a MCH and WatSan and CBDRM intervention to be implemented pretty much according to the design script.

Despite these potential sources of uncertainty, NHDM has made a major contribution to the health and well-being of people in its 30 target villages with some villagers making explicit the connection between the MCH and WatSan improvements and reduced vulnerability to future disasters.

MCH component The MCH component provided:

- Materials and technical support for communities to repair or construct village and sub-district health facilities including 44 village posyandu
- Training of 'front line' health workers – 46 government *puskesmas* staff including 31 mid-wives; 250 community volunteer *posyandu kaders*; and traditional birth assistants (TBAs) within each village
- A wide range of MCH 'intervention tools' and training models for health workers and IEC materials to support these.

WatSan component The WatSan component combined materials and technical support for the community construction of water supplies, hand-washing facilities and latrines with behaviour change education to support effective use of the facilities. These amounted to:

- More than 500 water supply facilities (rain-water tanks, dug-wells or gravity fed reticulated systems)
- 203 two-chamber septic-system latrines
- 131 hand-washing stations

Both of these components provided good access for women to benefits and also enabled facilitated their participation – women were active on WatSan committees in all villages and chaired the committees in four villages. Almost all of the MCH participants and beneficiaries were women (apart from six men who trained as *posyandu kaders*) and some became effective community mobilisers across all NHDM activities.

CBDRM component NHDM conducted Participatory Disaster Risk Assessment activities in all villages and from these, disaster risk mitigation plans were developed and are being implemented (or have been completed) in most villages. While valuable work has been completed, this component has been more problematic, stemming from some uncertainty about what constitutes CBDRM and what are the most effective ways to go about it. The report is clear that the focus of CBDRM has to include (a) "on ground" assessment of disaster vulnerabilities and capacities that can also be triangulated with scientific evidence in order to properly evaluate risk and (b) approaches that ensure community ownership through sound community development processes.

The main operational problem for NHDM was a high rate of staff turnover which put stress on staff – especially those with field responsibilities – and on the training capacity of the organisation. Difficulty in providing sufficient training for staff probably reduced the effectiveness of some project activities. Greater use of ToT and general capacity development expertise may have assisted with this and also contributed to strengthened outcomes in some areas. The project was otherwise well-managed, M&E data collection, six-monthly reporting and baseline and endline KAPC surveys were competently carried out.

As in many countries, gender equity issues in Nabire are difficult to deal with, especially when they are affected by long-standing cultural roles and practices. Project staff were conscious of gender issues and, although women constituted only 26% of the total staff, 39% of the front line field staff were women. Gender equity was reasonable across the project although mainly men were involved in the CBDRM component and mainly women in the MCH component. There were a few situations where NHDM could have been more proactive in supporting women's rights.

There is a concern about the sustainability of NHDM's benefits. This is because the implementation time (two years for most villages) may not have been long enough to produce behaviour changes and learning that will persist and skills that will continue to be applied in the absence of the project. Other experience would suggest that the time is probably too short to avoid losses unless a degree of ongoing support can be provided by the District Government or another program.

Lessons from NHDM

The "lessons" listed here are derived from responses from all of the NHDM stakeholders interviewed for this evaluation. By their nature, they tend to provide a critical perspective of NHDM. It is important however, to remember that NHDM has been successful in implementing its planned activities and achieving most of its targets. Thus, the list is best considered as possible ways to improve future interventions of a related nature.

General Design Issues

1. Development of a Detailed Implementation Plan should be part of a project inception process that includes renewed 'on ground' assessment and consultation with main stakeholders and target communities. In the case of NHDM, it appears that this was not the process, rather the DIP was developed mainly from the existing project proposal with only limited reference to current needs within staff, communities, government and NGOs.

2. Trial interventions such as NHDM need regular (probably six-monthly initially) assessment between the implementing organisation, AusAID and other experienced practitioners and participants in order to make adjustments to the implementation process and the intended activities and expectations as experience is gained. AusAID and the implementing organisation also need to be clear about the "trial" nature of such an intervention and its purpose beyond the specific objectives of the activity.

3. AusAID required a "Stop-Go Review" after 12 months of implementation. While not the only factor affecting the rate of NHDM staff turnover, this terminology and the stated implications of the Review may have been a contributing factor due to the uncertainty created for staff about job security.

MCH

4. The 'exclusive breast feeding' and 'community savings for pregnant women' elements of the MCH component are strategies that have been proven in other MCH interventions and were generally well supported in NHDM villages. However, in a small number of communities (eg. Gamey Jaya, Gerbang Sadu, Waroki) they were much less successful. This highlights the importance of well-trained, preferably experienced facilitators working with communities, especially where long-established cultural practices are likely to militate against the introduction of new approaches.

WatSan

5. A number of government or donor funded activities now pay community members for their labour and contributed materials. There are ethical and practical issues involved in the question of whether villagers should be paid for work done in their own villages, especially when a community is extremely poor and has little prospect of other sources of income. For a project such as NHDM, where payment is not possible or desirable, it is important that project staff are clear about their task, and well-trained and skilled in community organising and development theory and practice so that they can successfully work around these kinds of impediments.

6. Installation of household latrine septic systems brings with it a need for systematic maintenance and emptying of the systems every few years. While this issue was addressed in community training, it was not clear that the practical difficulties were sufficiently dealt with nor how this could be done prior to the project concluding in December. There is the potential for significant environmental health problems in villages if suitable planning and provision for action are not put in place.

CBDRM

7. CBDRM is a community development process that will be most successful when the activity design is sufficiently flexible to accommodate exploratory, progressive engagement approaches in pursuit of high level goals such as "reducing vulnerability. The more prescriptive approach of project "forms of aid" is likely to be less effective in this work.

8. Effective CBDRM is a mobilizing and empowering process and not a sector or a set of activities. It should be integrated with comprehensive, long-term community development processes guided by experienced facilitators where the uniqueness of each community and community ownership are the main guiding principles. In this kind of scenario, CBDRM is intimately linked with sustainable livelihoods.

9. DRM involves a degree of technical expertise in risk assessment and in the design and implementation of subsequent mitigation work. Thus, it is important that people responsible for CBDRM activities (including at community level) have sufficient technical experience and knowledge of DRR; understand when additional technical assistance is required; and can readily access such assistance when necessary[1].

Working with government

10. Successfully working with government agencies at any level and successful capacity development amongst government staff is only likely to occur when government resources (financial and human) are unequivocally allocated for the work and there is demonstrable commitment from senior and middle-level managers. Given normal government planning and budgetary constraints and processes, this will almost always be difficult.

Staff capacity, capacity development and quality issues

11. Activity designs need to take account of the difficulty for activities in less accessible and "attractive" locations to attract and retain suitably experienced staff. Managers in such locations need to have (and to exercise) flexibility, resources and suitable strategies to retain quality experienced staff. Where employment of local staff is crucial to successful implementation (as it is likely to be in most community based initiatives), activity designs, schedules and budgets need to make sufficient allowance for adequate training of staff, including periodic refresher training and training of replacement staff as required. If sufficient experienced staff cannot be employed or retained then the scope of the activity should be reviewed so that the quality of the work is maintained, if necessary by reducing the scope and original expectations of the activity.

12. Staff induction into an organization is vital in planting the seeds of the organization's vision, mission and ethos as well as the opportunity to equip staff with sufficient basic skills to work confidently on behalf of the organisation. In part, due to the high turnover of staff, NHDM field staff did not receive sufficient induction into the organisation before being required to take on responsible and complex field operations.

13. The office of a project is a centre of promotion for the project's work. It is an important tool in building awareness and attention needs to be paid to the way in which a project office presents an image of the project (and information about the project) to staff and visitors.

14. High staff turnover, insufficient training and high workloads for field staff meant that optimum support for NHDM project activities and village champions was not always able to be maintained. Fewer days and nights able to be spent in each of the target villages may have contributed to

[1] As well as providing technical knowhow about risk reduction, this is also about the necessary expertise to catalyse coordination and coherence with other development actors within and between communities when required.

reduced work quality[2]. There is likely to be value in regular assessment of the balance between the quantity and quality of work being done at any time in such community engagement interventions.

General capacity development issues

15. In a project of this size, with a large training component and dependent for success on affecting the will and capacity of community members and government staff to take greater responsibility for their own community development, advice from a person knowledgeable in recent (and changing) thinking about capacity development is likely to be beneficial.

16. There is evidence of effective transfer of knowledge and skills as a result of NHDM training, especially in the case of *posyandu kaders.* However, more systematic use of effective ToT (ie. with sufficient expertise and resources applied to its design and implementation) as a component of a contemporary capacity development approach may offer the opportunity for broader and deeper behaviour change and better sustainability. Whenever possible, villagers and project staff should also be exposed to innovative training methods that have been proven effective in other similar contexts eg. video programs; drama and role-playing, etc.

Sustainability

17. Sustainability of benefits in community development activities is always affected by many variables beyond the control (or even the knowledge) of the initiative. The most important variable that can be influenced by the implementing organisation is the quality of the community development processes that are used by the organisation and its field workers. This requires:

    - Staff with aptitude for the work and the basic "people-skills" required (community development work is difficult, challenging and skilful and not everyone has the necessary ability)

    - Adequate training (including regular follow-up, review and refresher training) to fully induct staff into the organisation and provide them with necessary knowledge, skills, tools, support and confidence

    - Recognised community development principles and practices that underpin the work and are thoroughly understood by all of the organisation's staff. In particular, acknowledgement that each community is unique and continual analysis is required, starting prior to community entry and ongoing throughout activities.

18. Sustainability of benefits will be influenced by the quality of leadership and level of cohesiveness within a community, especially in communities made up of different ethnicities (Papuan and transmigrants). As far as practicable, the issues of leadership and cohesiveness need to be addressed by community development initiatives

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[2] Community development facilitators need to stay at least several days every month with each of their target communities in order to maximise mutual understanding; strengthen proposed strategies and actions for change; and strengthen village empowerment in and ownership of community development processes. NHDM established "base camps" in an effort to reduce transport needs and travel times and to encourage FFs to stay longer with communities. It is unclear whether this was a successful strategy.

Gender

19. In more remote regions (where for example, access to quality media and other sources of information is less reliable) or regions that are likely to be more socially conservative and dealing with gender issues difficult, it may be necessary for activity designs to be quite specific about the ways in which gender equity and women's rights will be addressed. As well as a human rights perspective, this would need to be framed within the overall social benefits that accrue to a community when women's capacities and roles are enhanced. Implementation involving these kinds of issues will require soundly based community development processes implemented by competent facilitators discussed earlier in this report.

20. Gender equity is often a difficult or confusing issue for project staff to deal with, especially in more socially conservative contexts. Some NHDM staff at times found this to be the case. Simple but adequate awareness training and guidance on gender equity; the reasons why it is important; and how it can be advanced within current activities should be provided to all project staff as part of an organisation's induction training. Field staff with the main mandate to work with village women and men should be provided with additional practical training so that they can deal confidently with activities in the field that are designed to affect gender issues.

Recommendations

1. Given the limited consolidation of some of the changes introduced into villages through NHDM activities (due to the short implementation time), the sustainability of benefits could be strengthened if an appropriate agency can continue at least limited monitoring support for the changes. It is possible that this responsibility could be taken on by government if there is sufficient capacity and commitment. Present indications of this happening are not strong however and a better option would be to fund PCI so that they can provide limited monitoring and support for consolidation of outcomes for a further 12 to 18 months. Alternatively, a level of support could be incorporated into Oxfam/PRIME[3].

2. Improve the likelihood of effective and sustainable outcomes in CBDRM by increasing coherence and harmonisation amongst AusAID funded initiatives in the same region – in this case, NHDM (until December 2009), PNPM /RESPEK programs and Oxfam PRIME. This should encompass influencing necessary changes in public policy; sharing and harmonising community planning and engagement strategies; and optimising resources to obtain the most effective outcomes.

3. To contribute to the successful design and implementation of CBDRM activities, AusAID should develop principles, strategies and program management mechanisms for effective approaches to CBDRM based on its own experience and expertise and that of other organisations. This should include strategies for adequately resourcing the community development and disaster risk management aspects of the activities, especially in light of the difficulties PCI experienced in recruiting and retaining staff for NHDM.

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[3] AusAID is funding Oxfam to deliver 3 years of CBDRM activity in Eastern Indonesia including a two-year intervention in Nabire. If it is expected that NHDM work, especially in the CBDRM component, would be continued through Oxfam's activity then this role would be relatively simple to establish.

4. CBDRM is a part of broader community development processes and successful, high-quality community development initiatives from Indonesia and elsewhere should be referenced when designing activities that include CBDRM elements.

5. Sufficient allowance should be made in activity designs for community development initiatives to provide for comprehensive training of staff to ensure optimum quality of activity implementation. Such training will include formal and informal components; follow-up and refresher training and review; and mentoring; and is likely to continue throughout the initiative.

Evaluation Criteria Ratings

Evaluation Criteria	Rating (1-6)	Explanation
Relevance and quality of design	4	The MCH and WatSan components were effective in themselves and the design was aligned with GoI, GoA and Nabire District Government priorities, but it did not reflect understanding of DM generally or CBDRM in particular. The project was intended to be a trial of CBDRM but did not address the issue of integrating the MCH and WatSan components with the DRM core – they were simply juxtaposed in the design (with separate goals) and implemented almost independently of each other in the field. There was no requirement in the design for assessing the effectiveness of the CBDRM trial or the integration between components. In other aspects, the design (and DIP) was highly prescriptive and "top-down" for a predominantly community development intervention.
Effectiveness	5	Despite design issues, good results were attained in the MCH and WatSan components. NHDM achieved most of its planned outputs and outcomes but it was not a successful trial of CBDRM (except for the value of lessons learnt). The project was well-regarded by senior District Government staff who appear willing to integrate follow-on action into the District's forthcoming Medium Term Plan but implementation of these activities can not be guaranteed. Actual support from resource-strapped government agencies (especially DHO and DEO) was mainly limited to participation in NHDM funded and organised activities. Community members generally expressed satisfaction with NHDM's work and the benefits that the project contributed.
Efficiency	5	NHDM achieved most planned outputs and outcomes within budget and with good financial management. Project overheads were high by normal NGO standards but there are some plausible reasons for this. Improvements followed reallocation of some funds following the 2007 Review but project outcomes may have benefited from greater flexibility in the use of funds for recruiting, training and retaining staff and in making the project office a more inspirational and informative centre for staff and visitors.
Sustainability	4	The full implementation of NHDM has been limited to only two years. This will compromise long-term sustainability which requires persistence of behaviour changes to sustain project benefits. Further, necessary institutional requirements are not yet sufficiently in place at any level in the District to maintain NHDM initiatives. On the other hand, there has been some limited capacity development of government agency staff engaged with NHDM and each of the 30 target villages now has (a) Improved health-care options (b) accessible water supplies (c) a small number of household latrines and the experience to construct more (d) Experience in DRM planning and action to reduce disaster related risks and improve preparedness. Persistence of these changes will now be affected by factors outside NHDM's scope or

Evaluation Criteria	Rating (1-6)	Explanation
		intent including the quality of village leadership and the cohesiveness of communities. Some mechanism for 12 to 18 months of follow-on monitoring and low-level support for NHDM initiatives is highly desirable.
Gender Equality	5	NHDM directly addressed three of the dimensions of AusAID's Gender Policy in that (a) Outcomes in all three components directly benefited women –particularly in the MCH and WatSan components (b) Many women were involved in decision-making and participated in NHDM activities in all target villages (c) Participating women received a lot of training as well as knowledge and informal skills development from NHDM activities. Women expressed greater confidence in speaking in meetings and many have become effective community mobilisers. NHDM staff were aware of gender issues in development but not always proactive in pursuing them. The issue of women's rights did not seem to be specifically addressed although, in a number of examples of discrimination reported (eg. women not allowed to participate in activities) it would have been an appropriate action, but difficult for sometimes inexperienced field staff.
Monitoring & Evaluation	5	Following the 2007 Review, NHDM's six-monthly progress reporting was thorough and detailed against a comprehensive set of activity, output and outcome indicators. For a community development project such as this, it could be said that the project monitoring was, in fact, over-specified and reduced potential flexibility in the project. Reporting also included little analysis of NHDM's role as a CBDRM trial (NHDM staff seemed to not be clear about this aspect of the project). Overall results for output and objective indicators were determined in an endline KAPC survey conducted in May 2009. While the ICR team's capacity for verification of NHDM ACR results was limited, on the basis of the Nabire field work, the ICR team is satisfied that the results reported for NHDM based on the endline survey are a reasonable representation of project outcomes.
Analysis & Learning	4	NHDM was one of the first CBDRM activities funded by AusAID and initially designed by PCI who had no CBDRM experience. Despite AusAID's role in the design (especially the CBDRM trial component), it showed only limited cognisance of existing work in the field. AusAID's communication to PCI about the project's status as a CBDRM trial appears to have been unclear. Constructive changes to the design were made following the 2007 Review (although not so much in relation to the understanding of CBDRM or integration of the project components) and throughout the next two years, NHDM did learn from issues as they arose and adapted activities to improve outcomes.

1. Introduction

1.1 Activity Context and Preparation

Australian Indonesian Partnership for Reconstruction and Development

Following the earthquake and tsunami of 26 December 2004 in Aceh Province, Indonesia, the Australian Government announced support of $1 billion for Indonesia's reconstruction and development efforts in Aceh and other parts of the country over a five year period. This program was entitled the Australia Indonesia Partnership for Reconstruction and Development (AIPRD).

The inaugural AIPRD Joint Commission Ministers meeting on 17 March 2005 agreed that a number of disaster management and response activities be funded from Australia's post tsunami aid package. The activities included: strengthening of Indonesia's disaster management and response systems and partnerships between Indonesia's disaster coordination authorities ($10 million); and assistance measures to address needs arising from the earthquakes in Alor and Nabire ($5 million).

These programs fit within the overall objective for AusAID's emergency and humanitarian sector which is to respond to and reduce vulnerability of communities to disasters, conflict, acute humanitarian needs and complex emergencies.

Nabire Health and Disaster Management (NHDM) Project

The Nabire region had experienced two significant earthquakes in February and November 2004 resulting in 60 deaths; 300 injured; and extensive damage to over 2000 houses, public buildings and infrastructure. With the advent of AIPRD in March 2005 and a GoA commitment in September 2005 to increase development assistance to Papua, AusAID consulted other donors and possible implementing partners to develop a suitable activity.

The USA-based Project Concern International (PCI), with almost 10 years of experience working in Nabire District, and the only suitable partner to express interest in the proposed activity, developed an initial proposal based on their core expertise in maternal and child health (MCH) and water & sanitation (WATSAN) programs. The original proposal was then modified to include a community-based disaster risk management (CBDRM) component to comply with the disaster management focus of AusAID and the GoI. As a result, the project had two distinct goals and related objectives. These were:

Goal 1: Reduced mortality and morbidity among women of child-bearing age and children under five in selected sub-districts of Nabire.

MCH Component:

Objective 1: Improved capacity for community-based MCH

Objective 2: Sustainable behavioural change for improved MCH among caretakers

WATSAN Component:

Objective 3: Improved access and behaviours related to clean water supply and sanitation facilities.

Goal 2: Reduced community vulnerability to future disaster in selected sub-districts of Nabire.

CBDRM Component:

Objective 4: Improved capacity for risk reduction and emergency preparedness among affected communities and local authorities.

Approved funding for project implementation initially was $AUD3,745,029 over a three year period from 23 June 2006. It was originally designed to work in 50 villages in four sub-districts of Nabire District. This was reduced to 30 villages following a Review in July 2007. Splitting of some sub-districts increased the number from four to seven (Nabire, Nabire Barat, Wanggar, Yaro, Teluk Kimi, Uwapa and Makimi), with a population of approximately 39,130. The total population of Nabire District was estimated to be approximately 160,000. In May 2009, NHDM also undertook some WatSan and MCH work in Moanemani sub-district of Dogiyai Distict (adjacent to Nabire) as a result of an earlier outbreak of cholera.

July 2007 Review of NHDM

At the commencement of NHDM, AusAID had limited experience in working in Papua Province; working in the area of CBDRM; and working with a non-Australian NGO. As a result, NHDM was reviewed after approximately one year (July 2007) to assess progress; decide whether the Project should continue; and, if so, what changes in design or implementation, if any, could be made to improve outcomes.

In its findings, the review stated that … *"CBDRM activities were proceeding slower than anticipated. This is partly due to the earlier than optimal phasing-in of CBDRM activities (following on from WATSAN and MCH activities) to meet the 12 month pilot requirements. Alignment with the new [GoI] Bill on DM posed both a challenge and an opportunity to achieving joint planning depending on its timing. Despite some setbacks to implementation, the review found that good progress had been made in the first 12 months, and that NHDM was making a useful contribution to development efforts in Papua province. The review, thus, recommended the continuation of NHDM program, with a strengthened focus on achieving quality of and sustainability in activity implementation"*[4].

Subsequent to this review, changes were made to some activities in the MCH and WatSan components. In the CBDRM component, owing to a lack of resources and capability to commit to the program, the earlier focus on working with district government agencies was reduced in favour of increased effort to engage with communities about DRM and to better support CBDRM initiatives in the NHDM villages. Other changes included:

- Reinforced focus on delivering good quality results, within budget, to the neediest communities (pro-poor and pro-Papuan)
- MCH Component: maintained the target of 30 villages, but emphasized development of community MCH plans and targeting of the most vulnerable hamlets
- The P4K (previously Desa Siaga) pilot to be extended to all 30 villages, on a selective hamlet basis. Hamlets were to be prioritized based on their level of interest and support for the activity, maternal mortality, extent of poverty, proportion of Papuan residents and access to health facilities.
- ITN Pilot to be extended to all 30 villages
- WATSAN Component to be scaled back to 30 (from 50) villages to better target resources and benefits from hygiene promotion

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[4] *The Nabire Health and Disaster Management Program: First Year Stop-Go Review Mission Report*, AusAID, August 2007.

- CLTS Pilot to be extended to all 30 villages. At the end of Year 2 however, NHDM changed the initial approach and began to provide construction materials for latrines for poor or Papuan families
- CBDRM Component extended from 8 pilot villages to all 30 villages and focused more on community-based activities

In response to a cholera outbreak in neighbouring Dogiyai District, AusAID asked NHDM at the end of Year 2 to conduct a rapid assessment and emergency response focusing on the construction of latrines and promotion of hygiene(as emergency provision rather than using a community led approach).

1.2 Evaluation Issues and Objectives for this ICR

The key issues identified in the Terms of Reference for the evaluation were to assess:

- the effectiveness of the CBDRM approach implemented in the NHDM Program and identify factors constraining its success
- the most effective ways for conducting CBDRM activities
- the extent to which the NHDM CBDRM approach supported more active engagement of local government in disaster management.

The objectives of the evaluation were:

1. Assess the relevance, effectiveness, efficiency, impact and sustainability of NHDM Program, in order to provide information on accountability and generation of lessons learnt that could be applied across the aid program;
2. Review the effectiveness of the CBDRM approach applied by NHDM program, i.e. CBDRM implemented in conjunction with MCH and Watsan activities. The review should also assess how well the program addressed issues of gender equality, poverty and vulnerability in its design and implementation.
3. Identify factors constraining success and lessons learnt from the program and recommend mechanisms in order to enhance overall effectiveness of future and wider AusAID engagement in this CBDRM area;
4. Validate and follow-up the performance data and relevant assessments made by Activity Completion Reports.

The Terms of Reference for the NHDM ICR are included in Attachment 1.

1.3 Methodology

The scope of the evaluation was defined by the objectives (above) and the accompanying specific questions set out in the TOR (Attachment 1).

The main steps in the preparation of the ICR included:

- Review of key project documents prior to the in-country mission and formulation of evaluation questions and issues; including email consultation with the AusAID Activity Manager and between team members on matters related to the TOR, information gathering and the field visit agenda
- A one-day briefing in Jakarta with AusAID staff and senior PCI Jakarta office staff

- Consolidation of the evaluation team and review of methods and draft question guides for various informant groups [5]
- Field work in Nabire for approximately five days including:
    - Observation of a one-day workshop between NHDM and Nabire District government to begin handover of NHDM results and activities - all local project stakeholders were represented including senior district-level staff as well as government operational staff, NGO representatives and the heads and members of villages communities
    - Discussions with separate groups of women and men in nine of the 30 project villages
    - Inspection of local government infrastructure (eg. posyandu, puskesmas) and community facilities (eg. water supply systems and latrines) constructed with the assistance of NHDM
    - Meetings with all PCI field staff and supervising staff (including separate meetings with male and female Field Facilitators) and inspection of project records and administrative systems at the NHDM office
    - Group discussions with Nabire District operational and senior Dinas staff directly engaged with NHDM
    - Meetings with staff of local NGOs engaged in assisting NHDM; and
    - A meeting with the Oxfam (Australia) representative for the AusAID-funded Oxfam DRM Program in Eastern Indonesia who was visiting Nabire at the time of the ICR field visit.[6]
- A one-day meeting (in Biak) of the five ICR team members to Identify major findings, issues, lessons learned and recommendations from the Nabire field work
- Preparation of an Aide Memoire on preliminary findings and presentation to AusAID staff in Jakarta (Attachment 5)
- Completion of the first draft of the ICR
- Receipt of comments, amendments to the draft and submission of final ICR.

The evaluation team of six (including the interpreter) was able to maximise opportunities for discussions with NHDM stakeholders by working most of the time in two sub-teams, and occasionally in four.
The ICR team believes, its findings are a sound assessment of the outcomes of NHDM and the lessons that it has provided, particularly in relation to the CBDRM aspects of the project. Nonetheless, there were limitations to the study:

- The time available in the field (a total of 4.5 days of which only two days could be spent visiting nine (out of 30) NHDM villages) was limited. This made the review a rapid, rather than an in-depth, assessment
- It was not possible to verify all the results reported in the NHDM ACR prepared by PCI. The evaluation team however, believes that sufficient evidence was obtained

[5] The Evaluation Plan, question guides and lists of informants and main reference documents are included in Attachment 2 and 3.

[6] Actual time in Nabire was 4.5 days. Travel to and from Nabire required overnight stops in Biak. A full day and night stopover in Biak on the return journey was used by the team to consolidate initial findings and begin preparation of the Aide Memoire.

during the field work to substantially corroborate the claims concerning achievement of indicator targets in the ACR

- The sample of villages visited was chosen by NHDM management following discussion between AusAID staff and the consultants for the ICR Review. The nine villages included Papuan, transmigrant, and mixed communities and several where NHDM activities had been less successful. In the time available it was not practicable to organise comparative visits to non-NHDM villages.

Thanks are extended to all the people who organised the field work and who participated in the many discussions which form the core of this review – NHDM staff; Nabire District government staff; village community members; local NGO staff and our fellow team members from AusAID. The findings and recommendations presented in this report are the work of all five team members.

Evaluation Team

The ICR team comprised David Farrow (Team Leader), Mr. Methodius Kusumahadi (community development specialist experienced in community-based health, water and sanitation and disaster risk management) supported by Mr. Jeong Park, the AusAID Disaster Management Adviser, Ms. Santi Handayani, AusAID's Decentralisation Section and NHDM Activity Manager and Ms. Endang Dewayanti, Program Manager from AusAID's DRM Section. The team was also supported by Ms.Deanne … as interpreter.

2. Findings of the ICR Review

2.1 Relevance and quality of design

2.1.1 Relevance to strategic priorities

Government of Australia

The Australia Indonesia Partnership Country Strategy (AIPCS) 2008-2013 describes four pillars of GoA support to Indonesia: (i) Sustainable growth and economic management; (ii) investing in people (including health system strengthening, mother and child health, work in HIV and AIDS); (iii) Democracy, justice and good governance; and (iv) Safety and peace (including improved disaster preparedness and response, risk analysis and vulnerability to disaster). NHDM has made substantial contributions to the second and fourth pillars of the Country Strategy as well as building effective partnerships with Nabire District government agencies and local NGOs and working consistently to strengthen gender equity in project implementation and outcomes.

The location of NHDM in the Province of Papua is also consistent with the AIPCS geographic focus. As one of the poorer provinces in Indonesia and with low development indicators, Papua is one of AusAID's five priority provinces for receipt of development assistance[7]. Further, NHDM was conceived as a trial approach for AusAID to CBDRM when disaster risk management was not a major component of the Australian aid program but AusAID was the main donor supporting community based initiatives in Indonesia. The lessons from NHDM

[7] The other four are Papua Barat, Nusa Tenggara Barat, Nusa Tenggara Timur and Aceh

can make a significant contribution to the evolution of effective CBDRM at a time when disaster risk management is now a priority in the aid program.

Government of Indonesia

NHDM has contributed to a number of components of The National Action Plan For Disaster Reduction 2006-2009 as well as Indonesia's National Long Term Development Plan 2005-20025[8], in particular:

Part IV 1.5 Creating just and equitable development, especially :

- No.3 Develop isolated and less developed regions (Nabire District is one of the least developed and most under-served regions in Indonesia. More than half of the District is not accessible by land transport and lacks communication systems)
- No.12 Increase the capacity of local government officers and their institutions.
- No.20 Fulfil basic community needs for water and sanitation

Part IV 1.6 Maintaining the sustainability and beauty of the Indonesian environmental, especially:

- No.8 Mitigate the effects of natural disasters, taking account of geological conditions in Indonesia.

NHDM also contributed to components 2, 3, 4 and 5 of the Nabire District Medium Term Plan. These are: (2) Recovery and reconstruction in response to the 2004 earthquakes; (3) Increasing the quality and quantity of Human Resource development; (4) Increasing government services in (a) primary health care; (b) reducing disease transmission; (c) reducing morbidity and mortality; (d) increasing self- reliance of households especially with respect to food and nutrition; (5) Intensive intervention in HIV and AIDS prevention and facilitating the establishment of a Regional Commission for Prevention of HIV and AIDS.

2.1.2 Relevance for the needs of beneficiaries

Evidence of the relevance of NHDM to the needs of project beneficiaries included, for example:

- The population of Nabire is approximately 160,000 and malnutrition, respiratory infections, diarrhoea, malaria, TB and HIV are widespread. NHDM has improved community capacity in MCH (including HIV and Malaria), Watsan and CBDRM in 30 villages in seven Nabire subdistricts. The project staff believe that their work has affected approximately 39,000 people
- In general, community members interviewed described NHDM's Watsan, MCH and CBDRM activities in their villages as valuable. The project was able to use almost all Nabire-recruited staff for its Field Facilitator roles
- With support from NHDM, many community members in the 30 target villages have been active in construction of village and household facilities (community health facilities, water supply systems and latrines) resulting in enhanced skills in design, planning and construction for men and women
- NHDM was able to integrate capacity development for community members – increased knowledge and skills and changed attitudes and behaviour – into facilitation of and support for the provision of community services and facilities

[8] Attachment to Law No.17/2007 on National Long Term Development Planning 2005-2025

- NHDM received requests from villages near to the project's 30 target villages asking them to provide similar assistance (there are approximately 120 villages in Nabire District)
- In most cases the project used participatory development approaches that were effective in generating community involvement in project activities and supporting active roles for women.

2.1.3 Overall quality of design

NHDM was conceived by AusAID as an opportunity to trial an approach to CBDRM following the 2004 earthquakes that affected Nabire District. PCI, with almost 10 years experience in health and WatSan interventions in Nabire, was an appropriate organisation to implement such a project but it had no significant experience in CBDRM at the time. PCI's initial project design included only health and WatSan components but the CBDRM component was added following discussions with AusAID. Expectations were that implementation of the three components would be "integrated" without sufficient consideration given to what this meant in practice or how it would be achieved. There was also a lack of clarity about the elements of effective CBDRM.

The 2007 NHDM Review pointed out the "cobbled together" nature of the relationship between the CBDRM component and the MCH and WatSan components, summarising the issue by commenting that it *"… makes the activity appear to represent a compromise position between the interests of the donor and the experience of the implementing agency"*.[9] This has been an issue for the project since inception, affecting the development of a comprehensive CBDRM approach and embodying important lessons for the project.

A community development project such as NHDM relies on being able to recruit local field staff but recruitment and retention of suitable staff proved to be a major problem for the project. While not directly a design issue, design scope needs to take account of the likely availability of suitable staff in less accessible project locations. This could be reflected in a reduced scale of planned activities. Alternatively, for situations where experienced recruits are not available, designs need to include the resources and flexibility to provide sufficient, high-quality training so that the quality of project implementation can be maintained.

The design of the MCH and WatSan components – built on proven approaches and intervention tools – have generally been effective despite problems of staff retention. Based on the component designs and the Detailed Implementation Plan (DIP), NHDM has been able to systematically "roll out" the MCH and WatSan activities to the 30 target villages and by end-of-project will reach most of its logframe indicator targets. Further discussion of CBDRM, the CBDRM component design and the issue of integration between components is included in Section 2.2.3.

2.2 Effectiveness

Overall, the project has been able to deliver its designed outputs and has generally achieved impressive outcomes in the MCH and WatSan components. For the CBDRM component, indicator targets were mostly achieved, but the underlying effectiveness of the component was compromised by the design issues noted in the previous section. Consequently, while it

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[9] *NHDM First Year Stop-Go Review Mission Report*, August 2007, p2.

has provided valuable lessons for the design of future CBDRM initiatives, the value of its outcomes is less clear (and the subject of discussion later in this section). Community capacity in each of the components was enhanced in most of the targeted villages, especially where village cohesiveness and leadership were strong.

The remainder of this section is structured around the three main components of the NHDM design and a sub-section on project management. It does not include an assessment of the extension of NHDM activities to Dogiyai District in 2009 following a cholera outbreak.

2.2.1 Maternal and Child Health (MCH)

Findings

In the MCH component, NHDM initiated a comprehensive range of training and community-based activities targeting problems in MCH, malaria prevention and HIV and AIDS awareness and prevention. The activities benefited from PCI's previous health sector work in Nabire over almost 10 years, and in many of the same villages. Working in cooperation with DHO and sub-district staff, the wide-ranging interventions were designed to strengthen health services and outcomes within NHDM's 30 target villages. They included:

- Providing materials and technical support for communities to repair existing infrastructure (*polindes, puskesmas, pustu and posyandu*) or construct new ones following an Integrated Health Facility Assessment (IHFA). A limited amount of health equipment and kits were also provided early in NHDM following the IHFA.
- Training of 'front line' health workers – 46 government *puskesmas* staff including 31 mid-wives; 250 community volunteer *posyandu kaders*; and traditional birth assistants (TBAs) within each village
- Introduction of a wide range of MCH 'intervention tools' and training models for health workers and Information, Education and Communication (IEC) materials to support them. These included Ready-to-use Supplemental Food (RUSF); Village Ready/Transport/Stand-by for medically supervised deliveries (formerly Desa Siaga, now P4K); Insecticide Treated Bed Nets (ITN); Safe and Clean Delivery (SCD) ; Making Pregnancy Safer (MPS); Exclusive Breast Feeding (EBF); Early Initiation of Breast Feeding (EIBF); Life Saving Skills (LSS); Early Childhood Care and Development (ECCD); Integrated Management of Childhood Illnesses (IMCI, also C-IMCI, HH-C-IMCI); Positive Deviance (PD); and Interpersonal Communication and Counselling (IPCC).

Most intervention tools were initially introduced as part of the training for *puskesmas* staff. Subsequently, volunteer community *posyandu kaders* were trained and supported by NHDM for introduction of the health interventions into village communities. TBAs are no longer supported within the GoI health system but, as there is a shortage of community-based mid-wives[10], NHDM's work with the TBAs was focused on developing effective complementary working relationships between them and the mid-wives for the provision of ante-natal care, delivery support and post-natal care.

Puskesmas staff and midwives were initially trained in IMCI, ECCD, SCD, EBF, EIBF and IPCC. Training effect indicators for the health workers showed strong increases[11] and interviews

[10] DHO reports that there are 200 midwives and 147 villages in the District but many choose to remain in town or sub-district centres. Half the villages outside town lack midwives despite the fact that DHO has a financial incentive scheme to encourage midwives to provide services in villages.

[11] Attachment 4, Output 1.1, Indicators 1 and 2.

with village *posyandu kaders* provided evidence that the benefits of that training were beginning to affect health outcomes in NHDM villages. NHDM also supported the establishment or re-vitalisation of 44 posyandu in target villages. A vital component of this work was comprehensive training for *posyandu kaders* in coordination with local *puskesmas* – initially in HH-C-IMCI, SCD, EBF/EIBF and health promotion[12], and later, for some *kadesr*, in P4K, malnutrition and RUSF, de-worming and ECCD. Health promotion was supported by the training of 625 "social influencers" (religious leaders; respected elders, etc) in behaviour change promotion. *Posyandu kaders* also visit households to monitor the condition of children; quality and usage of WatSan facilities and other health related variables.

All of the 30 villages had completed and were implementing MCH Plans at the time of the review and all had been involved in sub-district-level inter-village meetings to share information. The MCH Plans formed the basis for NHDM MCH project activities and the work of the *posyandu kaders* in each village and NHDM carried out monthly monitoring and on-the-job training and coaching to improve *kader* performance. Currently, health service referrals (eg. to hospital) can only be provided by midwives. This disadvantages people in villages without a resident or easily accessible midwife and NHDM is in the process of exploring with the DHO whether *posyandu kaders* trained by the project can be given some responsibility for referring people with MCH-related problems to their *puskesmas*.

While some villages reported excellent outcomes for the P4K element[13] [14] of the MCH component, overall it proved to be the most problematic element. The main reasons for this were: (a) No tradition of community savings in most of Papua, except within a family or clan but not to support pregnancy (b) Transportation options are often very limited (eg. many villages do not have access to a vehicle) (c) Blood-type testing is not generally available (mainly due to the lack of the necessary reagent) and (d) Cultural beliefs about blood act as a barrier to testing and blood donations. Promised government funding has also not been made available. In this context, NHDM eventually decided that P4K would be more effective focusing on family and clan support for pregnant relatives rather than being presented as a community wide initiative.

Some of the behaviour-change expectations have not yet been fully realised (eg. in healthy child weight; good feeding practice; exclusive breast feeding; use of bed nets) or have been very successful in some villages and less so in others. Given the short implementation time however, reasonable gains have been made and were expected to improve further during the three month project extension to December 2009. In some villages, men occasionally opposed women's participation in NHDM activities, refusing to give permission for their wives to participate. Opposition to exclusive breast feeding also arose in some Papuan villages because of perceived conflict with traditional practices.

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[12] Health promotion topics included: malaria; hand washing with soap; immunization for children and pregnant women; environmental health; dental care; ending open defecation; nutrition for underweight infants; increasing participation by pregnant women and mothers of children under 5 in posyandu; diarrhoea prevention; pregnancy; and tuberculosis.

[13] P4K involves four elements - 1) identification/tracking of pregnant women; 2) Tabulin - household savings for pregnant women and Dasolin - community savings for pregnant women; 3) blood typing and blood donor registry; 4) transportation plans for pregnant women to health providers for delivery.

[14] For example, in Gamey Jaya, community savings exceeded IDR 5 m with 43 saving members and had developed into a simple health insurance scheme to include all the community member rather than just delivering women.

Although ITNs were only being used by about 60% of families (the target being 85%), a number of villages reported major decreases in the number of malaria cases and strong support for the value of the nets. About 75% of births were now assisted by trained health workers but current data to determine any immediate effect on child and maternal mortality was not available at the time of this review.

Analysis

PCI has considerable experience in community health and in Nabire and implementation of the component was relatively smooth, systematic and well monitored; relationships with DHO were productive, despite the lack of resources available within DHO to provide material support to many of the initiatives; and the results are generally impressive. In summary, the MCH component was:

- An important entry point for community engagement for the whole project
- Very important in community mobilisation, especially through the work of the *posyandu kaders* (six of whom were male) who were most effective in garnering participation by women and often active mobilisers across all three components of NHDM's work
- Successful in bringing about the beginnings of behaviour changes towards many healthier practices
- An important factor in strengthened links between the District and sub-district governments, village communities, and local NGOs.

NHDM data for MCH-related project indicators shows that most planned objectives and outputs have been achieved or are likely to be so by the time the project concludes in December. In particular, evidence indicates that the ITN initiative has had a dramatic effect in reducing malaria incidence. In the cases where expected targets will not be met, there are two main reasons: (a) unrealistically high targets set at project inception (eg. hand-washing) (b) a combination of high staff turnover, less experienced staff and high workloads. In the case of P4K outlined previously, part of the problem was perhaps a misjudgement on the part of NHDM about the effect of cultural factors on a planned initiative that has a positive history in other places. Given PCI's long history in Nabire District and Papua, this is a somewhat surprising oversight.

The MCH component provided a lot of training to government and community volunteer health workers and this was highly regarded by recipients who were interviewed for this review (mainly *posyandu kaders*). Some refresher training was also provided along with occasional opportunities for trainees to get together to share information and experiences. The project also used Training-of-Trainers (ToT) on a few occasions. However, these important follow-up opportunities and the use of ToT, seemed to be a little ad hoc rather than systematic components of an overall capacity development plan. As effective capacity development at many levels is crucial for success and particularly for sustaining project benefits, it may have been beneficial for NHDM to utilise some specialist capacity development advice. This is particularly relevant in a period when understanding of what constitutes effective capacity development is undergoing change[15]. While ToT is a complex tool, and often ineffective if poorly designed and implemented, it can also be powerful in supporting sustained change.

[15] See for example, Baser H and Morgan P, *Capacity, Change and Performance: Study Report,* ECDPM April 2008.

The main problem for the MCH component, as for the whole project, is that the two-year implementation time in most villages may prove too short to allow sufficient embedding of necessary behaviour changes thus compromising sustainability, especially when local government has not had the resources to be able to engage sufficiently with the work.

2.2.2 Water Supply and Sanitation (WatSan)

Findings

At the time of the ICR review, NHDM reported that at least 75% of households and 80% of primary schools and "first-line" health facilities in all 30 villages now obtained drinking water from an easily accessible, protected water supply[16]. Water supply systems were constructed with community labour while materials and technical support were provided by NHDM. Over the course of the project 376 dug-wells, 133 rain-water tanks and three reticulated water supplies have been completed. Village water supply development also included support for catchment management and protection. In a similar process, 202 dual-tank septic-system latrines have been built throughout the 30 target villages (with local materials incorporated into the designs in some villages). 131 hand-washing stations were also completed. The latrines will require periodic inspection and pumping out and it was not clear how this was to be managed and maintained into the future.

In each case, NHDM's purpose was to demonstrate practical, inexpensive options for water supply and latrines, encouraging people to replicate the approaches more widely in their communities using their own resources. The fact that only a small number of households were direct recipients of a latrine generated some discontent. However, many informants indicated that they understood NHDM's approach and that, with their new knowledge, the village was capable of constructing additional facilities. In one village (Gamey Jaya) water supply development resulted in all households being connected to a reticulated system through a water meter that is to be monitored for water usage and payment as a way of encouraging efficient use of water. This followed discussion in the community about how best to organise their water supply so that distribution was fair and equitable, especially during dry seasons and drought.

NHDM-initiated behaviour change related to the construction of the WatSan facilities included safe disposal of children's faeces and hand-washing. Approximately 60% of mothers of children under two years reported that they disposed of the child's faeces in a latrine or another covered place. NHDM's target was 80% compliance and lack of a latrine was the main reason cited for non-compliance. With respect to hand-washing behaviour, compliance in all four prescribed events[17] only increased from 2% to 6% while the project expectation was 70%. Given the difficult nature of the change being sought however, the target was unrealistic and the small change may represent a reasonable beginning given the short implementation time of the project.

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[16] 26 of the villages had NHDM facilitated water supplies and the other four were provided through alternative means. Nabire District Public Works Department has indicated that they want to complete water supplies and latrines for the remaining schools and health facilities. In the case of two villages, Gerbang Sadu and Waroki, villsgers considered the water to be of poor quality and only used it for bathing and washing.

[17] The four trigger events are: before feeding children; before preparing food; after defecation; and after attending children who have defecated.

The sanitation component of NHDM began with Community-Led Total Sanitation (the CLTS "no open defecation" approach)[18]. This proved unsuccessful in some villages however – mainly as a result of the undermining of volunteer self-help approaches by other programs that paid community members for "self-help" work done in their own villages[19] – and was revised towards the end of year two so that NHDM provided construction material for latrines in poor communities and community members provided the labour. This approach was generally successful, although in Gerbang Sadu even this compromise was rejected. Some informants claimed that this was because Papuan communities don't have a tradition of *gotong royong* or community self-help. However, community supported work on water and sanitation facilities observed in other Papuan communities indicates that the explanation is more complex.

Amongst almost all villagers who participated in FGDs for the ICR Review, the Watsan component was considered the most tangible and most popular of NHDM's work by both women and men. In all the villages visited by the ICR Review teams, both women and men considered that women played a major role in WatSan-related decision-making. In some villages however, there was also acknowledgement that men are more often the most influential actors and decision-makers. NHDM reported that, in all 26 villages where they had worked with communities on WatSan activities, women were active in the relevant village committees and chaired the committees in four villages. In 23 villages, they also participated in NHDM's WatSan technical training.

Analysis

In the design of NHDM, the WatSan component, like MCH, was considered a development contribution in its own right as well as an entry point through which community development incorporating CBDRM could be initiated. The component was clearly successful in the first aspect but less so in the second. The main reason for this was probably inherent in the NHDM design issues outlined in Section 2.1.3 and further elaborated in Section 2.2.3. Coupled with this, high NHDM staff turnover meant that inexperienced staff were often in the position of trying to implement activities as part of a supposedly integrated package when they did not have sufficient understanding of the components or the most effective ways to go about what was, in fact, a complex task.

The second significant problem encountered by the Watsan component was undermining of the village empowerment/ building self-reliance intentions of NHDM due to other programs paying villagers for their labour in construction of infrastructure in their own villages. This is clearly outside the control of NHDM but underscores the need in such situations for robust community development processes implemented by competent facilitators in order to be able to mitigate the effects of external factors such as this. Cultural and socio-economic differences between Papuan, Trans-migrant and mixed communities also affected the ways in which each responded to NHDM initiatives and again highlights the need for community development workers to understand the uniqueness of each community and to be able to tailor processes and content to the characteristics of each community.

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[18] CLTS began in Bangladesh and uses experiential learning techniques about the risks of faecal contamination caused by open defecation so that people are motivated to adopt a "no open defecation" policy and design and construct latrines appropriate for the community using their own resources. The program is based on awareness, personal motivation and building a village self-help ethic. No subsidies, incentives, training, blueprints or other assistance for latrine building is provided.

[19] For example, Oxfam during the emergency response period following the 2004 earthquakes and the governments PNPM and RESPEK Programs that routinely provided wages for work done.

Despite these difficulties, the evidence for behaviour change in personal and family hygiene (latrine use; hand-washing; awareness and use of clean water supplies) and environmental health (cleaning drains; reducing defecation in the bush) is impressive given the short time for implementation; the inherent difficulty in affecting some of these changes in personal behaviour; and the limited success with and eventual down-grading of the use of the CLTS approach.

2.2.3 Community Based Disaster Risk Management (CBDRM)

What is CBDRM?

The concept of community led disaster management has been evolving over recent years. It began with Community Based Disaster Preparedness (CBDP), helping communities to anticipate and prepare for likely disasters. Typical CBDP activities include pre-positioned emergency stocks, identification of escape routes and safe havens, community disaster simulations, awareness raising and community planning. Some CBDP projects expanded to include small-scale structural mitigation activities such as building a dyke or seawalls or planting protective tree barriers. At times it was combined with Community Based First Aid (CBFA) and other response-oriented activities.

More recently, community based approaches began focusing on disaster risks rather than impacts. This involves assessment of specific disaster vulnerabilities; corresponding community capacities for mitigation and response then, based on the known vulnerabilities and capacities, identifying and planning appropriate and feasible risk reduction options for the community. This is the kind of approach now identified as community-based disaster risk management or CBDRM. The Asian Disaster Preparedness Center (ADPC) defines CBDRM as:

> *"… a process of disaster risk management in which at risk communities are actively engaged in the identification, analysis, treatment, monitoring and evaluation of disaster risks in order to reduce their vulnerabilities and enhance their capacities. This means that the people are at the heart of decision making and implementation of disaster risk management activities."*[20]

ADPC also describes seven steps in this process: (a) selecting the community; (b) rapport building and understanding the community; (c) participatory disaster risk assessment; (d) participatory disaster risk management planning; (e) building and training a community disaster risk management organization; (f) community-managed implementation; and (g) participatory monitoring and evaluation.

Recent trends in CBDRM for analyzing the complexity of community vulnerability and identifying appropriate interventions now include three areas of analysis:

- unsafe conditions (e.g. fragile physical environment, vulnerable society)
- dynamic pressures (e.g. lack of local institutions, lack of training/expertise, lack of ethical standards in public life, rapid population growth, rapid urbanization) and

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[20] Abarquez, I. and Murshed, Z. 2004 *Community Based Disaster Risk Management Field Practitioners' Handbook.* Asian Disaster Preparedness Center (ADPC), Bangkok. Andrew Makrey put it in another way: In CBDRM, the community is the main actor, the project leader and decision-maker (Module on CBDRR for CBDM-2, ADPC 1998)

- root causes (e.g. limited access to power, structure and resources; political factors)[21].

In attempting to address causes of and responses to vulnerability, CBDRM incorporates principles of community development and sustainable livelihoods development. This can result in a wide variety of "risk-reduction" activities including: infrastructure development (eg. sea wall construction); water and sanitation improvements; primary health care and agriculture interventions; and risk transfer (rather than risk reduction) activities such as micro-credit facilities and community saving schemes.

Findings

Disaster risk management (DRM) constituted approximately one- third of the NHDM project design and received a commensurate proportion of the budget. PCI, mainly experienced in health programs and with little previous CBDRM experience, included five ambitious DRM "outputs" in its original design including extensive CBDRM capacity development with government agencies and subsequent engagement of those agencies in planning and implementing DRM activities.[22]

At the time of the ICR Review, disaster risk assessment, development of mitigation plans and first-aid training had been completed in all 30 villages. Implementation of plans was underway in 12 villages and already completed in seven. Disaster response simulations had also been completed in 51 schools and in most villages. Generally, planned project activities had been completed as specified in the Detailed Implementation Plan (DIP) [23].

An early problem for implementation was the fact that the District government had no ear-marked resources that could be applied to DRM and no designated staff or organisational capacity to participate to the extent envisaged in the original NHDM design[24]. Following the 2007 Review, this factor and evidence of the slow uptake of DRM in the eight pilot villages, led to a more realistic assessment of the CBDRM component and expectations were reduced to include only: (a) *Increased capacity of families and villages to develop and implement community-based disaster risk management programmes;* and (b) *District government authorities accept and support the community-based disaster risk management approach.* By this time, some resources had already been invested in what proved to be relatively unproductive endeavours with some government agencies (eg. efforts to involve SATLAK in CBDRM)[25] but other pre-Review activities, such as a study tour to Yogyakarta for District Government staff and the eight initial "CBDRM" pilot projects, provided some initial

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[21] From the disaster crunch/release model introduced by Piers Blaikie, TerryCannon, Ian Davis and Ben Wisner in *At Risk: natural hazards, people's vulnerability and disasters*. (2004)

[22] In fact, these five result-categories are more akin to outcome-level expectations than outputs. They were: (a) capacity building of district government; (b) increased coordination and planning between SATLAK, local government (district, sub-district and village) and communities; (c) establishment and capacity development of village disaster management committees for CBDRM; (d) Improved community and family knowledge about disaster preparedness; and (e) increased use of earthquake resistant design for community WatSan, health and education facilities *(Nabire Health and Disaster Management PDD, Attachment 2 (Logframe), April 2006)*.

[23] Results for the NHDM output indicators at the time of this ICR Review (September 2009) are included in Attachment 4.

[24] SATLAK, where NHDM had already invested some resources to try and build its role in DRM, was an ad-hoc multi-Dinas district government structure specifically for emergency response, and proved unable or unwilling to participate in building DRM capacity.

[25] Resulting in, perhaps, missed opportunities in other possible activities – for example, a structural survey of public facilities, if combined with proper vulnerability (or exposure) assessments for risk mapping, would have created greater impact.

community and government benefits and a foundation for eventual expansion of the revised CBDRM component.

A key aspect of the CBDRM activities was the disaster risk assessment process and development of a realistic community DM plan of action that contributes to and becomes a component of a community's broader development plans. The ICR Review was not able to formally assess the village disaster management plans. From comments by informants and field visits to nine of the villages however, it was clear that the focus of NHDM's CBDRM implementation was more often community-level disaster preparedness (e.g. community-level emergency kitchen sets; simulations; evacuation routes, etc) rather than a disaster risk reduction (DRR) approach based on thorough analyses of hazards, risks, capacities and vulnerabilities.

Most activities implemented were focused at community rather than household level. Simple domestic examples like raising house floor-platforms; elevating furniture; or storing valuables in a plastic bags, in anticipation of flash floods, or securing shelves and cupboards against walls for earthquakes were only infrequently initiated but, ironically, would have provided community members with easier access to CBDRM rather than did the community-level activities. If the focus is on households, it is easier to promote the equal participation of all family members as every member has a domestic role and responsibility within a household or family setting. Interviews with Village Committee members suggested that the community-level focus probably contributed to the predominance of men in CBDRM activities.

NHDM did introduce several risk reduction activities – including protective tree-planting and constructing a sea-wall to prevent coastal abrasion; cleaning village drainage channels to prevent localized flooding; and building bridges to improve identified evacuation routes – but, in some cases, with questionable results. For example: a seawall built with NHDM support was destroyed by wave action within months; initial results from foreshore tree planting in a coastal village have been disappointing; and some questions were raised about the capacity of an evacuation-route bridge to withstand a flood. Structural mitigation of disaster risks generally requires specialist expertise and it seems that NHDM wasn't always able to obtain sufficient expert advice.

On the other hand, NHDM's advocacy and working relationships with communities and local government meant that, at times, it was able to play an effective role in influencing government to support DRR actions – for example, two cases of stream diversion to reduce the probability of localized flash flooding. In one case NHDM facilitated an approach to the District Government which resulted in government funds being provided for the stream works. In the second case, RESPEK funds were used along with community labour[26].

One of difficulties that NHDM encountered is common to similar activities elsewhere, namely, engaging communities in CBDRM[27]. Anticipation of this difficulty was part of the reason for trying to integrate the CBDRM component with MCH and WatSan. NHDM worked on building an "integrated" view of all its project activities within communities and these activities did provide entry points for introducing CBDRM but the approach was not really an

[26] In other examples of cooperation, RESPEK funds were also used along with community labour in building a sea wall and conducting WatSan, health and education facilities surveys in target communities.

[27] This is a commonly mentioned experience eg. EMA in cross-cultural DM work in Australia; NGOs in the LANGOCA Program in Lao PDR working with village communities on DM.

integrated one. Contributing factors included: the Field Facilitators limited familiarity with CBDRM; field support specialists for each component whose focus tended to be on their specialty rather than on a broader CBDRM approach; and the difficulty in understanding the often indirect and complex associations between project activities and the behavioural changes upon which successful CBDRM is contingent. Despite the difficulties experienced in integrated implementation, there was some evidence that villagers, regardless, often viewed the three sectoral components as complementary in helping to improve their livelihoods and likely circumstances in the event of a disaster.

Analysis

Implementation of the CBDRM component of NHDM resulted in increased awareness about disasters, a systematic planning process and some disaster mitigation action being taken in target villages. However, the work focused mainly on disaster preparedness and much less on disaster risk reduction – the main intended outcome of CBDRM. As a trial in developing effective approaches to CBDRM, NHDM has provided valuable experience and many important lessons. The main factors affecting implementation were:

- In 2006, CBDRM was a new area for AusAID and NHDM was considered a pilot program to test approaches[28]. Ideally, a trial intervention such as this would require clear mutual understanding of the underlying purpose of the activity; a flexible, robust working relationship between the two organisations; and with both able and willing to access relevant CBDRM expertise so that exchanges of DRR ideas would improve project implementation. At project inception this did not appear to be the case. That NHDM was considered by AusAID as a CBDRM trial may not have been sufficiently clear to PCI who, as a competent project manager, saw their task as the successful implementation of a pre-defined (in the PDD and DIP) set of activities. Further, PCI expertise was in health and WatSan while AusAID had experienced little involvement in DRR (especially community-led initiatives), at that time being primarily focused on emergency response and preparedness[29].
- The intended central role of CBDRM in the overall project was not clear to many of the NHDM field staff (and, although clearer amongst NHDM senior staff, their focus on project management may have limited the flow of knowledge to field staff). In some cases, it was not clear if field staff had sufficient understanding of CBDRM to engage confidently and knowledgeably with villagers about it – in particular, that it should be about reducing disaster risks and vulnerability and that it should be based on sound, bottom-up community development practice
- The initial intention to establish local and District level planning mechanisms for disaster management was not able to be realised due to the lack of budget and human resources available to the District Government. This was compounded by the uncertainty surrounding likely district-level implementation of disaster management work flowing from National Law DM 24/2007. The new law was ratified by parliament in April 2007 and, among many other things, supports community participation in the planning, implementation, and supervision of disaster management activities. A somewhat irregular appointment (as there was no corresponding *Perda*) by the District Government of the head of the yet to be formed BPBD (the district level agency specified in DM 24/2007) in August 2009 did little to reduce the uncertainty.

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[28] From discussion with AusAID DM staff, NHDM was one of the first CBDRM projects funded by AusAID in Indonesia.

[29] AusAID recently released a policy on DRR: *Investing in a Safer Future: A Disaster Risk Reduction policy for the Australian aid program, June 2009* and a comprehensive DM Plan for the Australia-Indonesia Partnership.

- NHDM used Participatory Disaster Risk Assessment (PDRA) processes for village disaster risk assessment but this was not sufficiently robust to identify specific vulnerabilities and capacities required to reduce risks (ie. Risk = (Vulnerability x Hazard)/Capacity[30]). Community disaster simulations and identification of evacuation routes were often based on earthquake and tsunami scenarios when community members are probably more often challenged by localized flash floods. This may have arisen because village disaster risk assessments did not take sufficient account of hazards, vulnerability and capacity information.

An issue that affected all of the project components was high staff turnover which then necessitated regular recruitment and training of new staff. Staff said however, that NHDM induction training was not sufficient. It did not give them a good understanding of and confidence with the range of complex material necessary for field staff to know and it didn't help them enough in developing effective community engagement skills.

2.2.4 Project Management

NHDM management had to contend with high levels of staff turnover in a location that is relatively remote and unattractive to potential recruits from outside Papua. This was probably exacerbated by uncertainty about the project's future generated by the "Stop-Go" Review in 2007. It was also affected from time to time by a proliferation of government job vacancies. However, project management appears to have been effective in that almost all planned outputs and outcomes will be achieved by end-of-project and within budget, including additional activities in Dogiyai District to assist in containing a cholera outbreak. Assessment of the overall effectiveness of the project has been made elsewhere.

Good communication and understanding of the project task and processes was evident amongst senior staff (Director, sector specialists, site supervisors) along with a high level of solidarity, commitment and team-work amongst all staff evidenced by, for example, willingness of senior staff to provide guidance to inexperienced staff. There was also evidence that NHDM staff were effective in finding solutions too problems that inevitably arose during project implementation. Good relationships were established with NHDM stakeholders and AusAID. Communication of the organisation's ethos, tasks and methods to Field Facilitators and Field Technicians however, was sometimes not sufficient, for example, their imperfect understanding of other program mechanisms such as PNPM and RESPEK.

Only a limited set of strategies was available to deal with the staff turnover problem, namely: further increasing salaries; improving work conditions (reducing work loads); or convincing staff of the long-term security offered by the NHDM training and work experience. While loyal to the project, many staff interviewed expressed dissatisfaction about their workloads (and, to a lesser extent, their salaries). In a relatively remote location staffing will always present difficulties. The ICR team felt however that, after almost 10 years experience working in Nabire, PCI/NHDM could have been more proactive in tackling the problem (including negotiating more flexibility in project expectations and staff employment conditions with AusAID). High staff turnover also meant an increased staff training burden for NHDM. This was handled in a variety of ways but, particularly for new Field Facilitators, induction training was not adequate. Community development facilitation is complex and

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[30] From *Living with Risks* (2004), UN International Strategy for Disaster Reduction (UN/ISDR); *Building Capacities for Risk Reduction* (1997), a UN-led Disaster Management Training Program (DMTP) module by Interworks. The formula only showed "Disaster Risk = Vulnerability x Hazards", but exclusively added a description about building capacities.

very difficult without adequate experience or training. In particular, facilitators need to be confident in the philosophy and approach of their organisation and well-versed in the methodology of their work.

NHDM also had to contend with the inability of the District Government to materially support NHDM activities (mainly due to lack of relevant budget allocations) and, partly as a result of this, the community focus of the project was strengthened following the 2007 Review. However, DHO staff were participants in many of the MCH component activities (especially in *puskesmas* staff training); the project was supported politically and its results incorporated into government reporting; and it has been successful in developing some mutual understanding about its program at district level with BAPPEDA, DHO, DEO, PDAM, PU and BPMK (Community Empowerment).

2.3 Efficiency

With a contract value of nearly $3.75m over three years, the project was well resourced; maintained good control over expenditure and remained within budget. Good management was assisted by modifications to the project following the 2007 Review resulting in ~$241,000 being reallocated to increasing focus on community engagement; strengthening project M&E and improving the training, salary and conditions of project staff. In April 2009, NHDM was given approval to utilise under-spent funds in a "no-cost" extension for an additional three months, providing an opportunity to strengthen work completed in each component and improve the likelihood of sustainability in some activities. Thus, the project appears to have used its resources efficiently in implementing planned activities. However, a number of issues related to efficiency were notable:

- *Higher than normal overheads:* NHDM is unusual in that overhead costs[31] (~40%) were higher than normally found in NGO projects in Indonesia (~25%)[32]. This is partly due to the relatively remote location of the project and consequent high cost of transport, goods and services. NHDM also: retained a high proportion of specialist staff (relative to the number of Field Facilitators) in order to resource three different technical components working in 30 villages; and established three 'base camps' for field staff closer to target villages to increase the frequency of field visits and strengthen cooperation between NHDM, the villages and sub-district offices. Input from the PCI Jakarta Office was also generous, providing support for project management and M&E implementation, staff training and implementation of the baseline and endline KAPC surveys.
- *Staff turnover:* The rate of staff turnover, noted previously, stabilised somewhat when staff conditions and job security improved following the 2007 Review and the decision to continue the project. Nevertheless it remained sufficiently high throughout the next two years to have an affect on the implementation capacity of the project – particularly the project's ability to provide sufficient training for new staff and to maintain the quality and, ultimately, the morale of the staff.
- *Field Facilitators:* The staffing structure adopted for the project appears to be top-heavy for such a community development intervention, where one might expect ~50% of the staff to be in the role designated "Field Facilitator" within NHDM. At the time of the evaluation there were nine Field Facilitators out of a Nabire project staff of 43 (21%)

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[31] Personnel salaries and benefits, office costs and equipment.

[32] PCI-Nabire Health Disaster Management Project Proposal, Attachment 1: Detailed Budget, 2005.

and all of the Field Facilitators interviewed felt that their workloads were too high and that responsibility for progressing work in two or three villages was too much. Backing up the Field Facilitators was an array of specialist and technical staff for each of the three components to be called on when needed to progress specific community initiatives. Other experience suggests that there may have been alternative structures that would be more efficient and, allied with adequate training (see below), better able to provide an integrated CBDRM process.

- *Staff Training:* The ICR Review also has some concerns about the limited amount of training provided to new staff. Induction training – vital in planting the seeds of the organisation's philosophy, vision, and overall approach along with sufficient skills to ensure initial competence and self-confidence – was restricted to two or three days. The remainder was mostly "on the job" training as opportunities arose. This can be a reasonable approach provided that it includes continuous assessment, mentoring and assistance for new staff as there skills develop; and that the tasks they are given are commensurate with their expertise at the time. Some of the savings from project changes following the 2007 Review were directed to additional staff training however, Field Facilitators did not feel that there training or follow-up had been adequate. Despite these additional funds, senior NHDM staff said that the amount of training that they could provide for staff was constrained by AusAID restrictions on project budget allocations. Whatever the reasons, it is clear that poorly prepared staff will reduce both the efficiency and effectiveness of an intervention.
- *Project Office:* For such a major project in Nabire District, the NHDM office was a very plain, unadorned and, to some extent, unkempt work centre for the project and did not appear to provide inspiration or even basic information displays (eg. posters of community processes and tools; development awareness training posters and pictures, especially in MCH, WatSan and CBDRM) for staff. Basic maintenance of the office surrounds was also not very evident. The office of a project is the centre of promotion for the project's mission and vision and is an important tool in building internal (staff) and external (other stakeholders) awareness about the project, its context and rationale. While this may be a less important point in the context of the project's more significant successes and limitations, attention needs to be paid to the way in which a project office presents an image of the project (and information about the project) to staff and visitors to the office.

2.4 Impact, Sustainability and Cross-cutting Issues

2.4.1 Impact

The evidence from NHDM's monitoring and KAPC surveys, and that collected by this evaluation, clearly show that NHDM has made important immediate contributions to the well-being of its 30 target communities in each of the three components of the project – MCH, WatSan and CBDRM. Although there was some variability amongst the communities in there commitment to the project's activities and intentions, during interviews most were very positive about the subsequent benefits. Apart from one village, where strongly held cultural beliefs and practices meant that more sensitivity and persistence were necessary to build confidence and encourage engagement, there was no evidence of strong opposition to the project or negative outcomes resulting from its work.

Assessment of longer term impact is more difficult. Even though indicator data and other qualitative information collected during this evaluation are both suggestive of positive

behaviour change amongst many community members, the project has not been in place for a sufficient length of time to draw firm conclusions about the likelihood of sustained long-term change. In addition, the impact of DRM is difficult to assess due to the fact that this can only really be judged after a disaster occurs.

Ultimately, an important part of NHDM's impact will be dependent on the extent to which the Nabire District Government gives substance to its recent very supportive rhetoric about the project and its proclaimed intention to build into the forthcoming Medium Term Plan, activities to continue many aspects of NHDM's work. Whether this will survive competing dinas' priorities, the budget planning process and the multitude of other vagaries inevitable within the government bureaucracy, is unpredictable at this time.

In relation to DRM, until inauguration of BPBD (in August 2009) no formal structure for DRM existed within the Nabire District Government (as SATLAK was only an ad hoc committee for emergency response). However, the recent appointment of the first Head of BPBD and the District Government's stated intentions noted above are possible effects of the NHDM project that may result in medium to long-term outcomes with positive consequences for DRR in the region. NHDM was also, on a number of occasions, able to bring together some of its own resources with those of RESPEK in order to accomplish a significant piece of work – in one case diversion of a stream responsible for regular flooding of a village. Although RESPEK's methodology has more than once proved problematic for NHDM, successful demonstration of the use of RESPEK funds for such a project may have established a precedent for similar kinds of DRR work in future. However, the ability of a project such as NHDM to focus sufficient resources in producing a good result may not be easily replicable by the government program alone.

For CBDRM, community DRR outcomes so far have been limited but there was a lot more awareness abroad about disasters and the kinds of things that can be done to mitigate their effects. A more coherent approach to CBDRM based on an effective community development methodology may have strengthened outcomes in each of the NHDM components and is likely to be the most effective approach in future CBDRM activities.

2.4.2 Sustainability

It is important to note that the full implementation of NHDM has been limited to about two years[33] and this will inevitably compromise long-term sustainability. Sustainability ultimately requires the persistence of behaviour changes that can sustain project benefits. Experienced community development practitioners suggest that as long as five years may be required to sufficiently embed significant changes in the attitudes and behaviour of community members.

While NHDM worked hard at all levels to promote sustainability of benefits, it is clear that the institutional structures, systems, skills and financial resources are not yet sufficiently in place at any level (village, sub-district, district, local NGO) to maintain, let alone extend and replicate, many of the initiatives of the Project. Developmental change in Papua is also often confounded by frequent changes in laws and jurisdictions partly brought about by the Province's Special Autonomy status. Village communities, and sub-district and district

[33] In the first year, substantial delays in implementation were encountered; work was focused on the preparation and piloting various elements of the program in a few trial villages; and the looming "Stop-Go" review distorted the normal implementation process, retaining focus on the completion of pilot activities rather than commencing roll-out to more villages.

governments will require sustained and coordinated support if the initial benefits described in this report are to be maintained.

Government

The District Government's appointment of the Head of BPBD and clear, public statements of intent from him, the Bupati, the Head of Bappeda and SKPD leaders to incorporate the major DM outcomes of NHDM into the mandate of BPBD and the next medium-term plan (RPJMD) for the District[34] are promising commitments to policy development and action but will inevitably be circumscribed by competing priorities for resources.

Government appointed midwives and other *puskesmas* staff trained by NHDM will continue to practice and the government indicated its intention to work towards all villages having reasonable access to midwives whenever they are required. There has also been some limited capacity development of staff in some government agencies (particularly DHO and DEO) as a result of their engagement with NHDM.

Community

Community members in most of the villages visited for the evaluation expressed confidence and enthusiasm in their capacity to sustain and extend the work done in MCH, WatSan and CBDRM that was facilitated by NHDM – especially maintenance and replication of wells with hand pumps, hand-washing facilities, latrines and health facilities. The evaluation team were of the view that this could continue in some of the villages in the short-term – depending on local 'champions' or other characteristics of each village – but would become more difficult as the new facilities deteriorate or break down[35]. *Posyandu kaders* trained by NHDM are likely to continue their role and, in individual cases, may continue to mobilise community members in maintaining new attitudes and behaviours introduced by NHDM.

Project elements that are least likely to be sustained are those that proved controversial in many villages. These included exclusive breast feeding; blood testing for pregnant women; and putting aside money to support pregnant women (P4K)[36].

Evaluation evidence suggests that the extent to which NHDM outcomes are sustained will be affected by the level of cohesiveness within communities, especially within mixed Papuan and transmigrants communities. Generally, effective community leadership and community cohesiveness are almost prerequisites for sustainability of project outcomes and need to be consciously addressed as part of community development processes. This takes experience and time on the part of facilitators and is one of the reasons why short community development interventions are likely to enjoy only limited success.

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[34] The statements were made at the Workshop to discuss NHDM Hand over of results on September 9, 2009, and a meeting between Nabire Government senior staff on September 10, 2009 and the ICR Team.

[35] A new water supply pump in one hamlet was already showing signs of deterioration (built with PVC pipe that appeared too light for the application) but the community members seemed uncertain about how it might be repaired.

[36] Strong rejection of these ideas in some villages (eg. Gamey Jaya, Marga Jaya, Gerbang Sadu, Waroki) raises a question about how they became standard elements of NHDM's approach and consequently, about the community development process used by NHDM field staff. The result tends to indicate that the overall approach may have involved too much of a top-down style to introducing initiatives in to communities. It may also be an indicator that the Field Facilitator training did not provide staff with sufficient skills to enable them to bring villagers to an understanding of why these elements were important positive changes.

Project activities

Government support to continue NHDM activities and to continue monitoring existing NHDM outcomes would be preferable but may not eventuate. The best option would be for PCI to be provided with a small amount of funding to continue a limited monitoring and support role for a further 12 to 18 months, including working with the relevant government departments on an extended handover. The Oxfam/GB representative also acknowledged the mutual benefit in Oxfam/PRIME continuing support for the CBDRM work initiated by NHDM when the PRIME program starts in Nabire.

The two Nabire NGOs who worked with NHDM (one on CBDRM and the other on HIV and AIDS community education) are prepared to continue the work begun with NHDM. They have very few resources however, and would only be able to support the work in a limited number of sites.

2.4.3 Gender

The objectives of AusAID's gender policy are: (a) increased access for women to economic resources; (b) increased women's roles in decision-making; (c) support for women's rights (CEDAW convention); and (d) capacity development for women. The intent of NHDM was to focus mainly on Papuan-majority communities and Papuan house holds within those; poorer households; and women. In general, these intentions have been reasonably well fulfilled, mainly through the attraction of NHDM MCH and WatSan activities for women.

The NHDM senior management team supported gender equality principles and employed a significant proportion of women in positions with field responsibilities. At the time of the evaluation, female NHDM staff included four out of nine Field Facilitators; two out of six Site Supervisors; and three out of four Field Technicians. None of the five Technical Specialist positions was occupied by a woman.

NHDM's MCH and WatSan components, traditionally the domain of women, ensured that women were major beneficiaries of significant project outcomes and, due to their high levels of participation in these activities, contributed to increased women's participation in community decision-making and capacity development opportunities (on the other hand, six *posyandu kaders* trained by NHDM were men). According to community members in villages visited during the evaluation, women were active participants in NHDM's village teams (forming up to half the membership in some cases) and chairpersons in four villages. Women who were trained by NHDM as *posyandu kaders* said that, as a result, they had become confident in passing on knowledge to mothers and other women, and in speaking at village meetings where "women are more outspoken than men because they know what they need and they can provide good reasons for their needs to be prioritised". Most of the participants in CBDRM teams were men.

Women also noted that women generally (particularly *posyandu kaders)* are important agents in changing community behaviour towards healthier practices. In addition to disseminating knowledge on MCH, sanitation and hygiene practices, they also perform monitoring roles, eg. in Kimi village, the *kaders* visit villagers to check whether latrines are being used and maintained properly.

Those good results notwithstanding, the ICR team believes that gender equality and gender mainstreaming were infrequently considered as part of NHDM community development strategy planning, and strengthening women's rights only rarely. It is unclear whether this was because the issue wasn't considered a priority in the region (and therefore NHDM might

have seen itself as “out of step”); or it wasn’t considered a priority in PCI or the level of awareness amongst NHDM staff simply wasn’t sufficient to understand and act on its significance.

There was some evidence to suggest that greater emphasis in NHDM on gender issues would have been appropriate and, given the varied social and ethnic structure across the project villages, it almost certainly should have been a part of community entry analysis prior to visiting all villages. For example, in Yaro Makmur village, it was almost impossible for women to participate in village meetings since they were usually held at night as part of the men’s religious gathering. Air Mandidi village *kaders* said that it was difficult to recruit younger women to take on the role as they had to get permission from their husbands. In some villages men were influential in resisting changes towards improved breast-feeding practices.

2.4.4 Environment

The main environmental effects of NHDM occur in water supply installations; septic latrine systems; and various DRR strategies – stream diversion; sea-wall construction and protective tree planting.

Household septic latrine systems: These systems provide environmental and health benefits on installation. Once full however (depending on usage this could be after one to five years), they require pumping out and the waste material removed to a safe disposal site. While the number of systems in a locality is small, potential problems from blocked or overflowing latrines are, likewise, likely to be less severe. A large number of installed systems however, will require a well-organised procedure and equipment to ensure that full tanks are emptied appropriately and the waste disposed of so that it is not a threat to health and the wider environment. Comments from villagers suggested that some people were not conversant with these implications of the installed latrines.

Water supply: Water supply activities include installation of tanks, dug-wells and reticulated supply from catchment water sources as well as catchment conservation and management education – important for the retention of safe and reliable water supplies. The siting of a small number of dug-wells has resulted in them only providing poor quality water (discoloured or having a bad odour).

Major DRR infrastructure: Major interventions such as the stream diversions, sea-wall construction and protective tree plantings undertaken through NHDM will expose the new DRR systems or structures to high stress situations such as flooding streams or heavy seas ie. the events against which they are designed to protect. The failure of two of the village DRR structures implemented with the assistance of NHDM graphically illustrates that such interventions require high-level engineering, hydraulic, environmental and ecological expertise. This is necessary to ensure the interventions can stand up to extreme conditions and to assess the environmental effects that the interventions themselves may have on the local environment (eg. construction of sea walls can affect foreshore sand movement and ecology).

3. Evaluation Criteria Ratings

Evaluation Criteria	Rating (1-6)	Explanation
Relevance and quality of design	4	The MCH and WatSan components were effective in themselves and the design was aligned with GoI, GoA and Nabire District Government priorities, but it did not reflect understanding of DM generally or CBDRM in particular. The project was intended to be a trial of CBDRM but did not address the issue of integrating the MCH and WatSan components with the DRM core – they were simply juxtaposed in the design (with separate goals) and implemented almost independently of each other in the field. There was no requirement in the design for assessing the effectiveness of the CBDRM trial or the integration between components. In other aspects, the design (and DIP) was highly prescriptive and "top-down" for a predominantly community development intervention.
Effectiveness	4	Despite design issues, good results were attained in the MCH and WatSan components. NHDM achieved most of its planned outputs and outcomes but it was not a successful trial of CBDRM (except for the value of lessons learnt). The project was well-regarded by senior District Government staff who appear willing to integrate follow-on action into the District's forthcoming Medium Term Plan but implementation of these activities can not be guaranteed. Actual support from resource-strapped government agencies (especially DHO and DEO) was mainly limited to participation in NHDM funded and organised activities. Community members generally expressed satisfaction with NHDM's work and the benefits that the project contributed.
Efficiency	5	NHDM achieved most planned outputs and outcomes within budget and with good financial management. Project overheads were high by normal NGO standards but there are some plausible reasons for this. Improvements followed reallocation of some funds following the 2007 Review but project outcomes may have benefited from greater flexibility in the use of funds for recruiting, training and retaining staff and in making the project office a more inspirational and informative centre for staff and visitors.
Sustainability	4	The full implementation of NHDM has been limited to only two years. This will compromise long-term sustainability which requires persistence of behaviour changes to sustain project benefits. Further, necessary institutional requirements are not yet sufficiently in place at any level in the District to maintain NHDM initiatives. On the other hand, there has been some limited capacity development of government agency staff engaged with NHDM and each of the 30 target villages now has (a) Improved health-care options (b) accessible water supplies (c) a small number of household latrines and the experience to construct more (d) Experience in DRM planning and action to reduce disaster related risks and improve preparedness. Persistence of these changes will now be affected by factors outside NHDM's scope or intent including the quality of village leadership and the cohesiveness of communities. Some mechanism for 12 to 18 months of follow-on monitoring and low-level support for NHDM initiatives is highly desirable.
Gender Equality	5	NHDM directly addressed three of the dimensions of AusAID's Gender Policy in that (a) Outcomes in all three components directly benefited women –particularly in the MCH and WatSan components (b) Many women were involved in decision-making

Evaluation Criteria	Rating (1-6)	Explanation
		and participated in NHDM activities in all target villages (c) Participating women received a lot of training as well as knowledge and informal skills development from NHDM activities. Women expressed greater confidence in speaking in meetings and many have become effective community mobilisers. NHDM staff were aware of gender issues in development but not always proactive in pursuing them. The issue of women's rights did not seem to be specifically addressed although, in a number of examples of discrimination reported (eg. women not allowed to participate in activities) it would have been an appropriate action, but difficult for sometimes inexperienced field staff.
Monitoring & Evaluation	5	Following the 2007 Review, NHDM's six-monthly progress reporting was thorough and detailed against a comprehensive set of activity, output and outcome indicators. For a community development project such as this, it could be said that the project monitoring was, in fact, over-specified and reduced potential flexibility in the project. Reporting also included little analysis of NHDM's role as a CBDRM trial (NHDM staff seemed not to be clear about this aspect of the project). Overall results for output and objective indicators were determined in an endline KAPC survey conducted in May 2009. While the ICR team's capacity for verification of NHDM ACR results was limited, on the basis of the Nabire field work, the ICR team is satisfied that the results reported for NHDM based on the endline survey are a reasonable representation of project outcomes.
Analysis & Learning	4	NHDM was one of the first CBDRM activities funded by AusAID and initially designed by PCI who had no CBDRM experience. Despite AusAID's role in the design (especially the CBDRM trial component), it showed only limited cognisance of existing work in the field. AusAID's communication to PCI about the project's status as a CBDRM trial appears to have been unclear. Constructive changes to the design were made following the 2007 Review (although not so much in relation to the understanding of CBDRM or integration of the project components) and throughout the next two years, NHDM did learn from issues as they arose and adapted activities to improve outcomes.

4. Conclusions, Lessons and Recommendations

4.1 Conclusions

Each of the three NHDM components – MCH, WatSan and CBDRM – was implemented relatively smoothly – staffing and training problems notwithstanding – and each component resulted in impressive outcomes that have been summarised in Sections 2.2.2 – 2.2.3. The main concern about the longer-term effects of NHDM are whether the implementation time (two years for most villages) has been long enough to produce behaviour changes and learning that will persist and skills that will continue to be applied in the absence of the project. Other experience would suggest that the time is probably too short to avoid losses unless a degree of ongoing support can be provided by the District Government or other means.

The original conception of NHDM as a trial of an approach to CBDRM implementation turned out to be problematic in execution but it has proved a useful laboratory nonetheless, and has provided a number of lessons and pointers for future initiatives. The main problem in implementing NHDM as a CBDRM trial seemed to be a lack of clarity about what integration of the three components might look like and similarly, about what the meaning or reasonable content of CBDRM should be. These issues have been discussed in this report, identifying the fact that the focus of CBDRM has to include (a) assessment of disaster vulnerabilities and capacities in order to properly evaluate risk and (b) approaches that ensure community ownership through sound community development processes.

The main implementation problem for NHDM was a high rate of staff turnover which put stress on staff – especially those with field responsibilities – and on the training capacity of the organisation. Difficulty in providing sufficient training for staff probably reduced the effectiveness of some project activities. Greater use of ToT and general capacity development expertise may have assisted with this and also contributed to strengthened outcomes in some areas. The project was otherwise well-managed, M&E data collection, six-monthly reporting and baseline and endline KAPC surveys were competently carried out. Project staff were conscious of gender issues. Although only 26% of staff were women, most worked in front line field positions. Gender equity was reasonable across the project although mainly men were involved in the CBDRM component and mainly women in the MCH component. There were a few situations were NHDM could have been more proactive in supporting women's rights.

4.2 Lessons from NHDM

The "lessons" listed here are derived from responses from all of the NHDM stakeholders interviewed for this evaluation. By their nature, they tend to provide a critical perspective of NHDM. It is important however, to remember that NHDM has been successful in implementing its planned activities and achieving most of its targets. Thus, the list is best considered as possible ways to improve future interventions of a related nature.

General Design Issues

1. Development of a Detailed Implementation Plan should be part of a project inception process that includes renewed 'on ground' assessment and consultation with main stakeholders and target communities. In the case of NHDM, it appears that this was not the process, rather the DIP was developed mainly from the existing project proposal with only limited reference to current needs within staff, communities, government and NGOs.

2. Trial interventions such as NHDM need regular (probably six-monthly initially) assessment between the implementing organisation, AusAID and other experienced practitioners and participants in order to make adjustments to the implementation process and the intended activities and expectations as experience is gained. AusAID and the implementing organisation also need to be clear about the "trial" nature of such an intervention and its purpose beyond the specific objectives of the activity.

3. AusAID required a "Stop-Go Review" after 12 months of implementation. While not the only factor affecting the rate of NHDM staff turnover, this terminology and the stated implications of the Review may have been a contributing factor due to the uncertainty created for staff about job security.

MCH

4. The 'exclusive breast feeding' and 'community savings for pregnant women' elements of the MCH component are strategies that have been proven in other MCH interventions and were generally well supported in NHDM villages. However, in a small number of communities (eg. Gamey Jaya, Gerbang Sadu, Waroki) they were much less successful. This highlights the importance of well-trained, preferably experienced facilitators working with communities, especially where long-established cultural practices are likely to militate against the introduction of new approaches.

WatSan

5. A number of government or donor funded activities now pay community members for their labour and contributed materials. There are ethical and practical issues involved in the question of whether villagers should be paid for work done in their own villages, especially when a community is extremely poor and has little prospect of other sources of income. For a project such as NHDM, where payment is not possible or desirable, it is important that project staff are clear about their task, and well-trained and skilled in community organising and development theory and practice so that they can successfully work around these kinds of impediments.

6. Installation of household latrine septic systems brings with it a need for systematic maintenance and emptying of the systems every few years. While this issue was addressed in community training, it was not clear that the practical difficulties were sufficiently dealt with nor how this could be done prior to the project concluding in December. There is the potential for significant environmental health problems in villages if suitable planning and provision for action are not put in place.

CBDRM

7. CBDRM is a community development process that will be most successful when the activity design is sufficiently flexible to accommodate exploratory, progressive engagement approaches in pursuit of high level goals such as "reducing vulnerability. The more prescriptive approach of project "forms of aid" is likely to be less effective in this work.

8. Effective CBDRM is a mobilizing and empowering process and not a sector or a set of activities. It should be integrated with comprehensive, long-term community development processes guided by experienced facilitators where the uniqueness of each community and community ownership are the main guiding principles. In this kind of scenario, CBDRM is intimately linked with sustainable livelihoods.

9. DRM involves a degree of technical expertise in risk assessment and in the design and implementation of subsequent mitigation work. Thus, it is important that people responsible for CBDRM activities (including at community level) have sufficient technical experience and knowledge of DRR; understand when additional technical assistance is required; and can readily access such assistance when necessary[37].

[37] As well as providing technical knowhow about risk reduction, this is also about the necessary expertise to catalyse coordination and coherence with other development actors within and between communities when required.

Working with government

10. Successfully working with government agencies at any level and successful capacity development amongst government staff is only likely to occur when government resources (financial and human) are unequivocally allocated for the work and there is demonstrable commitment from senior and middle-level managers. Given normal government planning and budgetary constraints and processes, this will almost always be difficult.

Staff capacity, capacity development and quality issues

11. Activity designs need to take account of the difficulty for activities in less accessible and "attractive" locations to attract and retain suitably experienced staff. Managers in such locations need to have (and to exercise) flexibility, resources and suitable strategies to retain quality experienced staff. Where employment of local staff is crucial to successful implementation (as it is likely to be in most community based initiatives), activity designs, schedules and budgets need to make sufficient allowance for adequate training of staff, including periodic refresher training and training of replacement staff as required. If sufficient experienced staff cannot be employed or retained then the scope of the activity should be reviewed so that the quality of the work is maintained, if necessary by reducing the scope and original expectations of the activity.

12. Staff induction into an organization is vital in planting the seeds of the organization's vision, mission and ethos as well as the opportunity to equip staff with sufficient basic skills to work confidently on behalf of the organisation. In part, due to the high turnover of staff, NHDM field staff did not receive sufficient induction into the organisation before being required to take on responsible and complex field operations.

13. The office of a project is a centre of promotion for the project's work. It is an important tool in building awareness and attention needs to be paid to the way in which a project office presents an image of the project (and information about the project) to staff and visitors.

14. High staff turnover, insufficient training and high workloads for field staff meant that optimum support for NHDM project activities and village champions was not always able to be maintained. Fewer days and nights able to be spent in each of the target villages may have contributed to reduced work quality[38]. There is likely to be value in regular assessment of the balance between the quantity and quality of work being done at any time in such community engagement interventions.

General capacity development issues

15. In a project of this size, with a large training component and dependent for success on affecting the will and capacity of community members and government staff to take greater responsibility for their own community development, advice from a person

[38] Community development facilitators need to stay at least several days every month with each of their target communities in order to maximise mutual understanding; strengthen proposed strategies and actions for change; and strengthen village empowerment in and ownership of community development processes. NHDM established "base camps" in an effort to reduce transport needs and travel times and to encourage FFs to stay longer with communities. It is unclear whether this was a successful strategy.

knowledgeable in recent (and changing) thinking about capacity development is likely to be beneficial.

16. There is evidence of effective transfer of knowledge and skills as a result of NHDM training, especially in the case of *posyandu kaders.* However, more systematic use of effective ToT (ie. with sufficient expertise and resources applied to its design and implementation) as a component of a contemporary capacity development approach may offer the opportunity for broader and deeper behaviour change and better sustainability. Whenever possible, villagers and project staff should also be exposed to innovative training methods that have been proven effective in other similar contexts e.g. video programs; drama and role-playing, etc.

Sustainability

17. Sustainability of benefits in community development activities is always affected by many variables beyond the control (or even the knowledge) of the initiative. The most important variable that can be influenced by the implementing organisation is the quality of the community development processes that are used by the organisation and its field workers. This requires:

    - Staff with aptitude for the work and the basic "people-skills" required (community development work is difficult, challenging and skilful and not everyone has the necessary ability)

    - Adequate training (including regular follow-up, review and refresher training) to fully induct staff into the organisation and provide them with necessary knowledge, skills, tools, support and confidence

    - Recognised community development principles and practices that underpin the work and are thoroughly understood by all of the organisation's staff. In particular, acknowledgement that each community is unique and continual analysis is required, starting prior to community entry and ongoing throughout activities.

18. Sustainability of benefits will be influenced by the quality of leadership and level of cohesiveness within a community, especially in communities made up of different ethnicities (Papuan and transmigrants). As far as practicable, the issues of leadership and cohesiveness need to be addressed by community development initiatives

Gender

19. In more remote regions (where for example, access to quality media and other sources of information is less reliable) or regions that are likely to be more socially conservative and dealing with gender issues difficult, it may be necessary for activity designs to be quite specific about the ways in which gender equity and women's rights will be addressed. As well as a human rights perspective, this would need to be framed within the overall social benefits that accrue to a community when women's capacities and roles are enhanced. Implementation involving these kinds of issues will require soundly based community development processes implemented by competent facilitators discussed earlier in this report.

20. Gender equity is often a difficult or confusing issue for project staff to deal with, especially in more socially conservative contexts. Some NHDM staff at times found this

to be the case. Simple but adequate awareness training and guidance on gender equity; the reasons why it is important; and how it can be advanced within current activities should be provided to all project staff as part of an organisation's induction training. Field staff with the main mandate to work with village women and men should be provided with additional practical training so that they can deal confidently with activities in the field that are designed to affect gender issues.

Recommendations

1. Given the limited consolidation of some of the changes introduced into villages through NHDM activities (due to the short implementation time), the sustainability of benefits could be strengthened if an appropriate agency can continue at least limited monitoring support for the changes. It is possible that this responsibility could be taken on by government if there is sufficient capacity and commitment. Present indications of this happening are not strong however and a better option would be to fund PCI so that they can provide limited monitoring and support for consolidation of outcomes for a further 12 to 18 months. Alternatively, a level of support could be incorporated into Oxfam/PRIME[39].

2. Improve the likelihood of effective and sustainable outcomes in CBDRM by increasing coherence and harmonisation amongst AusAID funded initiatives in the same region – in this case, NHDM (until December 2009), PNPM /RESPEK programs and Oxfam PRIME. This should encompass influencing necessary changes in public policy; sharing and harmonising community planning and engagement strategies; and optimising resources to obtain the most effective outcomes.

3. To contribute to the successful design and implementation of CBDRM activities, AusAID should develop principles, strategies and program management mechanisms for effective approaches to CBDRM based on its own experience and expertise and that of other organisations. This should include strategies for adequately resourcing the community development and disaster risk management aspects of the activities, especially in light of the difficulties PCI experienced in recruiting and retaining staff for NHDM.

4. CBDRM is a part of broader community development processes and successful, high-quality community development initiatives from Indonesia and elsewhere should be referenced when designing activities that include CBDRM elements.

5. Sufficient allowance should be made in activity designs for community development initiatives to provide for comprehensive training of staff to ensure optimum quality of activity implementation. Such training will include formal and informal components; follow-up and refresher training and review; and mentoring; and is likely to continue throughout the initiative.

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[39] AusAID is funding Oxfam to deliver 3 years of CBDRM activity in Eastern Indonesia including a two-year intervention in Nabire. If it is expected that NHDM work, especially in the CBDRM component, would be continued through Oxfam's activity then this role would be relatively simple to establish.

Attachment 1: NHDM ICR Terms of Reference

Independent Completion Report for:

**Australia Indonesia Partnership for Reconstruction and Development -
Nabire Health and Disaster Management Program**

1. Introduction

These Terms of Reference are prepared for an Independent Completion Report (ICR) for Australia Indonesia Partnership for Reconstruction and Development (AIPRD) funded project, Nabire Health and Disaster Management Program (NHDM).
All initiatives classified as 'monitorable' require an ICR in addition to the Activity Completion Report (ACR). Monitorable activities are generally those that have total expenses greater than AUD3 million or smaller but sensitive activities.

2. Background

Australian Indonesian Partnership for Reconstruction and Development

At the inaugural Joint Commission Ministers meeting of the Australia Indonesia Partnership for Reconstruction and Development (AIPRD) on 17 March 2005 agreed a number of programs and activities to be funded from Australia's AUD1 billion post tsunami aid package. The funding includes a $10 million program to strengthen Indonesia's disaster management and response systems and build a closer partnership between Indonesia's disaster coordination authorities. An AUD5 million package of assistance measures will also be developed to address needs arising from the earthquakes in Alor and Nabire.

The program above should be considered in the context of the broader objective for the AusAID emergency and humanitarian sector which is to respond to and reduce vulnerability of communities to disasters, conflict, acute humanitarian needs and complex emergencies.

Nabire Health and Disaster Management Program

A major earthquake in Nabire on 26 November 2004 exacerbated the damage caused by an earlier earthquake in February 2004. The death toll from both is 60 with 300 injuries. They resulted in the extensive damage to over 2000 houses as well as public buildings and infrastructure. Following these earthquakes, NHDM was designed to respond to the immediate and long term chronic needs of Nabire.

This AUD3.7 program is implemented by Project Concern International (PCI) over three years (2006 – 2009). The program works to mobilize and strengthen local community capacities in

30 villages in seven subdistricts[40] (Nabire, Nabire Barat, Wanggar, Yaro, Teluk Kimi, Uwapa and Makimi) covering around 39,125 population.

The program goals are:

a) to reduce mortality and morbidity among women of child-bearing age and children under five in selected sub-districts of Nabire and;
b) to reduce community vulnerability to future disaster in selected sub-districts of Nabire.

The program has three components and objectives as follows:

a) Maternal and Child Health (MCH), including HIV and Malaria prevention
   Objective 1: Improved capacities for community-based MCH
   Objective 2: Sustainable behavioural change for improved MCH among caretakers
b) Water Supply and Sanitation
   Objective 3: Improved access and behaviours related to clean water supply and sanitation facilities
c) Community-based Disaster Risk Management (CBDRM)
   Objective 4: Improved capacity for risk reduction and emergency preparedness among affected communities and local authorities

In addition to the 30 villages in Nabire District, in May 2009 NHDM expanded the program to cover Moanemani sub-district of Dogiyai, the adjacent district of Nabire. This expansion is triggered by cholera outbreak happening in highland Papua in April – September 2008 that 575 people had been infected and 87 had died. The Dogiyai district government proposed NHDM's short-term assistance for two villages, Ikemanida and Idakotu, that need quick, focused assistance to prevent additional outbreaks of cholera by improving water and sanitation conditions.

NHDM was reviewed at the end of its first year implementation (July 2007) in order to recommend whether or not the program should continue. The review found that CBDRM activities were proceeding slower than anticipated. This is partly due to the earlier than optimal phasing-in of CBDRM activities (following on from WATSAN and MCH activities) to meet the 12 month pilot requirements. Alignment with the new Bill on DM posed both a challenge and an opportunity to achieving joint planning depending on its timing. Despite some setbacks to implementation, the review found that good progress had been made in the first 12 months, and that NHDM was making a useful contribution to development efforts in Papua province. The review, thus, recommended the continuation of NHDM program, with a strengthened focus on achieving quality of and sustainability in activity implementation.

AusAID is funding Oxfam to deliver 3 years CBDRM activity for Eastern Indonesia. One of the target areas is Nabire where NHDM is currently being implemented. It is expected that works already done especially on CBDRM component of NHDM would be continued through Oxfam's activity.

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[40] NHDM originally planned activities in four subdistricts. Since NHDM began, the government has subdivided some of the four subdistricts and there are now seven subdistricts.

The ICR's target audience is the community of professionals implementing Australian aid, all of whom need credible, independent advice on the results of past efforts. This community includes AusAID staff and management, government counterparts, implementing partners, and other donors.

2.1 Key Issues

a) Effectiveness of CBDRM approach implemented in the NHDM Program and factors for constraining success;
b) The most effective ways in conducting CBDRM activities;
c) The extent to which CBDRM approach support more active engagement of local government in disaster management.

3. Objectives of ICR

The objectives of the ICR mission are to:

a) Assess the relevance, effectiveness, efficiency, impact and sustainability of NHDM Program, in order to provide information on accountability and generation of lessons learnt that could be applied across the aid program;
b) Review the effectiveness of the CBDRM approach applied by NHDM program, i.e. CBDRM is implemented in conjunction with MCH and Watsan activities. The review should also assess how well the program addressed issues of gender equality, poverty and vulnerability in its design and implementation.
c) Identify factors constraining success and lessons learnt from the program and recommend mechanisms in order to enhance overall effectiveness of future and wider AusAID engagement in this CBDRM area;
d) Validate and follow-up the performance data and relevant assessments made by Activity Completion Reports.

4. Scope of ICR

The ICR will independently assess and rate the project's performance against the evaluation criteria of relevance, efficiency, effectiveness, impact (or potential impact), sustainability, monitoring and evaluation, gender equality, in addition to analysis and learning. The ratings will be based on the standard AusAID six-point scale, as outlined in the ICR template. Standard evaluation questions to guide the evaluation team in forming these ratings will be provided.

The evaluation must be able to provide an assessment and rating of the evaluation criteria above and will respond the following questions:

a) Are the activities undertaken consistent with the objectives outlined in the NHDM project proposal, and how they contribute to achievement of strategic objectives outlined in the Australia Indonesia Partnership (AIP) Country Strategy 2008-13 and the AIP Disaster Risk Management Sector Plan 2008-13?
b) To what extent the CBDRM approach is effective in achieving the project objectives?
c) What are factors contributing and constraining success in implementing CBDRM approach?
d) What are the lessons learnt from this project and how to integrate them into future AusAID's program? e.g. possible integration of DRR issues/CBDRM activities within existing community empowerment and sub-national government programs such as PNPM (National Program for Community Empowerment), ANTARA (Australia-Nusa

Tenggara Assistance for Regional Autonomy*)* or ACCESS (Australian Community Development and Civil Society Strengthening Scheme) or establishment of umbrella/facility mechanism to effectively manage various CBDRM partners;

e) What additional efforts are required for implementing CBDRM programs in the remote areas? A cost benefit analysis may be undertaken to identify this. If the ICR recommendations will be to continue supporting CBDRM in the remote locations in Indonesia despite of ineffectiveness, what are the reasons?
f) To what extent the CBDRM approach has enabled engagement with sub-national government on disaster management in the target areas?
g) How well the project has taken up the recommendations from the First Year Review?

If primary data to verify claims of achievements in this activity is not available, the ICR team should use their professional judgement to assess the impact of the program activities. The team should provide an evaluation plan (including methodology) and information required prior to in-country visit.

5. Evaluation Process

The ICR will take approximately 4 weeks and is planned for mid August 2009. The exact date of the ICR is to be confirmed.

In undertaking the ICR, the evaluation team will:

a) Conduct a desk study to assess relevant program documentation provided by AusAID and advice AusAID of any additional documents or information required prior to the in-country visit (2 days);
b) Appraisal of the M&E framework, gender strategy and sustainability strategy documents (2 days);
c) Develop an evaluation plan (including the methodology), issues paper, field research guide and instruments and identification of key respondents and further documentation required. The plan will indicate the roles and responsibilities of each team member for data collection, analysis and reporting (2 days);
d) In-country mission (11 days), including pre-mission briefing in Jakarta at the start of the in-country field visit (1 day), a field visit by team member including travel time to/from the project sites (8 days ie. 6 days on site), and preparation and presentation of the Aide Memoire (2 days);
e) Submit a draft ICR (7 days of writing for the team leader, consider if other team members are required to contribute and how much time they need);
f) Submit the final ICR (3 days of writing for the team leader).

6. Reporting Requirements

The ICR Team shall provide AusAID with the following:

a) **An Evaluation Plan (including methodology)** - to be submitted one week prior to the in-country visit and presented at the pre-mission briefing in Jakarta;
b) **An Issues Paper** based on review of the documents (2 pages maximum) – to be presented at the same time with the Evaluation Plan presentation at the pre-mission briefing;
c) **An Aide Memoire** (5 pages maximum as outlined at Attachment C) **-** summarising initial findings of the ICR and recommendations to be presented to AusAID staff and relevant stakeholders at the completion of the in-country mission.

d) **A Draft ICR** (25 pages maximum plus annexes) – to be submitted to AusAID within 2 weeks of completing field visit; and
e) **Final ICR** (25 pages maximum plus annexes) – to be submitted within 5 working days of receipt of AusAID's comments on the draft ICR.

5. Team composition

The ICR team will comprise two members, i.e. a senior and international evaluation expert with particular expertise in monitoring and evaluation (M&E) as a Team Leader and a local community development specialist with substantial knowledge in health, water and sanitation, and CBDRM areas.
The team will be supported by an AusAID Disaster Management Adviser to provide direction on the AIPRD DM Program Work Plan, AIP Disaster Risk Management Sector Plan, Performance Assessment Framework (PAF), in addition to CBDRM/DRR areas. AusAID Activity Managers will also assist the team to provide background information on the projects, oversight the review through regular feedback during the review process, facilitation of stakeholders meeting and logistics requirements.
The Team Leader will be responsible for:
a) Leading the review mission and responsible for overall management of the team inputs in achieving mission objectives outlined above;
b) Providing an evaluation plan, including methodology and instruments to be used;
c) Production of an Aide Memoire and;
d) Submission of a review report to AusAID.

The Community Development Specialist will be responsible for:
a) Providing advice and written inputs to the Team Leader, as instructed by the Team Leader, in order for the objectives and reporting requirements of the review to be met;
b) Providing inputs to the Team Leader on the evaluation plan;
c) Providing inputs to the Team Leader on the program's community engagement, particularly on local perspectives including gender strategies.

6. List of key documents

a) Project Proposal
b) Annual Plan and Report
c) Quality at Implementation (QAI) Reports
d) First Year Review Report
e) Six-monthly Progress Reports
f) Draft Activity Completion Report, including the Logframe and Risk Management Matrix
g) Draft AIP Disaster Risk Management Sector Plan and Performance Assessment Framework (PAF) 2008-2013
h) Indonesia National Action Plan on Disaster Risk Reduction (NAP-DRR) 2006-2009
i) Australian Government DRR Policy
j) Australia Indonesia Partnership (AIP) Country Strategy 2008-2013
k) Relevant AusAID policies (disaster risk reduction, gender, anti-corruption, partnerships, performance management and evaluation)
l) AIPRD DM Program Work Plan (July 2005)
m) AusGuidelines 5.1. "Preparing Completion Reports for AusAID – Interim Guidelines"
n) AusAID's Template on the Independent Completion Report and Aide Memoire
o) AusAID Standard Evaluations Questions to guide in forming the ratings.

Attachment 2: Evaluation Plan

Nabire Health and Disaster Management Project

Independent Completion Report, September 2009

1. The Task

The Terms of Reference for this Independent Completion Report (ICR) are in Annex 1. They list the Key Issues that the ICR should address as:

a) Effectiveness of CBDRM approach implemented in the NHDM Program and factors for constraining success;

b) The most effective ways in conducting CBDRM activities;

c) The extent to which CBDRM approach support more active engagement of local government in disaster management.

The corresponding objectives for the ICR are stated as:

1. Assess the relevance, effectiveness, efficiency, impact and sustainability of NHDM Program, in order to provide information on accountability and generation of lessons learnt that could be applied across the aid program;
2. Review the effectiveness of the CBDRM approach applied by NHDM program, i.e. CBDRM is implemented in conjunction with MCH and Watsan activities. The review should also assess how well the program addressed issues of gender equality, poverty and vulnerability in its design and implementation.
3. Identify factors constraining success and lessons learnt from the program and recommend mechanisms in order to enhance overall effectiveness of future and wider AusAID engagement in this CBDRM area;
4. Validate and follow-up the performance data and relevant assessments made by Activity Completion Reports.

In meeting these objectives the ICR is required to:

- independently assess and rate the project's performance against the evaluation criteria of relevance, efficiency, effectiveness, impact (or potential impact), sustainability, monitoring and evaluation, gender equality, in addition to analysis and learning[41]
- respond the following questions:
    1. Are the activities undertaken consistent with the objectives outlined in the NHDM project proposal, and how they contribute to achievement of strategic objectives outlined in the Australia Indonesia Partnership (AIP) Country Strategy 2008-13 and the AIP Disaster Risk Management Sector Plan 2008-13?

[41] The ratings are to be based on the standard AusAID six-point scale, as outlined in the ICR template. Standard evaluation questions to guide the evaluation team in forming these ratings are also provided.

2. To what extent the CBDRM approach is effective in achieving the project objectives?
3. What are factors contributing and constraining success in implementing CBDRM approach?
4. What are the lessons learnt from this project and how to integrate them into future AusAID's program? e.g. possible integration of DRR issues/CBDRM activities within existing community empowerment and sub-national government programs such as PNPM (National Program for Community Empowerment), ANTARA (Australia-Nusa Tenggara Assistance for Regional Autonomy*)* or ACCESS (Australian Community Development and Civil Society Strengthening Scheme) or establishment of umbrella/facility mechanism to effectively manage various CBDRM partners;
5. What additional efforts are required for implementing CBDRM programs in the remote areas? A cost benefit analysis may be undertaken to identify this. If the ICR recommendations will be to continue supporting CBDRM in the remote locations in Indonesia despite of ineffectiveness, what are the reasons?
6. To what extent the CBDRM approach has enabled engagement with sub-national government on disaster management in the target areas?
7. How well the project has taken up the recommendations from the First Year Review?

2. Evaluation Design

The approach to this evaluation is tightly constrained by the scope of the task and the limited time in the field to conduct the necessary evaluation activities. Table 1 sets out the evaluation questions that the design will address. These have been derived predominantly from the TOR. The main stakeholder groups are also identified in the table and , of these, the main contributors of information about each of the evaluation questions is also indicated.

Table 2 sets out AusAID's generic evaluation criteria to be assessed in relation to NHDM (and the standard evaluation questions for assisting in developing the each rating). The columns on the right side of Table 2 indicate the main sources of information for each of the criteria.

Based on Tables 1 and 2, questions guides have been developed for each of the main NHDM stakeholder groups. These are listed in sections 3.1 to 3.7.

Information in response to the question guides will be obtained from informants in individual or group interviews, focus group discussions (FGDs) or workshop settings. The appropriate format will be determined based on the time available and the number of people who will be involved in each session. The intention is to allow as much time as possible for discussion within groups of respondents in coming to some agreement on their responses to questions or groups of related questions. This will be difficult at times due to the limited time available to conduct workshop activities or FGDs.

The evaluation team will also review the NHDM six-monthly Progress Reporting; the Annual Plans; and the "Stop-Go" Review conducted after the project had been running for about one year. It will also consider work done in other recent AusAID-funded CBDRM activities such as the LANGOCA Program in Lao PDR.

AusAID documents consulted include:

AIP Country Strategy 2008-13

AIP DRM Plan (and PAF) October 2008

AIP DRM Sector Plan (v5.5) August 2009
AIPRD DM Concept Note 2005
AusAID DRR Policy June 2009
AusAID Gender Policy
Government of Indonesia documents consulted include:
National Action Plan for Disaster Reduction 2006-09

Evaluation Team

3 x AusAID (including DM Adviser and Program Managers)
M&E consultant
Community development consultant
Interpreter

Evaluation field work schedule

The schedule of field activities for the evaluation listed in Annex 2. The evaluation team will have an effective four days in Nabire in which to undertake all of the data collection. A further day will be taken up by a Handover Workshop conducted by the District Government and the NHDM project team. It is anticipated that the workshop will also provide useful input for the evaluation.

Table 1: Evaluation Questions and Sources of Information

Main information sources for each of the broad evaluation questions are marked. Each of these sources can contribute some, but not all, of the information needed to answer each of the evaluation questions. Also, the actual questions asked of the informants will be different in different situations. For example, Q3 could be, more or less, asked directly of PCI Management[42] but, in the case of village community members, evidence is likely to be indirect. A response to the evaluation question would be determined by ICR Team analysis of the contributions to the question from all the relevant informants.

Information source **Evaluation Questions (Mainly derived from the TOR)**	**PCI Manag-ement**	**PCI Field staff**	**Senior Dinas staff**	**Dinas staff directly engaged in NHDM**	**Village men in NHDM villages**	**Village women**	**Village youth**	**Other inform-ants: (Oxfam, Local NGOs, other donors/ projects**	**ICR Team analysis**	**NHDM docs**	**AusAID docs**
1. To what extent did NHDM meet its objectives?	✓		✓						✓	✓	
2. How were Stop-Go Review recs	✓								✓	✓	

[42] More likely as part of a number of questions. See later draft questions for PCI Management.

implemented?											
3. How effective was the MCH component?	✓	✓	✓	✓	✓	✓			✓	✓	
4. How effective was the Watsan component?	✓	✓	✓	✓	✓	✓	✓		✓	✓	
5. What was the NHDM "CBDRM approach"?	✓	✓	✓	✓					✓	✓	
6. How/to what extent was CBDRM integrated with MCH/Watsan?	✓	✓	✓	✓					✓	✓	
7. How effective was NHDM CBDRM in strengthening village resilience to disasters?	✓	✓	✓	✓	✓	✓	✓		✓	✓	
8. How/to what extent is this likely to be sustained?	✓	✓	✓	✓	✓	✓			✓		
9. How effective was NHDM CBDRM in engaging local govt in DRM?	✓	✓	✓	✓					✓	✓	
10. How/to what extent is this likely to be sustained?	✓	✓	✓	✓					✓		
11. What are the factors that contribute to and constrain successful CBDRM?	✓	✓	✓	✓	✓	✓			✓	✓	
12. What are the most effective ways of conducting CBDRM?	✓	✓	✓	✓	✓	✓			✓	✓	
13. What contribution has NHDM made to the AIP CS?										✓	✓
14. What contribution has NHDM (esp CBDRM) made to the AIP DRM Plan?									✓	✓	✓
15. What are the lessons from NHDM (esp the integrated CBDRM approach)?	✓	✓	✓	✓	✓	✓	✓		✓	✓	
16. What are the issues involved in implementing remote	✓	✓	✓	✓					✓	✓	

area CBDRM?											
17. What are the benefits from implementing remote area CBDRM?	✓	✓	✓	✓	✓	✓	✓		✓		
18. What are the specific implications/lessons from NHDM (and other examples) for using CBDRM in other locations?	✓								✓	✓	✓

Table 2: ICR Generic Evaluation Criteria, Standard Questions and Sources of Information

Generic criteria	AusAID Standard Questions	NHDM docs	AusAID docs	ICR Team analysis	Other
Relevance	• Were the objectives relevant to Australian Government and partner government priorities? • Were the objectives relevant to the context/needs of beneficiaries? • If not, what changes should have been made to the activity or its objectives to ensure continued relevance?	✓	✓	✓	
Effectiveness	• Were the objectives achieved? If not, why? • To what extent did the activity contribute to achievement of objectives?			✓	✓ from Table 1 data
Efficiency	• Did the implementation of the activity make effective use of time and resources to achieve the outcomes? o Was the activity designed for optimal value for money? o Have there been any financial variations to the activity? If so, was value for money considered in making these amendments? o Has management of the activity been responsive to changing needs? o Did the activity suffer from delays in implementation? If so, why and what was done about it? o Did the activity have sufficient and appropriate staffing resources? • Was a risk management approach applied to management of the activity (including anti-corruption)? • What were the risks to achievement of objectives? Were the risks managed appropriately?	✓		✓	
	• Did the activity produce intended or unintended				

Impact	changes in the lives of beneficiaries and their environment, directly or indirectly? • Were there positive or negative impacts from external factors?	✓		✓	✓ From Table 1 data
Sustainability	• Do beneficiaries and/or partner country stakeholders have sufficient ownership, capacity and resources to maintain the activity outcomes after Australian Government funding has ceased? • Are there any areas of the activity that are clearly not sustainable? What lessons can be learned from this?	✓		✓	✓ From Table 1 data and NHDM Handover Workshop
Gender	• What were the outcomes of the activity for women and men, boys and girls? • Did the activity promote equal participation and benefits for women and men, boys and girls? o Did the activity promote more equal access by women and men to the activity benefits, and more broadly to resources, services and skills? o Did the activity promote equality of decision-making between women and men? o Did the initiative help promote women's rights? o Did the initiative help to develop capacity (donors, partner government, civil society, etc) to understand and promote gender equality?	✓		✓	✓ From Table 1 data
M&E	• Does evidence exist to show that objectives have been achieved? • Were there features of the M&E system that represented good practice and improved the quality of the evidence available? • Was data gender-disaggregated to measure the outcomes of the activity on men, women, boys and girls? • Did the M&E system collect useful information on cross-cutting issues?	✓		✓	✓ From Table 1 data
Analysis & Learning	• How well was the design based on previous learning and analysis? • How well was learning from implementation and previous reviews (self-assessment and independent) integrated into the activity?	✓		✓	✓ From Table 1 data
Lessons	• What lessons from the activity can be applied to (select as appropriate: further implementation/designing the next phase of the activity/applying thematic practices [i.e. working in partner systems/environment/fragile stages] to the rest of the program/designing future activities).	✓		✓	✓ From Table 1 data

3. Questions for NHDM main stakeholder/informant groups

3.1 PCI Management – Jakarta

Format: Interview

To be compiled following initial Jakarta discussions

3.2 NHDM Project Management, Nabire

Format: Interview

1. Overall assessment of NHDM
    - What have been the (2 or 3) most significant accomplishments or contributions?
    - What, if any, have been the main disappointments?
    - To what extent do you feel that NHDM has met its objectives?
    - How was women's participation addressed by NHDM? To what extent has women's participation changed (in government, in communities)?
2. How effective was
    - the MCH component? Strengths/highlights? Weaknesses/disappointments?
    - the Watsan component? Strengths/highlights? Weaknesses/disappointments?
3. What was the NHDM "CBDRM approach"?
    - How/to what extent was CBDRM, MCH and Watsan integrated?
    - How was NHDM CBDRM effective in strengthening village resilience to disasters? Examples?
    - How/to what extent is this likely to be sustained?
4. How effective was NHDM in engaging local govt in supporting CBDRM?
    - What changes have occurred as a result (eg. in approach, systems, behaviour, conditions)?
    - Which level of government (district, sub-district, village) has benefitted the most from NHDM? How/why?
    - How has SATLAK/SATKORLAK (or the new structure under the DM Law) benefited?
    - How/to what extent are the changes within local government likely to be sustained?
    - Does the district government now have sufficient capacity to monitor NHDM initiated Health and DRM activities into the future?
5. What did you find are the factors that contribute to successful CBDRM?
    - What are the inhibiting or constraining factors?
    - What were the main difficulties in implementing CBDRM in remote areas?
    - Do the remote area outcomes justify the effort required?
    - What are the main lessons from NHDM's experience with CBDRM that may be applicable elsewhere?
6. Thinking about both the design of NHDM and its implementation, what would you do differently next time?

3.3 NHDM Field staff

Format: Workshop or FGD (to be discussed)

Field staff preparation and role

1. What preparation did you get for your role?

- Was it sufficient?
- Did you feel confident and sufficiently skilled in facilitating village processes?
- What was the most significant change you experienced in your own capacity in undertaking the role?

2. What other skills or experience would have made your work even more effective?

Effectiveness of village processes

3. What did you find were the most effective ways to work in villages to bring about change?
    - What was the level of interest in your work and extent of participation by villagers?
    - What was the level of participation by women? … by young people?
4. What were the most significant changes that you are aware of as a result of the NHDM work? Were these changes in knowledge, attitudes, or behaviours?. Why have you chosen them as the most significant?
    - What was the most effective part of the work done in the villages – MCH or watsan or CBDRM? Why?
    - What parts of the work were less successful? Why?
    - How were these components integrated/linked together in the work that you did?
    - How effective was CBDRM work in strengthening village resilience to disasters?
    - How effective were government agencies in supporting your work in villages?
5. To what extent do you think that the changes will persist after NHDM?
    - How/why?
    - Are there 'village champions' for the changes?
    - Are leaders committed to the changes?, etc
6. What do you think are the most important factors that …
    - support long-term change in villages in CBDRM and health?
    - limit the possibilities for change?
7. What would you do differently next time (especially to strengthen CBDRM in villages and improve its sustainability)?
8. Are there any other things that you have learnt in working for positive changes in CBDRM and health in villages?

3.4 Senior Nabire District Dinas staff

Format: Group interview/discussion

1. What have been the most significant things about your relationships with NHDM?
    - What has your dinas gained from its relationship with NHDM?
    - What do you think have been the strengths of NHDM's work with you?
    - How effective was NHDM in engaging with you in its health/CBDRM work?
    - Have there been some difficulties?
    - What do you think will remain in place after NHDM? What will be able to continue? How? (eg. resources. inclusion in work plans, etc)

- Has the capacity of your office to carry out its work changed ? Are there things that you do differently in your dinas now as a result of NHDM?
- Has your ability to provide health services/respond to a disaster changed? How/why?

2. In terms of NHDM's effectiveness, especially in their work with your dinas, what would you do differently next time?
3. What was your view of NHDM's "CBDRM approach" and its integration with MCH/Watsan?
    - How effective do you think that NHDM CBDRM has been in helping strengthen village resilience to disasters?
    - What will be necessary for this to be sustained?
4. What do you think are the most important factors that contribute to successful CBDRM?
    - What are the main constraints
    - What are the main lessons about CBDRM/supporting village health that come from the experience of NHDM?
5. What are the issues involved in implementing remote area CBDRM?
    - What are the benefits? Do these justify the effort required?

3.5 Dinas field staff engaged in NHDM activities

Format: Workshop or FGD (to be discussed)

1. What have been the most significant things about your relationships with NHDM?
    - What have <u>you</u> gained from your relationship with NHDM?
    - What has your dinas gained from its relationship with NHDM?
    - What do you think have been the strengths of NHDM's work with you?
    - How effective was NHDM in engaging with you in its health/CBDRM work?
    - Have there been some difficulties?
    - What do you think will remain in place after NHDM? What will be able to continue? How? (eg. resources. inclusion in work plans, etc)
    - Has the capacity of your office to carry out its work changed ? Are there things that you do differently in your dinas now as a result of NHDM?
    - Has your ability to provide health services/respond to a disaster changed? How/why?
2. What were the <u>most significant changes</u> in villages that you are aware of as a result of the NHDM work? Were these changes in knowledge, attitudes, or behaviours?. Why have you chosen them as the most significant?
    - What was the most effective part of the work done in the villages – MCH or watsan or CBDRM? Why?
    - What parts of the work were less successful? Why?
    - How were these components integrated/linked together in the work that you did?
    - How effective was CBDRM work in strengthening village resilience to disasters?
    - To what extent do you think that the changes will persist after NHDM? How/why?

- Are there 'village champions' for the changes? Are leaders committed to the changes?, etc

3. What do you think are the most important factors that …
    - support long-term change in villages in CBDRM and health?
    - limit the possibilities for change?
4. What would you do differently next time (especially to strengthen CBDRM in villages and improve its sustainability)?
5. Are there any other things that you have learnt in working for positive changes in CBDRM and health in villages?

3.6 Village men, women, and youth in NHDM villages (separate meetings)

Format: Workshop or FGD (to be discussed) for separate groups of women, men, youth

1. Has life been different in the village since the earthquakes (or the same)?
2. What other kinds of events have a big effect on village life (ie. other kinds of "disasters" eg floods, fire, drought, animal/plant pests, etc)?
3. How has the village dealt with events such as these in the past?
4. Has it been different in any way since NHDM (or whatever it is that might identify the period of the NHDM activities) started?
    - Have there been any changes
    - What kind of changes eg. in facilities, behaviour, organisation, etc
    - Have there been any changes in health services? What has happened?
    - Have there been any changes in how you prepare for future events such as earthquakes or other possible disasters? What has happened? What do you do differently now?
    - How does the village make decisions about changes such as this (eg. what is the role of the VC)?
5. In all the changes that have happened since NHDM started, What have been the most significant changes (or most important benefits) in that time?
    - Why are these the most significant?
    - What will continue when NHDM finishes? How?
    - What are the things that have made these kinds of changes easier?
    - What things have made them hard to do?
    - If you had a chance to start the work with NHDM again, what would you do differently next time?
    - What are the most important things that you have learnt, especially about preparing for possible disasters?
6. Have there been changes in the ways that local government (kabupaten, kecematan, desa) support your efforts to improve village health services and CBDRM?
    - Are they more aware of your needs and more responsive?
    - Is the community now able to "demand" better performance by local government?
7. Do women participate actively in village decision making?

- How?
- Has this always been the case?
- Has NHDM's work affected this in any way?

3.7 Other informants (PRIME-Oxfam, Local NGOs, other donors/projects, etc)

Format: Interview

Questions to be selected for use as appropriate with different informants.

1. What has been the purpose and duration of your relationship with NHDM?
2. What have been the most significant things about your relationships with NHDM?
    - What has your organisation and staff gained from its relationship with NHDM?
    - What do you think have been the strengths of NHDM's work with you?
    - How effective was NHDM in engaging with you in its health/CBDRM work?
    - Have there been some difficulties?
    - What do you think will remain in place after NHDM? What will be able to continue? How?
    - Has the capacity of your office to carry out its work changed ? Are there things that you do differently now as a result of NHDM?
    - Has your ability to provide health services/respond to a disaster changed? How/why?
3. What were the <u>most significant changes</u> in villages that you are aware of as a result of the NHDM work that you have been involved in? Were these changes in knowledge, attitudes, or behaviours?. Why have you chosen them as the most significant?
    - What was the most effective part of the work done in the villages – MCH or watsan or CBDRM? Why?
    - What parts of the work were less successful? Why?
    - How were these components integrated/linked together in the work that you did?
    - How effective was CBDRM work in strengthening village resilience to disasters?
    - To what extent do you think that the changes will persist after NHDM? How/why?
    - Are there 'village champions' for the changes? Are leaders committed to the changes?, etc
4. What do you think are the most important factors that …
    - support long-term change in villages in CBDRM and health?
    - limit the possibilities for change?
5. What do you think should be done differently next time in working in such a project?
6. Are there any other things that you have learnt in working with NHDM for positive changes in CBDRM and health outcomes in villages?

7. Has Local Government (district – executive and legislative, sub-district, village) demonstrated support for the NHDM work? How does it compare to their support of other programs such as KDP, PNPM?
8. How did you address the need to increase women's participation in the NHDM work in which you were involved?
9. What is the significance of NHDM's role in supporting the development of CBDRM and health services in Nabire? In the wider context of Papua?

For PRIME/Oxfam

1. What is the PRIME-Oxfam "CBDRM approach"?
2. How does their CBDRM approach involve integration with MCH/Watsan and other community development elements?
3. How does it intend to engage local govt in DRM?
4. From PRIME/Oxfam's experience:
    - what are the factors/elements that contribute to successful CBDRM?
    - what are the main inhibiting/constraining factors?
    - What do you think are the most effective ways of conducting CBDRM?
    - What are the issues/benefits involved in implementing remote area CBDRM?

4. Some issues for the evaluation identified prior to the field visit

Issues for the evaluation to consider are primarily those articulated in the Terms of Reference and subsequently summarised in the evaluation questions derived from the TOR. In terms of the main requirements of the TOR – namely, to assess the effectiveness of the CBDRM approach adopted by NHDM – the most significant questions to be answered are:

- What did the NHDM "CBDRM Approach" entail and how effective was it in:
    - strengthening village preparedness for and resilience to disasters?
    - engaging local govt in CBDRM?
    - building sustainability into both these aspects of the work?
- What are the most effective ways of conducting CBDRM and what are the factors that contribute to and constrain successful CBDRM? In particular:
    - did the NHDM CBDRM approach involve a truly "bottom-up" strategy for engagement with village communities?
    - was it a holistic, community development approach or a DRM focus grafted on to health strengthening and Watsan strategies?
- What are the lessons from NHDM, particularly those relevant to the use of CBDRM approaches in other places?
- What are the difficulties and benefits related to implementing remote area CBDRM and what are the trade-offs involved?
- What contribution has NHDM made to the AIP DRM Plan?

Related issues for investigation include:

- What difficulties were encountered in getting traction for DRM within Nabire communities and local government and how was this addressed?

- What can NHDM tell us about effective approaches to CBDRM or effective integration of DRM with other community development activities?
    - what sort of integration was involved with MCH and WatSan (processes and content)?
    - How effective was this?
    - what precedents/experiences for CD/DRM integration exist in other places (Indonesia and elsewhere)? eg. EMA (Australia); LANGOCA (Laos)
    - What are the main factors in effective approaches to CBDRM in Nabire? How generalisable are these?
- What has been the effect of GoI DM Law 24/2007; the subsequent slow establishment of BNPB and the new district BPBDs; and the resulting effect on SATLAK and SATKORLAK? Also, is local government aware on the need to provide stronger legislation and ready to provide increased political and budgetary support for Disaster Risk Reduction and CBDRM ?
- If the main focus of NHDM was on DRM, why was only ~30% of the project funds spent on this?
- What kinds of disasters are known to occur in Nabire? What are the connections between specific “disasters” and poverty? What defines vulnerable house holds and communities in Nabire?
- What are the effects of “remoteness” on CBDRM outcomes in Nabire? Specifically, on:
    - “provision” of CBDRM
    - commitment to CBDRM and the responses of communities
    - effectiveness
    - likely sustainability (given the intermittent nature of most disasters, the approach must have built in mid/long-term sustainability otherwise it’s a waste of effort)
- Marginal community as the main actors - The poorest and most disadvantaged (children, disabled, women, elderly) are the most affected by disasters. To what extent has NHDM, particularly through its CBDRM component, worked to increase the capacity and reduce the vulnerability of the most disadvantaged?

Attachment 3: List of Informants and Documents

(a) Itinerary and List of Informants

Summary of in-country itinerary

Date	Location	Activity
Sun 06/09	Jakarta	Team arrived in the evening at Jakarta, Aryaduta Hotel
Mon 07/09	AusAid Office Kebon Sirih, Jakarta	Meeting with AusAID on the idea of NHDM-ICR with Initiative Manager, DRM's Advisor, DRM Program Manager, NHDM Activity Manager & Patricia Bachtiar. Meeting with PCI Jakarta (Pak Iskandar and dr. Agustini).At 21.00- Flight to Nabire, Papua.
Tue 08/09	Biak / Nabire	Arrived Biak at 05.30 stay in Hotel Irian, Biak. At 14.14-Flight to Nabire by Merpati. Arrived Nabire at 16.10, stay at Hotel Nusantara and Anggrek. Discussion with Senior Management Staff of NHDM at PCI Nabire Office
Wed 09/09	Nabire, Auditorium of the local RRI.	Workshop attended by Bupati and Head of Legislator and all Head of Government offices in Nabire, Head of Districts, Head of Kampung, NGO leaders, Oxfam, etc.
	PCI Office	Meet with PCI Nabire filed staff
Thu 10/09	Bappeda Nabire Office	In-depth interview with Senior Officers of Nabire District Officers and decision makers also Oxfam in the evening
	PCI Office	• Meet with the newly appointed Head of BPBD • Meet with local NGOs (LSPK, Primari)
	Hotel Nusantara	Meet with Oxfam Coordinator for Papua (Leny Veronika)
Fri 11/09	Field visit to 5 Kampung	Field visits and discussions with community members and village leaders of Gamey Jaya, Marga Jaya (Team A), Makimi, Air Mandidi and Kimi.(Team B)
Sat 12/09	Field Visit to 4 Kampung	08.00 leaving Hotel went to Villages: Gerbang Sadu, Waroki, (Team A) Yaro Makmur, Wiraska (Team B). returned at 15.30
	PCI Office	Wrap up meeting with PCI Nabire
Sun 13/09	06.10 Flight leaving Nabire for Biak.	07.30 Arrive in Biak Airport. Stay at Hotel Irian, Biak. 10.00-16.00 Preliminary drafting of findings. 19.30 Dinner with "RESPEK" Monitoring Mission Team
Mon 14/09	09.15 Flight Biak-Jakarta	Depart to Jakarta. Arrived Jakarta early evening, continue working on the Aide Memoire.
Tue 15/09	08.30 at AusAid, Jkt.	Drafting Aide Memoire
Wed 16/09	Jakarta / travel 'home'	09.00 Continue discussion on the draft of the Aide Memoire 14.00-16.30 Presentation of Aide Memoire to AusAID

List of persons consulted

Date	Name	Gender	Position	Agency/Org.	Meeting Location
Mon 07/09/2009	Santi Handayani	F	NHDM Activity Manager	AusAID	AusAid Office of Kebon Sirih, Jakarta 7 respondents (4 Female 3 Male)
	Jeong Park	M	DRM Advisor		
	Eko	M	DRM Senior Program Mgr		
	Patricia Bachtiar	F	Program Manager for Papua		
	Endang Dewayanti	F	DRM Program Manager		
	Isklandar	M	Director	PCI	
	Dr. Agustini Lamusu	F	Health Advisor		
Tue 08/09/09	Adji Setioprojo	M	Director	PCI	PCI Office, Biak (6 Male respondents)
	Hamranuddin	M	Watsan Assistant Specialis		
	Noor Dwiantoro	M	MCH Assistant Specialist		
	Teguh Prihatoro	M	CBDRM Specialist		
	Krisna Tohariadi	M	Assistant Specialist HIV/		
	Wilson Rumanium	M	Junior Site Supervisor		
Wed 09/09/09	Hendrik Kaisiepo	M	Bupati	District Govt.	At the Auditorium RRI Nabire 50 respondents (18 Female 32 Male)
		M	Head of Legislature		
	Peter Eltari		Head of Planning Bureau		
	Jerry Ramandae	M	Head of Social welfare		
		M	Head of PDAM		
	Norbertus Mote	M	Camat of West Nabire		
	Sem Sihi	M	Head of BPBD		
	Almond Rumatrai	M	Head of Section at BPMK		
	Daniel Maipon	M	Camat of Nabire		
	Levina Niwari	F	Head of Kalibobo		
	Usman Pambayo	M	NGO-PRIMARI		
	30 Representatives	M	30 Head of Kampungs		
	Leny Veronica	F	PRIME	Oxfam	
Wed 09/09/09 evening	Johana	F	Field Technician	NHDM	At the NHDM Office 7 Female respondents
	Emiliana	F	Field Facilitator		
	Linda	F	Field Facilitator		
	Aquilla	F	Junior Supervisor		
	Ibox	F	Field Facilitator		
	Menna	F	Field Technician		
	Laura	F	Field Facilitator		
Thurs 10/09/2009	Magdalena Arronggear	F	Women Empowerment & Popul	PP&K	Bappeda Office 8 respondents (2 Female 6 Male)
	Orpa Sayuri	F	Social Cultural	Bappeda	
	Edward	M	Road Construction	P.Work	
	Abbas	M	Program and Reporting	Educatin	
		M	Head State water Authority	PDAM	
	Amond Rumatrai	M	Head of Business Desk	BPMK	
	Mulyadi	M	Administration	Health O	
Thurs 10/09/2009	Lukas	M	Field Facilitator	Yabimu	At the NHDM Office
	Usman	M	Administration	Yabimu	

Date	Name	Gender	Position	Agency/Org.	Meeting Location
	Octo	M	Firld Program	Yabimu	5 respondents (1 Female 4 Male)
	Iin Iriani	F	Director	LSPK	
	Usman Fambanyo	M	Program Manager	Primari	
Thurs evening	Leny Veronica	F	PRIME coordinator, Papua	Oxfam	Hotel Nusantara
Friday 11/09/2009	Timotius Yupee	M	Head of Kampung	Gamey Jaya Community	At the Village Office Of Gamey Jaya (29 respondents) (10 Female and 19 Male) The name of women participants were not identified
	Titus Jumari	M	Farmer – Cadre-Transmigrant		
	Daniel Makae	M	Farmer – Cadre-Teacher		
	Supandi	M	Farmer –Cadre		
	Sudarno	M	Farmer-Transmigrant		
	Anton	M	Local People-Assist Teacher		
	Imron	M	Farmer-Cadre-Transmigrant		
	Jainuri	M	Farmer-Transmigrant		
	Sungkono	M	Farmer-Transmigrant		
	Junus	M	Farmer-Transmigrant		
	Jonas Dodian	M	Farmer-Local People		
	Julia	F	Women –Cadre		
	Monica	F	Women- Cadre		
Friday afternoon at Marga Jaya	Yulianus	M	Village Apparatus	FDG for the Men Group of Marga Jaya Community	At the Village Office of Marga jaya (14 Male and 16 Female respondents) 30 attendents
	Kusran	M	Water Technician		
	Yan Mote	M	Head of Village/Local People		
	Aznan	M	Village Apparatus-Trans		
	Suparno	M	PKK Section- Trans		
	Frans Sumbawi	M	Head of Neighborhood-Trans		
	Gunarto	M	Head of Neighborhood-Trans		
	Sodikin	M	Village Team-Trans		
	Susilo Sudarman	M	Village Team-Trans		
	Anwar Yusuf	M	Head of Neighborhood-Trans		
	Sukardi	M	Farmer- Transmigrant		
	Sunardi	M	Farmer-Transmigrant		
	Sunanto	M	Farmer-Transmigrant		

Date	Name	Gender	Position	Agency/Org.	Meeting Location
	Sumarno	M	Farmer-Transmigrant		
	Dalilah	F	PKK (women group) - Cadre		
	Ria	F	PKK – Cadre		
	Beti	F	PKK – Cadre		
	Hartini	F	PKK – Cadre		
	Warsini	F	PKK – Cadre		
	Teresia	F	Teacher		
	Magdalena	F	Head of PKK Cadre		
	Tafriati	F	PKK – Cadre		
	Ermince	F	PKK – Cadre		
	Komariah	F	PKK – Cadre		
	Musrihah	F	Posyandu Cadre		
	Rita	F	Desa Siaga (Prepared Village) – Cadre		
	Siti Komariah	F	Desa Siaga – Cadre		
	Lesmina	F	PKK – Cadre		
	Usmali	F	Posyandu – Cadre		
	Sumaryati	F	Posyandu - Cadre		
Sat 12/09/2009	Yusak Ogipo	M	Farmer-Local People	Men and Women of Gerbangsadu Community	At the Village Office of Gerbangsadu (10 Male 3 Female respondents)
	Moses	M	Farmer-Local People		
	Alex	M	Farmer-Local People		
	Osong Oligau	M	Farmer-Local People		
	Pius Kayus	M	Farmer-Local People		
	Daniel	M	Farmer-Local People		
	Marie Ogipa	F	Women-Local People		
	Ayub	M	Farmer-Local People		
	Damianus	M	Farmer-Local People		
	Hem	M	Farmer-Local People		
	Julius	M	Farmer-Local People		
	Thomas	M	Farmer-Local People		
	Magda	F	Farmer-Local People		
	David	M	Farmer-Local People		
	Natalis	M	Farmer-Local People		
	Lezia Songgonao	F	Women – Cadre-Local people		
	Ramanday	M	Farmer-Cadre-Local People	Community Members of Waroki	Village Office of Waroki
	Rumayumi	F	Farmer-Local People		
	Stephanus Wouda	M	Farmer-Local People		

Date	Name	Gender	Position	Agency/Org.	Meeting Location
	Veronica	F	Farmer-Local People		7 respondent (3 Female and 4 Male)
	Getty	F	Farmer-Local People		
	Lince	F	Farme-Local Peopler		
	Ayer Dougby	M	Farmer-Local People		
	Paulus Dougby	M	Farmer-Local People		
Wed 16/09/2009	Presentation of The Aide Memoire by The ICR Consultants	F M	AusAid Program and Project Staff	AusAID	Kebojn Sirih (16= 8F/8M Attendants)
Mon 28/09/2009	Iman	M	Community Radio Specialist fpr Biha Village, Subdistrict of Makimi, Nabire	Indonesia Network of Community Radio (JRKI)	At The SATUNAMA, Yogyakarta.

(b) List of Documents Consulted

a. Project Proposal
b. Annual Plan and Report
c. Quality at Implementation (QAI) Reports
d. First Year Review Report
e. Six-monthly Progress Reports
f. Draft Activity Completion Report, including the Logframe and Risk Management Matrix
g. Draft AIP Disaster Risk Management Sector Plan and Performance Assessment Framework (PAF) 2008-2013
h. Indonesia National Action Plan on Disaster Risk Reduction (NAP-DRR) 2006-2009
i. Australian Government DRR Policy
j. Australia Indonesia Partnership (AIP) Country Strategy 2008-2013
k. Relevant AusAID policies (disaster risk reduction, gender, anti-corruption, partnerships, performance management and evaluation)
l. Attachment to the Law of Republic of Indonesia No. 17/ 2007 on The Long Term National Development Plan 2005 – 2025.

<u>References Related to CBDRM</u>

Boughton, G.1998. "The Community: central to emergency risk management" in The Australian Journal of Emergency Management, vol.13 no.2 Winter 1998.

Kaseje, M. 1992. Community Based Development: A Manual for Facilitators. Henry Dunant Institute, Geneva.

Korten, D.1998. Community-based Natural Resources Management in Asia

Makrey,A. 1998. Module on Community Based Disaster Risk Reduction for CBDM-2, Asian Disaster Preparedness Center, Bangkok.)

Victoria, L.P. “Community Basede Approaches To Disaster Mitigation” theme paper during Regional Workshop on Best Practices in Disaster Mitigation, Bali, Indonesia, September 2002

Attachment 4: Results for NHDM Objective and Output Indicators (September 2009)

Results of NHDM project activities until September 2009. Some data also taken from the KPC survey conducted last May 2009.

Objective 1: Improved capacities for community based MCH.

1. % of birth with trained health providers (target 75%).

Target met. 77.3% of births of children under two were supervised by trained health providers according to the final KPC survey (70.6% - 84% confidence interval).[43]

2. % of fully inoculated children before their first birthday, among children aged 12-23 months (target 50%)

Target met. 53.5% of children aged 12-23 months were fully inoculated before their first birthday according to the final KPC survey (40.6% - 66.4 confidence interval).

3. % of all target villages in which there is a functional partnership between trained midwives and TBA to provide ANC, delivery and PNC (target 50%)

Target not yet met. NHDM observations indicate that 30% of villages (9 villages) have a functional partnership between midwives and TBAs. The lack of midwives in many villages has been a key limiting factor.

Output 1.1. Improved knowledge and skills of first liner government health staff to provide MCH services.

1. % of trained clinical staff of all *Puskesmas* in target area who demonstrate increased knowledge based on results of pre and post tests in trainings that they participate in (target: 90%).

Target met. NHDM facilitated training for *Puskesmas* staff (including midwives) on IPCC, SCD, IMCI, EBF/EBFI and ECCD. 93% of trained *Puskesmas* staff demonstrated increased knowledge (43 of 46 trainees) based on pre and post tests. IPCC average scores increased from 8% to 58%, SCD average scores increased from 69% to 85% and ECCD average scores increased from 55% to 73%. (Scores were not computed on the other trainings, but similar results were likely obtained.)

2. % of midwives who demonstrate increased knowledge based on results of pre and post test in training that they participate in (target: 90 %).

[43] 95% confidence interval.

Target met. NHDM facilitated training for midwives on IPCC, SCD, IMCI, EBF/EBFI and ECCD (a subset of the *Puskesmas* staff above). 97% of trained midwives demonstrated increased knowledge (30 of 31 trainees) based on pre and post tests in SCD/IPCC/ECCD.

Output 1.2 Community based institutions (existing or new ones) are mobilized and strengthened to collaboratively address local MCH problems.

1. # of community MCH plans that are implemented during the project duration (target: 30 villages).

Target met. All 30 villages implemented MCH plans.

2. % of target villages' VCs that are active in subdistrict inter-village meetings, sharing information and lesson learned across their subdistrict and improving communication with local health providers (target: 50%) .

Target met. 100% of village VCs have been active in subdistrict meetings to share information and lessons learned.

3. # of villages that conduct routine monthly *Posyandu* sessions with at least 3 active *Kaders* (target: 30 villages).

Target met. Routine monthly *Posyandu* sessions are held in all 30 villages with at least 3 active *Kaders*. The *Posyandu* have more than the 3 minimum Kaders, with over 5 trained *Kaders* per *Posyandu* on average.

4. % of all children under 5 that were weighed (D/S) in the last 4 months – (target: 70%).

Target not yet met. 61% of children under two were weighed[44] (as confirmed by KMS cards) according to the KPC survey (53.1% - 68.9% confidence interval). Most children are brought to *Posyandu* during their first year of life for immunizations, but *Posyandu* attendance drops off significantly after the first year.

5. % of *Posyandu Kaders* completing KMS correctly 6 months after training (target: 60%).

Target partially met. *Puskesmas* data indicates that 90% of *Posyandu Kaders* are completing KMS correctly, but NHDM's own observations show that this figure is high because the scales are not always set or functioning properly and some new *Kaders* do not properly fill in the KMS correctly. NHDM observations indicate that 40% of *Kaders* understand how to complete KMS card while about 80% of KMS cards are completed properly (because the knowledgeable *Kaders* are assigned to complete the cards.)

6. % of *Posyandu Kaders* using KMS as a basis for counselling mothers (target: 60%).

Target partially met. NHDM found that 40% of *Kaders* use the KMS as a basis for counselling mothers. However, mothers often go to midwives, rather than *Kaders*, for this type of counselling and NHDM

[44] The KPC survey only measured children under two, not under five.

found that 60% of children whose KMS cards indicated they were underweight received counselling from a midwife, nurse or *Kader*.

7. # of VCs representing proportionately the existing ethnic groups and having gender balance (target: 20 VCs).

Target met. The makeup of VCs fluctuate based on different activities (MCH, WATSAN, CBDRM), but overall VCS were proportionately representative. In Papuan villages, the VCs were largely Papuan while in transmigrant villages, the VCs were largely transmigrant. 16 of the water committees included women and 4 *Posyandu* included male *Kaders*.

8. # of villages in which at least one hamlet has established the 4 main components of P4K (target: 30 villages)

Target not yet met. No villages have established all 4 main components of P4K, largely due to the absence of blood-type testing capacity among local Puskesmas. NHDM recently completed agreement with DHO to conduct joint-fund blood-type testing for P4K in June and July 2009 for Nabire Barat sub-district. Total 2,416 person from 4 villages under Nabire Barat sub-district had been tested their blood type. 15 villages have established systems to track pregnant women, 9 villages have established personal or group savings for pregnancy and 10 villages have identified transportation options for pregnancy complications.

Objective 2: Sustainable behavioural change for improved MCH among caretakers.

1. % mothers with good feeding practises for children 0-23 months (target: 50%).

Target not yet met. 31.5% of mothers of children under two practised good feeding practises according to the KPC survey (23.5% - 39.4% confidence interval).

2. % of infants 0-5 month old children who were exclusively breastfed in the last 24 hours (target: 50%).

Target not yet met. 29.8% of children 0-5 months were exclusively breastfed in the last 24 hours according to the KPC survey (21.9% - 37.7% confidence interval). Bottle feeding is very common in Nabire.

3. % of mothers 0-23 month old children who immediately breastfed their newborns within the first hour of birth (target: 50%).

Target not yet met. 39.3% of children under two had been immediately breastfed according to the KPC survey (31.4% - 47.2% confidence interval).

4. % of children 0-23 month old children with diarrhoea who were given the same amount or more food and fluids during their diarrheal episode (target: 60%).

Target met. 62.5% of children with diarrhoea were given the same amount or more of food and fluids according to the KPC survey (42.6% - 70.4% confidence interval).

5. % of 0-23 month old children in all 30 villages that slept under ITN during the previous night (target: 85%).

Target not yet met. 58.0% of children under two slept under an ITN during the previous night according to the KPC survey (50.1% - 65.9% confidence interval). Although the target has not yet been met, the result indicates a substantial and significant increase over baseline (3.7%) and NHDM completed to distribute ITNs to all 30 kampongs..

6. % of adults reporting a willingness to acknowledge that someone in the family is HIV positive (target: 69.7% - increase of 20% over baseline).[45]

Target apparently not met. 44.3% of adults reported a willingness to acknowledge that someone in the family was HIV positive according to the KPC survey (37.6% - 51% confidence interval). This result may have been corrupted by confusion over the meaning of the question during the baseline survey.

7. % of adults reporting a willingness to care for a family member who is HIV positive (target: 81.7% - increase of 20% over baseline).[46]

Target apparently not met. 48.1% of adults reported a willingness to care for a family member with HIV according to the KPC survey (41.3% - 54.9% confidence interval). This result may have been corrupted by confusion over the meaning of the question during the baseline survey. Among mothers of children under two (as opposed to the general population), there was a significant increase over baseline (from 26% to 44%).

8. % of adults reporting the use of a condom during the most recent act of sexual intercourse with a non-regular sex partner (target: 24% - increase of 10% over baseline).[47]

Target apparently met. 40% of adults reported using a condom during the most recent act of sex with a non-regular partner. However, the denominators in both the baseline and endline surveys were too small to allow conclusive results.

Output 2.1. Increased knowledge and skills about recommended key health behaviours and safe motherhood issues among care-givers.

1. % of mothers/caretakers who know at least two danger signs of childhood illness that indicate a need for treatment by a health provider (target: 75 %).

Target not yet met. 59.7% of mothers know at least two danger signs of childhood illness that indicate a need for treatment according to the KPC survey (55.9% - 63.5% confidence interval).

[45] Baseline was 58.1%.

[46] Baseline was 68.1%.

[47] Baseline was 21.9%.

2. % of mothers/caretakers who know at least two danger signs during pregnancy (target: 75%).

Target not yet met. 56.0% of mothers knew at least two danger signs during pregnancy according to the KPC survey (confidence interval: 48.1% - 63.9% confidence interval). Although the target has not yet been met, the result was a substantial and significant increase over baseline (25.7%).

3. % of households in all 30 villages that are using ITNs (target: 85%).

Target not yet met. 62.0% of households used ITN during the previous night according to the KPC survey (54.2% - 69.8%% confidence interval). Although the target has not yet been met, the result was a substantial and significant increase over baseline (3.7%) and NHDM completed to distribute ITNs to all 30 kampongs.

4. % of mothers of children 0-23 months who know the correct ways to dispose of children's faeces (target: 80%).

The KPC survey measured reported practise, not merely knowledge. For results, see Objective 3, Indicator 2.

5. % of mothers and primary school children who are able to describe four critical times for washing hands with soap (target: 70%).

Target partially met. School hygiene contest results indicate that at least 70% of primary school children were able to describe the four critical times. Mothers were not formally measured because the KPC survey measured reported practise, not merely knowledge. (See Objective 3, Indicator 3.)

6. % of mothers and primary school children who are able to describe the hygienic ways they treat water for family consumption (target: 70%).

Target met. 81.0% of mothers of children under two reported that they treated water in hygienic ways (74.7% - 87.3% confidence interval).

7. % of adults with no incorrect beliefs about HIV transmission (target: 28% - increase of 30% over baseline)[48]

Target met. 33.6% of adults had no incorrect beliefs about HIV transmission according to the KPC survey (27.2% - 40% confidence interval). Among mothers of children under two (as opposed to the general population), the result is even more significant – increasing from 6.8% to 36.7%.

Objective 3: Improved access and behaviours related to clean water supply and sanitation facilities.

[48] Baseline was 21.8%

1. % of households in target villages using a protected water supply for consumption from sources within less than 100 metres of their homes (target: 70%).

Target met. At least 75% of households in all 30 villages use a protected water supply for consumption from sources within less than 100 metres of their homes. This represents a significant improvement in access to protected water supply.

2. % of household that dispose children faeces in the toilet or covered disposal (target: 80%).

Target not yet met. 60.3% of mothers of children under two disposed of child's faeces in the toilet or a covered disposal according to the KPC survey (56.5% - 64.1%). The lack of latrines for many households was a key limiting factor. NHDM initially employed the CLTS (no-subsidies) approach for CLTS construction but this approach was not successful and NHDM began providing material support for latrine construction in Year 3, which increased latrine construction.

3. % of households reporting the habit of washing hands with soap before feeding children, preparing food, after defecation and attending children who have defecated (target: 70%).

Target not yet met. 6% of mothers of children under two reported that they washed their hands during all four critical times according to the KPC survey (2.2% - 9.8% confidence interval). While many mothers reported washing hands after some activities (such as defecating), few washed hands regularly at all four critical periods. Although well below the target, the result does represent a significant increase over baseline (2%).

4. # of villages with water committees that have women in leadership (decision making) positions (target: 15 villages).

Target met. Women were directly involved in WATSAN decision-making in all 26 villages in which NHDM facilitated construction of water supply facilities and 4 village WATSAN committees were chaired by women. Women also participated in WATSAN training in 23 villages.

Output 3.1 Protected community clean water supply systems are constructed including facilities for schools and health facilities

1. **#** of villages with year round functioning water supply systems constructed/ rehabilitated on a self-help basis with NHDM assistance (target: 26 villages).

Target met. 26 villages have year round functioning water supply systems constructed or near completion on a self-help basis with support from NHDM. The other four villages in NHDM already had gravity-fed systems (three being built by Public Works and one previously built by PCI's earlier project in Nabire).

2. % of primary schools and first-line health facilities with year round access to clean water facilities (target: 100%).

Target partially met. 80% of schools and health posts have year round access to clean water and Public Works informed NHDM that they want to handle remaining villages.

Output 3.2 Sanitation facilities to prevent open defecation are constructed including for schools and health facilities

1. # of villages with sanitation facilities constructed/ rehabilitated on a self-help basis with NHDM assistance (Target: 30 villages).

Target met. All 30 villages have constructed household latrines using their own donated labour and locally available materials. NHDM stopped the CLTS "no subsidies" approach because the method was not working in Nabire to trigger latrine construction, but communities were still required to donate their labour and available local resources (such as sand). (NOTE: An additional CLTS-specific indicator was deleted because CLTS was not continued for latrine construction.)

2. % of primary schools and first-line health facilities with access to sanitation (target: 100%).

Target partially met. 80% of schools and health posts have access to sanitation and Public Works and Education Office informed NHDM that they want to handle remaining villages.

Objective 4: Improved capacity for risk reduction and emergency preparedness among affected communities and local authorities

1. % of villages that successfully stage a disaster simulation exercise (target 80%).

Target met. 100% of villages successfully staged a disaster simulation exercise.

2. Incidence and quality of village CBDRM plans.

Target met. 30 villages successfully completed CBDRM assessment planning processes and 28 have developed proposals to NHDM for funding of small-scale disaster mitigation plans. To date, 28 mitigation plans have been implemented and 2 more are in progress, with the remaining under review by Public Works.

Output 4.1 Increased capacity of families and villages to develop and implement community-based disaster risk management programs (CBDRM)

1. # of VCs that demonstrate increased knowledge and improved practises (target: 30 VCs).

Target met. 30 VCs have demonstrated increased knowledge/ skill on CBDRM.

2. # of villages that implement appropriate community disaster mitigation plans (target: 30 villages).

Target not yet met. 28 villages have completed community disaster mitigation plans and 2 villages have begun to implement their mitigation plans.

3. % trained students demonstrating improved knowledge and practises (target: 75 %).

Target met. Over 75% of students demonstrated improved knowledge about appropriate disaster preparedness practises in focus group discussions and contests facilitated by NHDM.

4. # of subdistrict workshops to share information on jointly felt CBDRM needs and objectives (target: 7 subdistricts).

Target met. 7 subdistricts were facilitated in multiple workshops to share information on CBDRM.

Output 4.2 District government authorities accept and support the community-based disaster risk management approach.

1. % relevant government sectors (health, police, social, education, administration, etc.) participating in community based CBDRM activities and trainings (Target: 75%).

Target met. 100% of relevant government sectors were involved in CBDRM activities such as school disaster simulation exercises, first aid trainings and CBDRM planning.

Attachment 5: NHDM ICR Review Aide Memoire

Aide-Memoire - Independent Completion Report (ICR) mission
Nabire Health And Disaster Management (NHDM)
16th September 2009

Background

- NHDM commenced in October 2006 and, following a 3 month "no cost" extension will conclude in December 2009
- Design included three components – MCH, Watsan and CBDRM. The over-arching purpose was intended to be CBDRM although this was not reflected in the structure of the project's goals and objectives (G1 MCH/Watsan; G2 CBDRM; O1&2 MCH; O3 Watsan; O4 CBDRM)
- The project was considered by AusAID as a trial of CBDRM methodology (cf DRR, CBDP, etc)
- The main focus of this review was deriving lessons learned from the CBDRM implementation (TORs) and how MCH/Watsan was integrated with CBDRM

Main Findings

Relevance of design

Findings

- Relevant to the AusAID Country Strategy – sector (health, HIV, DRR) and geographic focus (Country Strategy No.4 and Strategic framework Pillar No.2, 4)
- Relevant to the Nabire Kabupaten Regional Development Strategy, especially to components 2, 3 and 4 (These are: 2. Recovery/ reconstruction in response to the 2004 earthquakes; 3. Increasing quality and quantity of HR development; 4. Increasing government services in (a) primary health care; (b) reducing disease transmission; (c) reducing morbidity and mortality; (d) increasing self-reliance of households especially with respect to food and nutrition).
- Able to fulfil some of the perceived needs/improve living situations of some households within the 30 project target villages through Watsan, MCH (including HIV), CBDRM components.

Issues/lessons

- Three distinct "sectors" with separate objectives meant that integration within an overall CBDRM framework was difficult to describe and to implement.
- Given the overall task, the NHDM logframe and DIP were rigidly specified with too many indicators and restricted flexibility
- The DIP was completed before sufficient 'on ground' assessment at the beginning of implementation. Thus, it was developed mainly from the existing project proposal rather than current needs within staff, communities, government, NGOs.

- CBDRM is, essentially, a community development (CD) process but the design 'structure' was too rigid to allow sufficient flexibility and too heavily focussed on disaster responses and preparedness while comparatively weaker on vulnerability and hazards analysis.

NHDM needed to use a sound CD process based on the principle that every community is unique (ie. has its own identity and capacities for self-reliance). Unintentionally, it is likely that the project structure and the pre-determined intervention models utilised by NHDM undermined these principles.

In CD processes that are essential in CBDRM, consideration of the most appropriate 'Form of Aid' is important (project; program; partnership/cooperation agreement; facility; Sector-wide Approach, etc). In particular, the inflexibility of a project structure is often inappropriate.

Effectiveness

Overall, the project has been very effective in delivering planned outputs. It also appears to have made a substantial contribution to community capacity building in many of the targeted villages. Nevertheless, some villages have struggled to make progress, particularly where there is weak or bad local leadership.

Findings and issues are briefly summarised below by project component.

1. MCH

Findings

The MCH component included activities designed to strengthen village and kecamatan health facilities (polindes; puskesmas; and posyandu - sometimes providing materials for communities to repair existing buildings or construct new ones); training of 'front line' health workers (mid wives; posyandu kaders; TBAs); and to introduce a number of MCH 'intervention models' such as RUSF; ECCD; desa siaga; ITN; SCD, etc.

The NHDM MCH work probably benefited from PCI's previous health sector work in Nabire and, while occasional opposition was encountered by NHDM staff, NHDM data for MCH-related project indicators shows that, with only a few exceptions, the objectives have been achieved (in particular, available information suggests that the ITN program has had a dramatic effect in reducing malaria incidence.

In general, implementation proceeded smoothly but, on occasions (usually in Papuan-majority villages), some elements of the MCH programs were not readily accepted. This included male opposition to women's participation in activities; opposition to exclusive breast feeding because of conflict with traditional practices; and contributions to a community fund for health services for pregnant women. The last issue limited efforts to establish 'desa siaga' in a number of villages and, overall, this facility met with only limited success.

Health service referrals (eg. to hospital) can only be provided by midwives. This disadvantages people in villages without a resident or easily accessible midwife. The project is currently discussing with government whether kaders trained by the project can also be given responsibility for referring people in need.

The MCH component :

- was an important entry point for community engagement for the whole NHDM implementation

- was important in community mobilisation, especially through the work of the kaders (three of whom were male)
- was important in mobilising women's participation in village communities and
- was successful in bringing about the beginnings of behaviour changes towards healthier practices
- provided a connection between kabupaten and kecamatan government, communities, NHDM and local NGOs.

Issues/lessons

No outstanding issues at this stage

2. Water and sanitation

Findings

Amongst villagers this was the most tangible and the most popular component. It included a range of water supply options (water catchment management and protection; gravity fed reticulated water supply systems; HH water tanks; dug-wells); CLTS; latrines. In most cases, NHDM provided materials and technical assistance and communities provided labour and local materials.

All latrine construction consisted of two-chamber septic systems, an improvement over earlier pit-toilet designs. However, these will require periodic inspection and pumping out.

NHDM's purpose was to demonstrate practical, inexpensive options for water supply and latrines, encouraging people to replicate the approaches using their own resources. This created a minor issue in that only a small number of households were the recipients of water supply or latrine materials.

As for MCH, the Watsan component was an important community engagement entry point for all NHDM activities. It also resulted in some evidence of behaviour change (latrine use; hand-washing; awareness and use of clean water supplies) and introduced ideas about environmental health (eg. cleaning drains; reducing defecation in the bush).

In one village (Gamey Jaya) all households are now connected to the water system through a water meter that will be monitored for water usage and payment as a way of encouraging efficient use of water. Eventually, the government intends that Gamey Jaya will be the first kampung integrated with PDAM systems.

Issues/lessons

The major problem encountered by the Watsan component was undermining of the village empowerment/self-reliance approach of NHDM due to other projects (eg. PNPM, RESPEK, etc) paying villagers for their labour in construction of village infrastructure. In one case, a Papuan village rejected NHDM's Watsan proposal because of this payment issue. More generally, the failure of the CLTS approach initially piloted by NHDM (where villages had to be completely self-reliant in reducing 'bush' defecation and building latrines - providing labour and materials) was partly attributable to this problem.

While NHDM and village communities have considered the fact that septic systems will need emptying periodically, it was not clear whether the potential burden of achieving this is apparent to communities at this stage.

NHDM has provided access to water but, apart from simple filtering technology, more effort may have been required to ensure that wells in some villages were better situated in order to provide adequate water quality.

3. CBDRM

Findings

Planned activities were generally completed as specified in the DIP. The focus of the CBDRM implementation was closer to a community-level disaster preparedness approach rather than DRR (eg. community-level emergency kitchen sets; simulations; evacuation routes, etc) and most activities were focused at village rather than household level. This probably contributed to the predominance of men in the NHDM CBDRM activities. If the focus is households, it is easier to promote the equal participation of all family members. There were isolated examples of household-level DRR, such as securing household items.

A DRR approach was evident in two examples of stream diversion to reduce flood risk. In one case NHDM facilitated an approach to the kabupaten government which has resulted in government funds being provided for the stream works. In the second case, RESPEK funds were used along with community labour. Sea wall construction and tree planting to reduce coastal abrasion were also implemented but were not successful.

Early in NHDM implementation, CBDRM was considered as a sectoral component and less integrated with the other components – MCH and Watsan. However, within communities there was evidence that people viewed the components as complementary to CBDRM activities. In effect, some villagers seemed quite able to integrate all the NHDM inputs in a holistic way into their survival/"livelihood" needs.

There was evidence that NHDM used PDRA processes for village disaster risk assessment but that this was not sufficiently robust to identify specific vulnerabilities and capacities required to reduce risks (ie. Risk = (Vulnerability x Hazard)/Capacity)

Issues/lessons

Effective CBDRM is a mobilising and empowering process rather than a set of activities. That is, it must be based on comprehensive CD approaches guided by experienced facilitators where community ownership is the main principle.

Important that people responsible for CBDRM activities have sufficient technical experience and knowledge of DRR and/or seek out experienced assistance when necessary. In the case of the sea wall construction, the design was inadequate and in one case of tree-planting, more detailed expertise on suitable species and their requirements for successful growth was needed.

4. Overall Project Management

- It was evident that NHDM staff were effective in working through or around the many problems that inevitably arose in implementation of the project and had established good relationships with NHDM stakeholders and AusAID
- Good communication and understanding of the task and processes was also evident at senior levels (Director, sector specialists, site supervisors) but the communication to (and resulting understanding of) FFs/FTs was sometimes not sufficient eg. their understanding of other program mechanisms such as PNPM; RESPEK

- On the other hand, it was clear that there were high levels of solidarity, commitment and team-work amongst staff, eg. Guidance provided to inexperienced staff by senior staff
- The district government was unable to contribute materially to the projects (little or no budget allocation for NHDM-related activities) however, the project was supported politically; its results incorporated into government reporting; and it has been successful in developing some mutual understanding at kabupaten level with BAPPEDA; DHO; DEO; PDAM; PU; BPMK (Community Empowerment)
- NHDM, as for other organisations in Nabire, faced high staff turnover rates (especially when a lot of government jobs became available) and had only limited strategies available to deal with the problem, namely: further increasing salaries; improving work conditions (reducing work loads); or convincing staff of the long-term security offered by the NHDM training and work experience.
- High staff turnover meant an increased staff training burden for NHDM. This was handled in a variety of ways but, particularly for new FFs, induction training may not have been adequate. CD facilitation is complex and difficult without adequate experience or training. In particular, facilitators need to be confident in the philosophy and approach of their organisation and confident in the methodology of their work.

Efficiency

The project appears to have used its resources efficiently in implementing all planned activities. It maintained good control of expenditure – with under expenditure being utilised for a "no cost" extension of three months – but it may be the case that use of additional funds in staff training and other activities could have strengthened already good results even more.

Project monitoring has been organised properly with full supervision from PCI Jakarta Office. NHDM also established three 'base camps' closer to targeted communities to increase frequency of field visits and develop better cooperation between NHDM with other development actors.

Impact

Impact assessment is difficult - even though indicator data and other qualitative information collected during the field work for this review are both suggestive of changes in behaviour, the project has not been in place for a sufficient length of time (effective implementation in villages has only been in progress for approximately two years) to draw firm conclusions. In addition, impact of DRM is difficult to assess due to the fact that this can only really be assessed after a disaster occurs.

Until inauguration of BPBD (August 2009) no formal structure for DM existed as SATLAK was only an ad hoc committee for emergency response. However, the recent inauguration of the BPBD and the kabupaten government's stated intention to include elements of NHDM into the kabupaten's next RPJMD (2010-14) are possible effects of the NHDM project that may result in medium to long-term outcomes with positive consequences for DRR in the region.

Although there was variability among the 30 NHDM target communities in there enthusiasm for or commitment to the project's activities and intentions, most were very positive about the benefit to their communities. There was no evidence of strong opposition to the project or negative outcomes resulting from its work.

There are a number of indications however, that a more coherent approach to CBDRM based on an effective CD methodology may have strengthened outcomes.

Sustainability

The fact that the full implementation of NHDM has been limited to about two years will inevitably compromise long-term sustainability. Experienced CD practitioners suggest that at least five years is required to embed significant changes in attitudes and behaviour of community members.

NHDM tried consistently to build sustainability into the project. Apart from the practical MCH, Watsan and CBDRM activities in 30 villages, it worked to strengthen village committees and planning processes; local NGOs who assisted NHDM with field facilitation and HIV awareness; and relevant government departments and processes through regular interaction and getting them involved in the project or in CBDRM-related activities whenever possible. For the reasons noted above however, it is not feasible to assess the eventual outcomes and longer-term sustainability resulting from these activities. It is clear however, that both village communities and kecamatan and kabupaten governments will require ongoing and sustained support if the initial gains achieved by NHDM are to be sustained.

An assessment of short and medium-term sustainability of NHDM outcomes is summarised below:

Government level

Government appointed midwives trained by NHDM will continue to practice and the government indicated its intention to work towards all villages having reasonable access to midwives when required.

. Apart from noting the information about the kabupaten government's intentions with regard to DM, in particular that NHDM focus areas are to be incorporated into the next kabupaten RPJMD, the review cannot comment on the possible future effects and whether they are related to the current work of NHDM.

Community-level

Use of water supplies, hand-washing, latrines is likely to continue in the short-term and, depending on local 'champions' or other characteristics of each village, may be maintained at some level, at least until facilities break down or deteriorate. It was unclear to what extent villagers might maintain facilities, especially wells with hand pumps. In villages visited by the ICR team, community members were generally enthusiastic about replicating facilities based on the knowledge and skills gained from NHDM but the team was not confident that this will happen very often.

Posyandu kaders trained by NHDM are likely to continue their role and, in individual cases, may continue to mobilise community members in maintaining new attitudes and behaviours introduced by NHDM.

Gender

The intent of the project was to focus mainly on Papuan-majority communities and Papuan house holds within those; poorer households and women. In general, these intentions have been reasonably well fulfilled.

AusAID's gender policy includes four dimensions for assessment: increased access for women; increased women's roles in decision-making; women's rights; and capacity development for women. NHDM has

been effective in addressing access to project benefits, increased roles in community decision-making and capacity development for women who participated in project activities.

To some extent, it is possible to conclude that these effects would have also transferred to women in NHDM communities who did not necessarily take an active role in project activities. The promotion of women's rights wasn't specifically addressed by the project although there was some evidence to suggest that it would have been appropriate in some circumstances.

Participation of men or women in particular project activities was, to some extent, determined by the nature of the activities. Most MCH participants were women (although three posyandu kaders trained by NHDM were men) and most CBDRN participants were men. Women were better represented on NHDM's village teams with numbers varying from one up to almost half of the team members.

Provisional Recommendations

1. Further (limited) support to an appropriate agency to continue a monitoring role that will strengthen sustainability of NHDM outcomes… (based on the fact that two years is not enough)
2. Improve the likelihood of sustainable outcomes by increasing coherence amongst AusAID funded initiatives in the same region eg. NHDM, PNPM /RESPEK programs and Oxfam PRIME. This could encompass influencing changes in public policy; community engagement strategies; optimising resources (eg. NHDM assets) to maximise effective outcomes.
3. CBDRM is a process not a sector or a set of activities and approaches should be based on CD principles and methodologies … more open/flexible design and form of aid (process orientated and towards behavioural change).
4. Currently there is no clear description of quality CBDRM principles and strategies within AusAID policy and practices. Such a description would be of assistance in the design and implementation of future CBDRM initiatives.
5. Development of DIPs based on current activity context (not pre-determined) and reviewed annually

Final thought …

AusAID considered NHDM to be a trial of a possible CBDRM approach. PCI delivered the project, as written, effectively and efficiently but perhaps didn't spend sufficient time (with AusAID) reflecting on the work done/approach/possible alternatives, etc and doesn't appear to have (even in the CR) spent sufficient time in identifying "lessons learned".

This may also have been affected by the rigid, "indicator-rich" project design – resulting in PCI having to focus so much attention on getting the job done that not enough time was available to spend on making sense of what was happening.