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# Opportunities and Approaches for Better Nutrition Outcomes through PNPM Generasi

## A Qualitative Study

Conducted in:  
Sukabumi (West Java),  
East Manggarai (Flores, East Nusa Tenggara),  
and Pamekasan (Madura, East Java)



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acknowledged here.

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and Pamekasan (Madura, East Java)

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**Prepared for:**

PNPM Support Facility (PSF)  
Poverty Reduction Support Facility (PRSF)

**April - July 2013**

# INDONESIA



Opportunities and Approaches for  
Better Nutrition Outcomes  
through PNPM Generasi

A Qualitative Study location



Sukabumi (West Java),  
East Manggarai (Flores, East Nusa Tenggara),  
and Pamekasan (Madura, East Java)



East Manggarai  
(Flores, East Nusa Tenggara)

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# Ringkasan Eksekutif

## Latar Belakang:

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Pemerintah Indonesia memandang PNPM Generasi sebagai salah satu instrumen pembiayaan pembangunan berbasis pengguna layanan yang dapat mendorong pertumbuhan ekonomi masyarakat. PNPM Generasi membantu mengurangi jumlah balita pendek (*stunting*) dan memperbaiki gejala malnutrisi kronis lainnya di wilayah perdesaan Indonesia. Pernyataan ini sebagian dilakukan berdasarkan hasil evaluasi dampak yang menunjukkan bahwa PNPM Generasi mampu menekan jumlah penderita gizi buruk. Namun demikian, temuan evaluasi tersebut tidak menjelaskan pendekatan (“bagaimana” dan “kenapa”) PNPM Generasi mampu mengatasi malnutrisi kronis terutama pada konteks sistem kesehatan yang menekankan pada deteksi dan penanganan malnutrisi akut namun tidak mendorong terciptanya perilaku sehat yang dibutuhkan untuk memperbaiki tingkat nutrisi ibu dan anak dalam jangka panjang.

Penelitian “Peluang dan Strategi untuk mencapai Tingkat Nutrisi yang Lebih Baik dalam PNPM Generasi” (*Opportunities and Approaches for Better Nutrition Outcomes in PNPM Generasi*) dilakukan untuk mengidentifikasi dan mendokumentasikan kontribusi PNPM Generasi terhadap Pemerintah Indonesia yang berupaya untuk mengurangi jumlah penderita malnutrisi kronis di seluruh nusantara. Hal ini penting karena mulai tahun 2014 kegiatan PNPM Generasi berfokus pada perbaikan gizi ibu dan anak terutama pada penderita malnutrisi kronis.

## Pertanyaan Penelitian (Research Questions - RQ):

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Tiga pertanyaan (RQ) akan dibahas pada kajian ini. Secara singkat, pertanyaan-pertanyaan berikut berkaitan dengan upaya-upaya yang dilakukan PNPM Generasi untuk mendorong interaksi sosial dengan masyarakat (dan sebaliknya) dalam rangka memperbaiki tingkat gizi ibu dan anak terutama pada penderita malnutrisi kronis.



### RQ 1



Bagaimana indikator malnutrisi kronis membaik atau memburuk di desa-desa penerima PNPM Generasi?



### RQ 2



Sejauh mana dana hibah bersyarat kinerja yang disalurkan PNPM Generasi dapat mempengaruhi perilaku masyarakat terkait perbaikan gizi dan mendorong respon kolektif dalam menangani kasus berat badan kurang (*underweight*) atau malnutrisi?



### RQ 3

Sejauh mana kegiatan PNPM Generasi mempengaruhi para kader kesehatan setempat, pemimpin desa, penyedia layanan, dan pengguna layanan? (Sebagai contoh: kesadaran masyarakat terhadap isu kesehatan mendorong masyarakat untuk meningkatkan penggunaan layanan kesehatan.)

## Metode Penelitian dan Pemilihan Lokasi:

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Selama sebulan penuh tiga peneliti kualitatif mengadakan wawancara semi terstruktur (*semi-structured interviews*), diskusi kelompok terarah informal (*informal focus group discussions*), dan observasi etnografis di satu desa lokasi *pre test* di Jawa Barat, dua desa di Nusa Tenggara Timur (NTT), dan dua desa di Jawa Timur. Pemilihan lokasi ditentukan untuk melakukan perbandingan berdasarkan wilayah dan pencapaian indikator nutrisi yaitu membandingkan sebuah kabupaten di NTT yang memiliki pencapaian rata-rata dengan kabupaten di Jawa Timur yang memiliki pencapaian dengan peningkatan paling tinggi selama beberapa tahun terakhir. Setiap kecamatan di tiap kabupaten dan dua desa di tiap kecamatan dipilih untuk kajian mendalam (*in-depth study*). Pemilihan ini dilakukan berdasarkan pendekatan kualitatif murni dan pengamatan di lapangan. Lama kajian adalah sekitar dua minggu untuk setiap kecamatan. Dua desa di setiap kecamatan dipilih berdasarkan desa mana yang memiliki pencapaian nutrisi terbaik dan rata-rata. Daftar pertanyaan lebih rinci dan topik diskusi secara garis besar terkait gizi ibu dan anak disajikan pada lampiran 2. Tabel 1 dan 2 menunjukkan karakteristik desa-desa yang terpilih dalam kajian ini.

## Hasil Temuan:

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# RQ 1

### Kaitan dengan Indikator Nutrisi yang Membaik atau Memburuk (RQ1)

**1.1.** Pengadaan dan pendistribusian Pemberian Makanan Tambahan (PMT) yang dilakukan PNPM Generasi tidak berkaitan dengan perbaikan gizi.

**1.2.** Seorang bidan yang aktif dan berdedikasi, dan tinggal di desa dimana ia bertugas penuh waktu serta memperlakukan masyarakat dengan rasa hormat dan kesabaran cenderung dapat:

- Memastikan ibu kurang gizi dan anak-anaknya tidak keluar dari batas aman jaringan pengamanan sosial (*social safety net*).
- Lebih aktif mengelola dan mengawasi kegiatan posyandu dengan terus memberikan dukungan dan pendidikan bagi kader yang bekerja untuknya.
- Dapat memfasilitasi koordinasi antara PNPM Generasi dan Puskesmas.
- Membantu terbentuknya legitimasi kegiatan kesehatan PNPM Generasi di desa.

**1.3.** Partisipasi kepemimpinan masyarakat yang strategis di posyandu dan kegiatan kesehatan ibu dan anak lainnya secara tidak langsung mendorong pengguna dan permintaan terhadap pelayanan masyarakat.

**1.4.** *Elite control* dan *elite capture*, tidak hanya terkait dengan penyalahgunaan material dan keuangan secara strategis, namun juga pada penyebaran informasi dan pengetahuan yang dapat melemahkan upaya masyarakat dan keluarga untuk memperbaiki taraf kesehatan mereka.

**1.5.** Pemahaman lokal mengenai siapa yang lebih layak mendapatkan pelayanan kesehatan ibu dan anak dapat berakibat pada munculnya perbedaan akses terhadap pelayanan dan penjangkauan.

**1.6.** Pola makan yang monoton dan konsumsi makanan rendah protein berhubungan dengan gizi rendah yang dialami oleh ibu dan anak.

**1.7.** Perilaku masyarakat dan keluarga dalam menjaga kebersihan berakibat langsung terhadap kesehatan ibu dan anak termasuk kesehatan gizi.

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## RQ 2

### **Efektivitas Pemberian Dana Hibah dengan Insentif (*general incentivized block grants* RQ2)**

**2.1.** Para pemimpin desa (formal maupun informal), penduduk desa, dan bahkan pelaku PNPM Generasi di desa-desa menunjukkan pemahaman yang terbatas mengenai penyaluran dana hibah dengan insentif.

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## RQ 3

### **Dampak PNPM Generasi terhadap kader dan Penyedia Layanan Kesehatan (RQ3)**

**3.1** Salah satu kesuksesan terbesar PNPM Generasi adalah revitalisasi posyandu desa, termasuk dukungan PNPM Generasi terhadap kader posyandu.

**3.2.** PNPM Generasi memberikan alat kepada masyarakat untuk dapat membayangkan pelayanan kesehatan yang mereka harapkan.

**3.3.** Ketika seorang bidan desa hadir dan aktif bekerja dalam masyarakat penerima program PNPM Generasi, maka akan terbuka kesempatan untuk menjalin kerjasama yang saling menguntungkan antara layanan kesehatan dan PNPM Generasi.

**3.4.** Ketika seorang bidan desa tidak hadir dan aktif bekerja dalam masyarakat penerima program PNPM Generasi, maka akan terjadi berbagai miskomunikasi dan salah pemahaman terhadap kegiatan PNPM Generasi. Hal ini berujung

pada munculnya rasa tidak suka atau bahkan membuat para penyedia layanan kesehatan mengundurkan diri dari pekerjaannya.

**3.5.** PNPM Generasi tidak memiliki dampak langsung terhadap pemahaman dan praktik dukun anak (TBA) di desa-desa penerima program PNPM Generasi. Namun kajian ini menemukan bahwa banyak ibu terutama kaum ibu yang terpinggirkan secara ekonomi dan sosial (*social margins*) atau tinggal jauh dari klinik masih menggunakan jasa dukun anak pada masa sebelum dan setelah melahirkan. PNPM Generasi sebaiknya melihat dukun anak sebagai sumber daya yang belum tersentuh yang dapat diberdayakan untuk kegiatan pendidikan dan advokasi ibu di masa depan.

## Rekomendasi:

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### Pemberian Makanan Tambahan (PMT):



PNPM Generasi menghabiskan sebagian besar anggarannya untuk pengadaan makanan tambahan. Namun demikian, hasil yang didapat tidak sepadan dengan biaya yang dikeluarkan. Berikut adalah rekomendasi untuk membatasi dan memodifikasi alokasi yang tidak proporsional tersebut:

- Membatasi alokasi dana PNPM Generasi untuk PMT.
- Memperbaiki kualitas makanan tambahan dengan meminta PNPM Generasi agar membeli bahan makanan segar dari petani lokal daripada membeli dari kota/menggunakan makanan pabrikan.
- Merancang mekanisme yang transparan yang memungkinkan untuk dapat membeli PMT dari petani lokal namun tetap sesuai dengan ketentuan akuntabilitas dan audit PNPM Generasi.
- Merancang sebuah mekanisme yang fleksibel untuk penanganan cepat dan tepat sasaran terhadap kasus malnutrisi akut yang teridentifikasi dengan PMT pemulihan.

### Posyandu:

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Posyandu tetap berfungsi sebagai institusi desa yang berpotensi besar. Namun demikian, para peneliti menemukan berbagai pelaksanaan yang tidak konsisten. PNPM Generasi dapat meningkatkan dukungannya terhadap posyandu melalui berbagai cara berikut:

- Meningkatkan insentif bagi kader sesuai dengan hasil kerja yang dapat dipertanggungjawabkan.
- Melatih dan memberdayakan kader sehingga mereka dapat mengidentifikasi tanda-tanda gizi buruk, infeksi, resiko kehamilan, dan bahkan gangguan kesehatan jiwa sebagai catatan rujukan untuk diberikan kepada tenaga terlatih dan profesional.

- Melatih dan menugaskan kader untuk mengukur panjang bayi dan tinggi balita. Rekomendasi ini kemungkinan akan membutuhkan modifikasi indikator kesehatan PNPM Generasi sehingga dapat menyesuaikan dengan pertumbuhan anak berbadan pendek (*stunting*).
- Meningkatkan fungsi posyandu sebagai ujung tombak pemberi layanan kesehatan ibu dan anak sehingga dapat lebih efektif menjangkau para orangtua setiap bulannya.
- Memberikan advokasi dan memberdayakan perkumpulan (*associations*) masyarakat untuk memastikan mereka turut bertanggungjawab atas penyaluran pemberian makanan tambahan (PMT) penyuluhan di Posyandu serta insentif lain seperti kegiatan arisan yang dapat meningkatkan partisipasi masyarakat.

### Dukun beranak (*traditional birth attendants – TBAs*):

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PNPM Generasi sebaiknya tidak mengabaikan peran dan potensi dukun beranak di desa-desa. Menurut pedoman kementerian kesehatan, dukun beranak dapat mendukung kinerja bidan. Mereka dapat turut mendidik dan memberdayakan para ibu terkait masalah kesehatan ibu dan anak. Berikut adalah beberapa rekomendasi untuk PNPM Generasi:

- Menyertakan dukun beranak dalam kegiatan pelatihan yang diadakan PNPM Generasi bagi kader posyandu.
- Mengembangkan dan memberikan advokasi bagi terciptanya kerjasama yang bersifat adil antara bidan dan dukun beranak. Kerjasama ini hendaknya dilakukan berdasarkan pedoman nasional kementerian kesehatan.
- Dilarang keras mendorong terciptanya kerjasama yang menerapkan taktik menakutkan dan hukuman yang dapat memperkuat stigma dan mengucilkan dukun beranak. Dukun beranak telah bertahan sebagai institusi desa di hampir seluruh perdesaan di Indonesia.

### Advokasi:

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- Hindari menggandakan (*doubling*) atau mengganti kegiatan pelatihan yang berada di bawah kegiatan puskesmas. Lebih baik melakukan advokasi dan mendukung puskesmas dalam mengadakan kegiatannya secara penuh bagi semua pihak yang berkepentingan.
- Alihkan kegiatan PMT PNPM Generasi menjadi kegiatan yang dapat membantu puskesmas dalam pengajuan dan penerimaan anggaran PMT Posyandu dari dinas kesehatan kabupaten serta membantu puskesmas untuk dapat mengelola anggaran tersebut secara benar.

- Mempertimbangkan untuk memperkerjakan fasilitator di level kabupaten atau propinsi dengan kualifikasi yang diakui di bidang kesehatan untuk mengadakan kegiatan advokasi yang meyakinkan dengan penyedia layanan kesehatan.
- Dorong para pelaku PNPM Generasi untuk belajar dan mengevaluasi resiko dan gejala malnutrisi serta untuk memahami alat yang digunakan PNPM Generasi untuk mengatasi permasalahan malnutrisi masyarakat.
- Fasilitator kecamatan dan kabupaten sebaiknya lebih sering melakukan kegiatan yang menjangkau masyarakat (*outreach activities*) di desa-desa secara terbuka dan menginformasikan para keluarga mengenai kebijakan kesehatan dan layanan yang mereka butuhkan.
- Menjangkau masyarakat pria terutama kaum ayah.
- Mengidentifikasi dan mendukung para pemimpin formal maupun informal di desa-desa penerima program PNPM Generasi yang berpotensi menjadi juru bicara kesehatan ibu dan anak bagi masyarakat.
- menjajaki kemungkinan untuk mengalihkan pekerjaan advokasi kepada organisasi masyarakat lokal terkait dengan masalah kesehatan dan tata kelola.

# Executive Summary

## Background:

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The Government of Indonesia has identified PNPM Generasi as one of several demand-side financing instruments through which to reduce stunting and improve other indicators of chronic malnutrition in rural Indonesia. This decision was based partly on impact evaluation findings that show Generasi reduced malnutrition, but the findings did not shed light on the approaches (“how” and “why”) through which Generasi might specifically address chronic malnutrition, especially in the context of a health system that emphasizes the detection and treatment of acute malnutrition, but does not promote or incentivize healthy behaviors needed to improve long-term maternal and child nutrition. The “Opportunities and Approaches for Better Nutrition Outcomes in PNPM Generasi” research was commissioned to identify and document ways in which PNPM Generasi might contribute to the Indonesian government’s efforts to reduce chronic malnutrition throughout the archipelago. This is especially critical given Generasi’s overall shift toward maternal and child nutrition, with a growing emphasis on chronic malnutrition, beginning in 2014.

## Research Questions:

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Three research questions (RQ) guided this study. In short, these questions ask how Generasi’s efforts facilitate community-based social interactions (and vice versa) to improve nutritional outcomes among mothers and their young children, with particular attention paid to chronic undernutrition:



### RQ 1



How do chronic malnutrition indicators improve or worsen in Generasi villages?



### RQ 2



To what extent do Generasi’s incentivized block grants precipitate community actions that affect nutrition behaviors and collective responses to treating cases of underweight or malnutrition?



### RQ 3

To what extent have local health volunteers, village leaders, service providers, and service users behaved differently due to Generasi activities? (e.g. raise awareness of particular health issues, and incentivize communities to improve service utilization?)



## Methods and Site Selection:

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Three qualitative researchers spent one month conducting semi-structured interviews, informal focus group discussions, and ethnographic observations in one pilot study village in West Java, two villages in East Nusa Tenggara (NTT), and two villages in East Java. Site selection aimed for comparison by region and nutrition indicator outcomes, comparing an *average performing* district in NTT with the *most improved* district in East Java during the past few years. Using a purely qualitative and investigative approach in the field, a sub-district in each district and then two villages in each sub-district, were selected for in-depth study, with roughly two weeks spent in each sub-district. The two villages in each sub-district were selected based on which village had the best and average nutritional outcomes. A detailed list of questions and discussion topics broadly related to maternal and child nutrition is provided in Appendix 2. Tables 1 & 2 report summary characteristics of the selected villages.

## Findings:

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# RQ 1

### Associations With Improved or Worsened Nutrition Indicators (RQ1)

**1.1** Generasi's current system of food supplement procurement and distribution does not appear to be associated with improved nutritional outcomes.

**1.2** An active and engaged midwife that lives in her assigned village full time and treats her clients with dignity and patience is more likely to:

- ensure that undernourished women and their children do not slip through the social safety net.
- more actively manage and supervise posyandu activities with ongoing support and education for her volunteers.
- facilitate coordination between Generasi and the sub-district puskesmas clinic.
- lend legitimacy to Generasi health activities in the village.

**1.3** Strategic community leadership participation in posyandu and other maternal and child health outreach activities and services indirectly encourages (or softly compels) wider community service utilization and demand.

**1.4** Elite control and elite capture refer to more than just the strategic manipulation of material and monetary resources, but also of information and knowledge, which may disempower community and household efforts to improve health outcomes.

**1.5** Local conceptions of who is more or less deserving of maternal and child health services lead to differential access to care and outreach.

**1.6** Monotonous, protein-poor diets are associated with poor nutritional health among mothers and their children.

**1.7** Public and household hygiene practices have direct consequences upon maternal and child health, including nutritional health.

## Findings:

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# RQ 2

## Effectiveness of General Incentivized Block Grants (RQ2)

**2.1** In the villages, formal and informal leaders, ordinary residents, and even some Generasi actors themselves showed limited understanding of the incentivized block grants.

## Findings:

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# RQ 3

## Generasi's Effect on Health Volunteers and Health Service Providers (RQ3)

**3.1** One of Generasi's biggest successes has been the revitalization of village posyandu, and this includes Generasi's support for the posyandu volunteers.

**3.2** Generasi provides communities with the tools to imagine alternative possibilities of what health services might provide that contrast with the status quo.

**3.3** When a village midwife is present and active in Generasi communities, there are opportunities for mutually beneficial collaborations between health services and Generasi.

**3.4** When a village midwife is not present and active in Generasi communities, there are opportunities for miscommunication and misunderstanding of Generasi's activities, leading to resentment or even abdication of responsibilities among health service providers.

**3.5** Generasi has no direct effect on the knowledge and practices of traditional birth attendants (TBAs) in Generasi villages, but the findings from this study show that many mothers, especially at the social margins or at great distances from clinics are still using TBA services throughout the entire pre- and post-natal childbearing cycle. Generasi should view TBAs as an untapped human resource for future education and advocacy activities with mothers.

## Recommendations

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### Food Supplements:



Generasi spends most of its health-related expenses on food supplements, but their impact is not commensurate with their expense. The following recommendations suggest ways to limit and modify this disproportionate allocation of Generasi's budget:

- Put limits on Generasi's budget allocations for food supplements.
- Improve the quality of food supplements by requiring Generasi to purchase from local vendors of fresh food instead of packaged products from the cities.
- Devise a transparent mechanism that enables purchase of food supplements from local farming communities but also meets Generasi's accountability and audit requirements.
- Devise a more flexible mechanism for rapid and targeted treatment of identified cases of acute malnutrition with food supplements.

### Posyandu:

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The posyandu remains a village-level institution with great potential, but researchers observed inconsistent variations in its implementation. Generasi could increase its support for posyandu in the following ways:

- Increase volunteer incentives in exchange for performance accountability.
- Train and empower volunteers to identify signs of undernutrition, infections, pregnancy risks, and even mental health disorders for referral to trained health professionals.
- Train and require volunteers to measure the lengths of infants and the heights of toddlers and young children under five. This recommendation may require modifying the Generasi health indicators to include stunting.
- Leverage posyandu as a front-line maternal and child health service to provide more effective monthly outreach to parents.
- Advocate for and empower neighborhood associations to assume responsibility for their own posyandu outreach food supplements and other incentives such as *arisan* activities to improve participation.

## Traditional Birth Attendants (TBAs):

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Generasi should not overlook the role and untapped potential of the TBAs in the villages. According to Ministry of Health guidelines, TBAs should complement the technical medical skills of midwives by educating and empowering mothers on maternal and child health issues. Some recommendations for Generasi to consider:

- Include TBAs in all training activities that Generasi supports for posyandu volunteers.
- Develop and advocate for more inclusive and equitable midwife-TBA partnership agreements based on Ministry of Health national guidelines.
- Strictly avoid supporting partnership agreements that employ scare tactics and punitive approaches that stigmatize and marginalize TBAs, who endure as a village institution across nearly all of rural Indonesia.

## Advocacy:

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- Avoid doubling or replacing training activities that fall under the puskesmas' purview and instead advocate and support the puskesmas to conduct these activities in full and for all intended stakeholders.
- Transition away from providing outreach food supplements at the posyandu and instead assist the puskesmas to demand and receive a budget for posyandu food supplements from the district health office (and correctly administer it).
- Consider hiring district and/or provincial level facilitators with recognized health credentials to conduct more convincing advocacy work with health service providers.
- Require Generasi actors to learn and appraise the risks and symptoms of malnutrition, and understand the tools Generasi may use to address it in their communities.

- Sub-district and district facilitators should more explicitly conduct outreach activities in the villages to inform families about health policies and services that meet their needs.
- Conduct active family health outreach to men in the villages, particularly fathers.
- Identify and support the formal and informal leaders in Generasi villages who show potential to become maternal and child health “spokespersons” in their communities.
- Explore outsourcing advocacy work to local civil society organizations concerned with health and governance issues.

# Introduction and Background

In 2007 the Government of Indonesia introduced PNPM *Generasi Sehat dan Cerdas* (PNPM Healthy and Smart Generation—PNPM Generasi) as one of two large-scale pilot projects aimed at stimulating demand for and improving access for poor, rural communities to basic health and education services. PNPM Generasi utilizes incentivized block grants and trained PNPM facilitators to assist communities to plan and implement activities that address 12 target health and education indicators linked to Millennium Development Goals to improve maternal and child health, ensure universal access to primary education, and reduce poverty.

PNPM Generasi was accompanied by a rigorous impact evaluation to test program impacts on health and education outcomes, as well as the differential impacts of a model which provided block grants to villages based on the number of pregnant women and school-aged children (in “Treatment B” sub-districts) against a model which provided performance bonuses to communities based on the relative achievement of the 12 target indicators (in “Treatment A” sub-districts). The evaluation found that overall the program reduced childhood malnutrition, and increased community uptake of a range of services offered at village health posts. The evaluation also found that the incentivized model improved performance on health. In 2010, the government decided to scale up PNPM Generasi in locations with low baseline health and education performance.

The PNPM Support Facility (PSF) is working with Government stakeholders, including the PNPM Generasi Implementing Agency, the Directorate General for Community and Village Empowerment (PMD), Ministry of Home Affairs; the National Planning Agency

(Bappenas); the Coordinating Ministry for People's Welfare (Menkokesra); and the Vice President's Office for the Acceleration of Poverty Reduction (TNP2K) to develop a medium-term strategy for PNPM Generasi expansion. The strategy will outline a critical path to expand PNPM Generasi coverage to at least 500 rural sub-districts with poor health and education performance by 2014, increasing to as many as 800 sub-districts in subsequent years.

The strategy is also intended to incorporate design changes needed to improve program efficacy, including revisions to community-level target indicators required to ensure PNPM Generasi supports new Government priorities<sup>1</sup> and is responsive to evolving community demands. Government priorities relevant to PNPM Generasi include reducing the prevalence of stunting from the 2010 level of 42% in rural areas, increasing rural sanitation coverage from the 2010 level of 38%, and achieving 86% enrollment in early childhood education and development (ECED) services by 2025. Work is underway with the Ministry of Health (MoH), Bappenas, the World Bank Health, Nutrition, and Population (HNP) team, and AusAID to introduce incentives for communities through PNPM Generasi to utilize local nutrition counseling services, deemed necessary by MoH to improve behaviors that contribute to reductions in chronic malnutrition levels. This work, which is part of the MCC-supported Community-based Health and Nutrition to Reduce Stunting program, is also intended to promote healthy sanitation behaviors. In addition, the Government's PNPM Mandiri Roadmap identifies the integrated planning, delivery, and oversight of local poverty reduction programs as a central focus of its community empowerment poverty reduction cluster. The Road Map also includes an objective of utilizing PNPM community-based poverty targeting mechanisms to improve targeting outcomes of its household based poverty reduction programs.

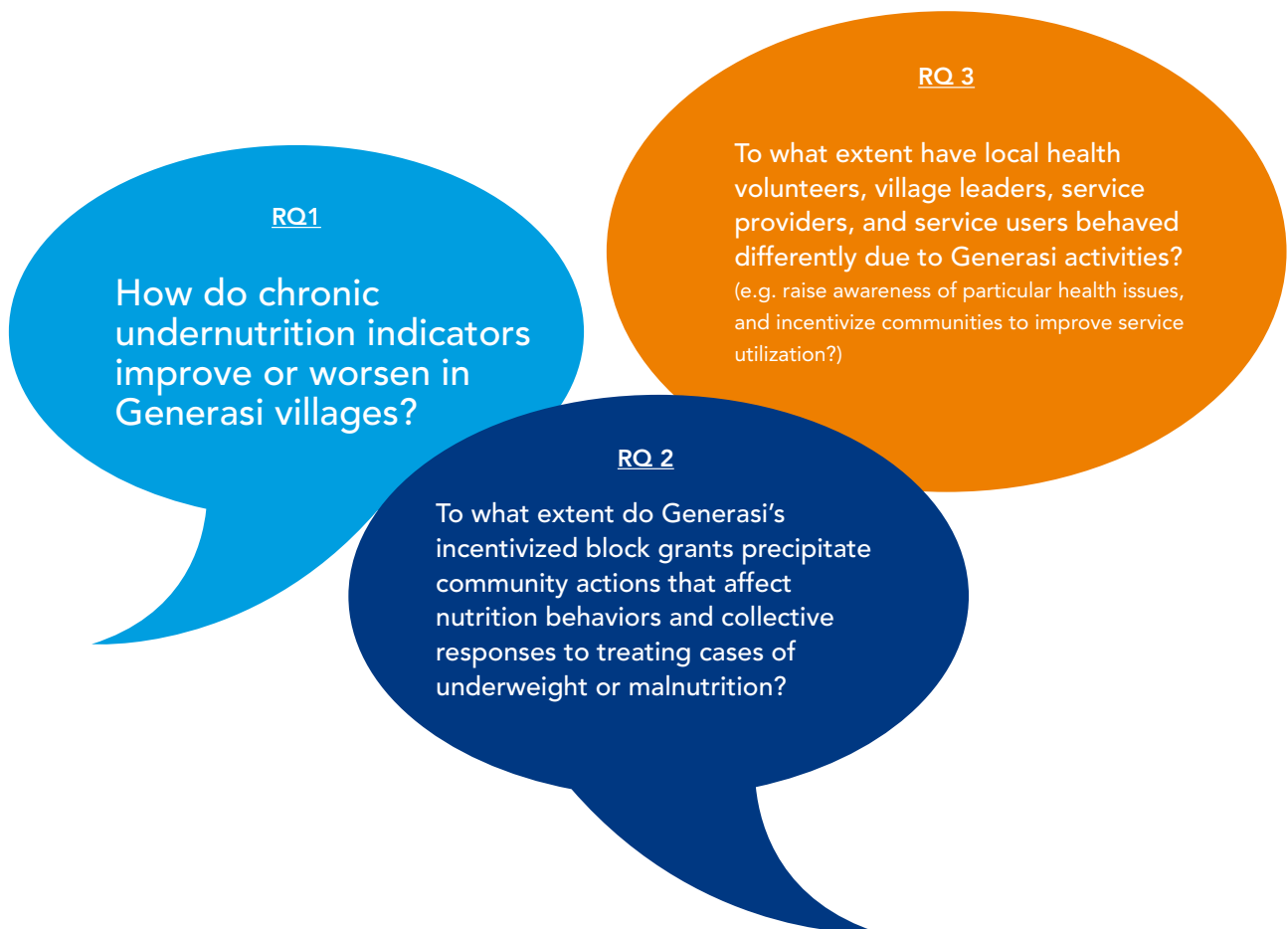
The Government of Indonesia has identified PNPM Generasi as one of several demand-side financing instruments through which to reduce stunting and improve other indicators of chronic malnutrition in rural Indonesia. This decision was based partly on impact evaluation findings that show Generasi reduced malnutrition, but the findings did not shed light on the approaches ("how" and "why") through which Generasi might specifically address chronic malnutrition, especially in the context of a health system that emphasizes the detection and treatment of acute malnutrition, but does not promote or incentivize healthy behaviors needed to improve long-term maternal and child nutrition. The "Opportunities and Approaches for Better Nutrition Outcomes in PNPM Generasi" research was commissioned in order to identify and document ways in which PNPM Generasi might contribute to the Indonesian government's efforts to reduce chronic malnutrition throughout the archipelago. This is especially critical given Generasi's overall shift toward maternal and child nutrition, with a growing emphasis on chronic malnutrition, beginning in 2014.

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1. > As reflected in the latest draft of the National Master Plan for Poverty Reduction and Inclusion (MP3KI)

## Research Questions

The following overarching research questions (hereafter referenced as RQ1, RQ2, and RQ3) guided the qualitative field research:



In short, these questions ask how Generasi's efforts facilitate community-based social interactions (and vice versa) to improve nutritional outcomes among mothers and their young children, with particular attention paid to chronic undernutrition. Appendix 2 includes a detailed list of research questions that guided the interviews during the fieldwork.



## Methods

The field research relied upon qualitative research methods to focus on identifying domains and approaches Generasi might explore to improve nutritional outcomes. Methods include:



The semi-structured interviews and FGDs were based on question/discussion guides covering a range of social and behavioral subjects related to maternal and child nutrition (see Appendix 2). Observations included detailed descriptions of interviews and discussions, and of sites visited, including government offices, health facilities, village geography, public resources, and respondent households. Whenever possible, the research team sought and prioritized participant-observation opportunities at village *posyandu*, the monthly integrated maternal and child health service posts staffed by village health volunteers and supervised by the village midwife and *puskesmas* (sub-district public health clinic) staff.

All interviews, FGDs, and descriptive observations were documented with comprehensive and organized field notes. Interview and FGD field notes address the questions listed in Appendix 2 tailored to each respondent. The interviewers'

analytical evaluations of the interview content and setting (household descriptions, interview dynamics, etc.) appear at the bottom of each interview or FGD report. Regional profiles summarize the districts, sub-districts, and villages that the researchers visited. When permissible, the lead researcher documented most interview settings and field observations with a digital camera. Appendix 1 provides a chronological list of all interviews and discussions conducted throughout the duration of the fieldwork.

Site selection aimed for comparison by region and nutrition indicator outcomes, with a focus on the provinces sampled in the Generasi impact evaluation. The research team relied upon the PNPM Generasi MIS database to select districts based on their nutrition indicators through 2011, comparing *average* performing districts with the *most improved* district during the past few years. The district of Sukabumi in West Java province was chosen for the pilot phase due to its proximity to Jakarta and average nutrition indicators. For an average performing district, East Manggarai district on the island of Flores in NTT province was selected. Pamekasan district on the island of Madura in East Java province was selected for its most improved nutritional outcomes. For selecting sub-districts and villages, the research team relied upon a purely qualitative and investigative approach in the field, speaking with as many district-level stakeholders as possible in order to determine the locations that most closely fit the desired selection criteria. With only two weeks to visit each district, the research team focused on one sub-district in each district, an average performing sub-district in East Manggarai, and a most-improved sub-district in Pamekasan. Two villages under the purview of a single *puskesmas* (public clinic) in each sub-district were selected for in depth field research, one with the best available nutritional outcomes and the other with average outcomes.

Selected  
Field Site  
Profiles

Tables 1 and 2 describe the selected communities, using pseudonyms for the sub-districts and villages. Brief narrative descriptions of the selected districts, sub-districts, and villages immediately follow the tables.

**Table 2: Village Profiles**

	Ciperi	Dantena	Bena	Badran	Suruan
<b>1. Population</b>					
1.1. Total Population	10266	949	7329	4280	3229
1.2. Total Households	2680	238	727	1027	799
<b>2. Health Facilities</b>					
2.1. Puskesmas (sub-district clinic)	1	1	1	1	1
2.2. Polindes/Ponkesdes (village clinics)	1	1	0	1	2
2.3. Posyandu (classified by their development status)*	13 madya 1 purnama	2 madya	7 madya	6 madya 1 purnama	2 madya 3 purnama
2.4. Private Health Clinics	0	0	1	0	0
<b>3. Health Care Workers</b>					
3.1. Village Midwives	1	1 (does not live on site)	0 (due to proximity to Puskesmas, but there are 7 based there)	4 (one village midwife, three student midwives in training)	2
3.2. Village Nurses	0 (due to proximity to Puskesmas, but there are several there)	1	0 (due to proximity to Puskesmas, but there are several there)	0	1
<b>4. Distance from farthest hamlet to a health facility</b>	7 km	2 km (from Hamlet 2 to village clinic)	2 km	4 km	2 km

**Table 1: Selected Communities \***

Province (Propinsi)	District (Kabupaten)	Sub-district (Kecamatan) **	Village (Desa) **
West Java (pilot phase)	Sukabumi	Ciperi	Ciperi
NTT	East Manggarai (avg)	Bonde (avg)	- Dantena (avg) - Bena (+)
East Java	Pamekasan (+)	Pandeyan (+)	- Badran (avg) - Suruan (+)

\* "+" indicates most improved nutritional outcomes over the past three years .

"avg" indicates average nutritional outcomes.

\*\* All kecamatan (sub-district) and desa (village) names are pseudonyms to protect the confidentiality and honesty of a full variety of PNPM Generasi stakeholders in these communities.

<b>5. Health Related Programs</b>	PNPM Generasi (active); PNPM PKH (active); Desa Siaga (not active)	PNPM Generasi (active)	PNPM Generasi (active)	PNPM Generasi (active); Desa Siaga (not active)	PNPM Generasi (active); Desa Siaga (active)
<b>6. Periurban or Rural</b>	Periurban	Rural	Rural	Rural	Rural
<b>7. Other Infrastructure</b>					
7.1 Schools (by type)**	4 SD 1 MI 1 SMP 1 MT	1 SD	3 SD 1 SMP	2 SD 1 SMP	2 SD 1 MI 1 SMP 1 MT
7.2 Roads	Nearly all roads are paved.	Almost no paved roads	Roughly half of main village roads are paved	Main roads are paved, some smaller roads paved	Nearly all roads are paved.
<b>8. Other Human Resource Development</b>					
8.1 Average Educational Attainment**	SMP	SD	SMP	SMP	SMP
8.2 Average Household Income (per month)	Rp600,000	Rp500,000	Rp500,000	Rp350,000	Rp500,000
<b>9. Nutritional Profile</b>	?	?	?	?	?

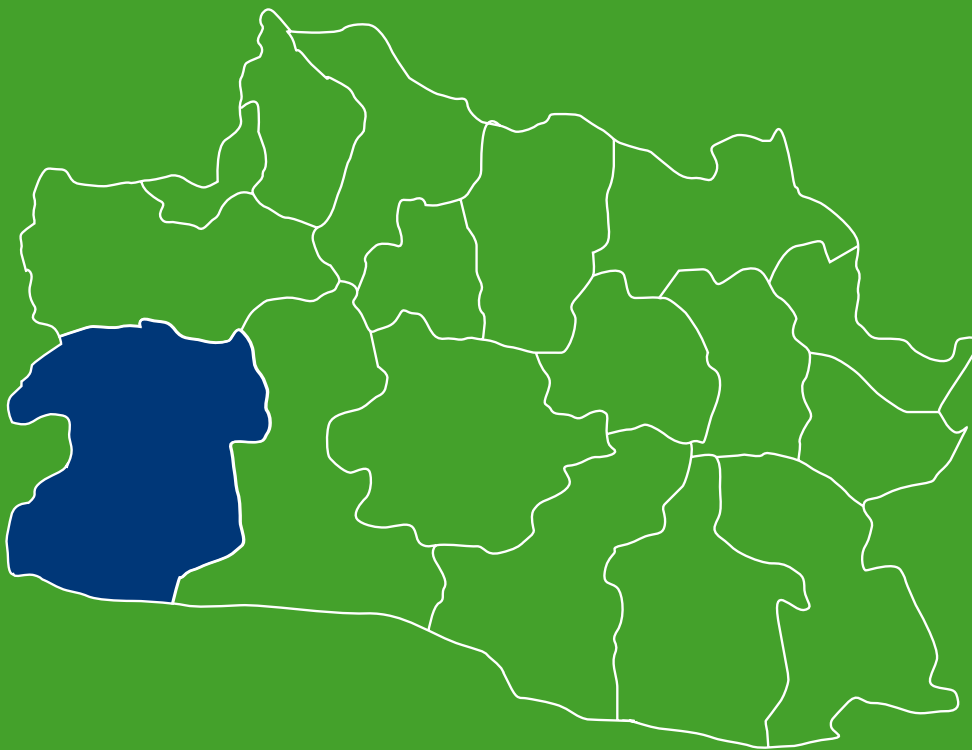
\* Posyandu are evaluated by their capacity at four levels. From lowest to highest, they are: *pratama*, *madya*, *purnama*, and *mandiri*, but researchers observed large variations among posyandu that were formally classified at the *madya* level.

\*\* School types listed include: SD = elementary school (*sekolah dasar*); MI = Islamic elementary school (*madrasah ibtidayah*); SMP = middle school (*sekolah menengah pertama*); and MT = Islamic middle school (*madrasah tsanwiyah*).

# Sukabumi

## West Java (pilot)

(30 April — 3  
May, 2013)



Map 1: Location  
of Sukabumi  
District



source: [http://id.wikipedia.org/wiki/Kabupaten\\_Sukabumi](http://id.wikipedia.org/wiki/Kabupaten_Sukabumi)

The largest and most diverse along the urban-rural continuum among the three districts sampled in the Generasi nutrition research, Sukabumi occupies 3,934km<sup>2</sup> of the southwest corner of West Java, which also makes it the largest district (by area) in the province (see Map 1 below). Out of Sukabumi's 47 sub-districts, 22 of them currently participate in the PNPM Generasi program, and according to Generasi's 2012 annual report, 63% of the Generasi budget is allocated to health activities. Because the research team visited Sukabumi as part of the pilot phase of the field research, the researchers spent only three nights there, which only allowed a quick visit to one village in one sub-district. According to West Java's Department of Health, Sukabumi district reported the highest absolute number of maternal and children-under-five mortality cases in 2012 (76, or 9.4% of all maternal deaths, and 521, or 10.3% of all children-under-five deaths in West Java), though this in part reflects Sukabumi's large size and population.<sup>2</sup>

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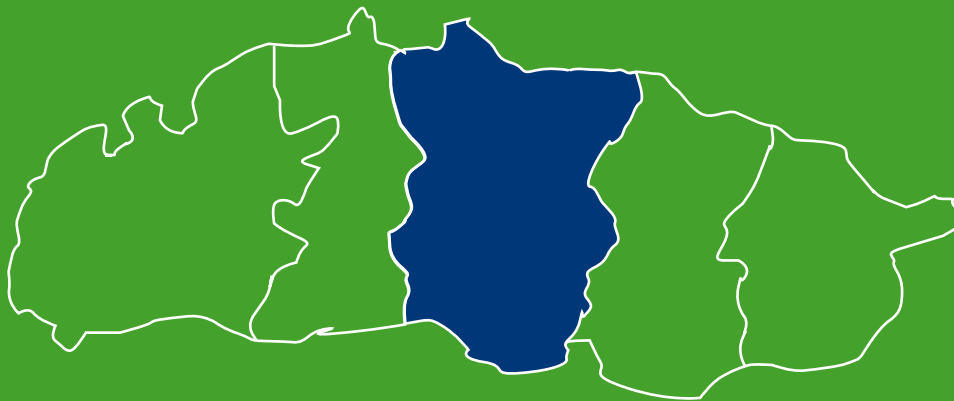
2. > Profil KIA Gizi Dinas kesehatan provinsi Jawa Barat tahun 2012

### **Ciperi Sub-district & Village, Sukabumi (pilot)**

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The research team visited the rapidly urbanizing sub-district of Ciperi, and village of the same name. Ciperi may be growing so fast because it has relatively easy access to markets in Bogor and Jakarta to the north. The research team chose to visit Ciperi during the pilot phase for several reasons. First, Generasi's district facilitator for Sukabumi used to be the sub-district facilitator in Ciperi, so he could help researchers navigate the finer details of this community more rapidly. Second, Ciperi would be the research team's only opportunity to visit a sub-district that is currently undergoing a rapid rural-to-urban transition, with 16 factories in Ciperi, most of which opened within the last five years. The transition has resulted in an increase of migrants from other parts of West Java to work in these factories, though most of the factory workers are sourced from the young women originally from Ciperi. These women leave their children at home with their grandparents to supervise them. One of the factories is a well-known bottled mineral water company; the extraction of spring water increasingly depletes the supply of natural clean water for Ciperi's residents. Unregulated factory pollution and boarding house construction for the migrants to Ciperi are also on the rise, posing new environmental health hazards. The third reason why the research team chose to visit Ciperi is related to the second, which is the shocking figure that five out of the six maternal mortality cases in Ciperi in 2012 were among young factory workers. Fourth, the sub-district has initiated new nutritional awareness programs that the researchers wanted to directly observe. In Ciperi village, the research team met a potent mix of community leaders, posyandu volunteers, traditional birth attendants, health service refusers due to religious reasons, as well as the aforementioned factory workers, which all combined to make Ciperi a fascinating, if brief, fieldwork site.

# East Manggarai, Flores, NTT (5 — 17 May, 2013)



Map 2:  
Location of  
East Manggarai  
District



source: [http://id.wikipedia.org/wiki/Kabupaten\\_Manggarai\\_Timur](http://id.wikipedia.org/wiki/Kabupaten_Manggarai_Timur)



The mountainous East Manggarai district straddles the mid-section of the western half of Flores island in East Nusa Tenggara (NTT) province (see Map 2 below). East Manggarai is a young district, having recently been established in mid-2007, breaking away from Manggarai district to the west. The PNPM Generasi district facilitator (FasKab) still manages both Manggarai and East Manggarai in his portfolio. As district government facilities and infrastructure in East Manggarai's new district seat of Borong are still under development on the south coast, the research team resided in the Manggarai district seat of Ruteng up in the mountains, which offered easier access to our selected sub-district of Bonde in the interior. The majority of East Manggarai's population of just over 250,000 people depend on farming their own gardens, sometimes at a great walking distance from their home village, typically growing commodities such as coffee and cacao instead of vegetables for home consumption or local markets. The vast majority of East Manggarai's population is Catholic, though local church leaders do not appear to take an active or influential role in local governance. Since 2012, East Manggarai has formally joined the rest of NTT province in implementing the Maternal and Child Health Revolution (known as *Revolusi KIA*) program,<sup>3</sup> a program discussed in more detail in the "Thematic Findings" section below.

### **Bonde Sub-district, East Manggarai**

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According to the PNPM Generasi sub-district facilitator (FK) for Bonde, as of 2012 there were 53,508 residents in Bonde living in 42 villages. Volcanic activity in the region keeps the hills fertile and supports a dense population. It takes three hours to travel from the seat of Bonde's sub-district government facilities to the farthest village, 2.5 hours on decent roads to the district capital of Borong, and a half hour to reach the former district capital of Ruteng in neighboring Manggarai district. Bonde has two puskesmas clinics, and the two villages included in this research both fall under the purview of one of them, Puskesmas Bonde. This puskesmas refers health emergencies to the hospital in Ruteng. The Generasi program has been active in Bonde since 2010, but with 42 villages to monitor, the FK has an enormous workload and can not give proper attention to the needs of each community under his surveillance.

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3. > Peraturan Bupati (Perbub) Manggarai Timur No.01, Tahun 2012, tentang Revolusi KIA.

**Dantena Village,  
Bonde, East  
Manggarai:**

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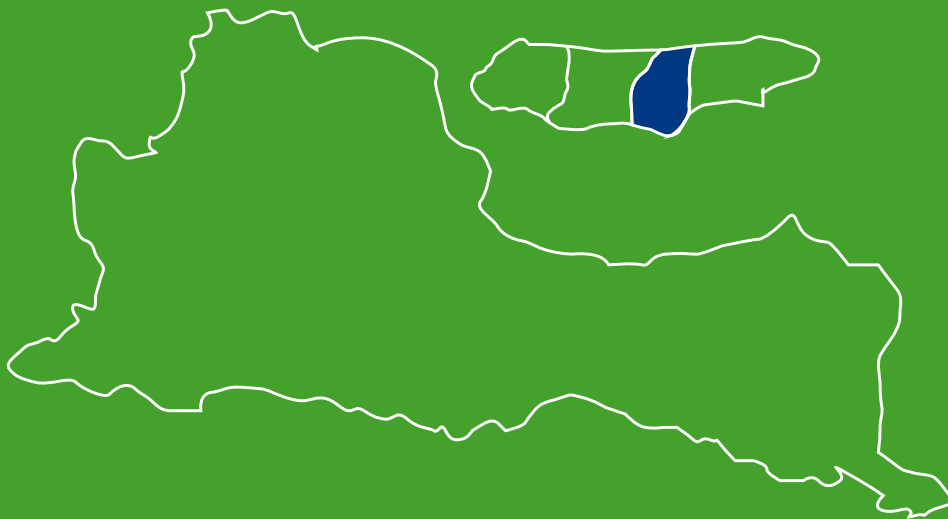
From Puskesmas Bonde, it takes forty minutes along a treacherous mountainside road with partial and narrow pavement to reach the Dantena village head's office, elementary school, and village clinic, all located around a soccer field clearing in Hamlet 1 (see Image 6). Dantena's more isolated Hamlet 2 requires an additional half hour walk down a recently stone-paved path (financed by PNPM Rural). There are 1,027 residents living in 255 households in Dantena, nearly all farming coffee and cacao. The village clinic was recently built in 2010, and Dantena has two full time health workers—one nurse and one midwife—assigned to work and live there, but the clinic remains empty, staffed only by its nurse who commutes from Ruteng on weekday mornings. Dantena's village midwife lives near Puskesmas Bonde. Dantena's women and children face significant undernutrition, though it does not stand out in Puskesmas Bonde's records, nor does their frequent reliance upon traditional birth attendants (*dukun*, hereafter TBA). Each hamlet hosts their own monthly posyandu. The research team selected Dantena for these reasons, but also because of a recent maternal mortality case in which neither health officials nor Dantena neighbors even knew that the deceased woman was pregnant. For more about Dantena's midwife and how Dantena manages in the absence of nearby health professionals, see Case Study #1.

**Bena Village,  
Bonde, East  
Manggarai:**

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Bena has a formal status as *kelurahan* instead of *desa*, a distinction that marks Bena as more urban and with a standardized governing structure. Bena hosts the Bonde sub-district administration and Puskesmas Bonde. Bena is larger (2,716 residents living in 720 households) than Dantena, and has well-paved roads into all five of its hamlets, but it would be a misnomer to call it urban. As with Dantena, most residents in Bena are farmers, though Bena does have more civil servants living there. The research team chose Bena because of its excellent progress in achieving PNPM Generasi's performance indicators as well as in the data reported by Puskesmas Bonde.

# Pamekasan, Madura, East Java (20 — 31 May, 2013)



Map 3: Location  
of Pamekasan  
District



source: [http://id.wikipedia.org/wiki/Kabupaten\\_Pamekasan](http://id.wikipedia.org/wiki/Kabupaten_Pamekasan)

Located just off the north coast of East Java province, road access from Surabaya to Madura island via the new Suramadu Bridge was only inaugurated in 2009 in hopes of stimulating the economy and reducing out-migration from Madura to Java and other parts of the archipelago. Madura is divided into four administrative districts that each cross the width of the island from north to south, and whose administrative centers are all located along the south shore facing Java. The Suramadu Bridge reaches Madura at its west end, and Pamekasan is the third district heading eastward (see Map 3 below), with a population of 881,662 living across 792km<sup>2</sup>, which makes Pamekasan the most densely populated district that the Generasi nutrition researchers visited. Pamekasan town in the south has recently become famous for its vibrant and colorful batik, and researchers encountered dozens of rural households engaged in batik home industry during the fieldwork. Pamekasan has a more diversified economy than East Manggarai, though local prosperity and health indicators decrease as one travels from south to north. Like many other districts in East Java, and in contrast with East Manggarai, religious leaders (Muslim *kya'i*) play an enormously influential role behind the scenes in local governance and in health practices too. More immediately apparent to the research team was the outsize role played by village leadership in determining the success or failure of village programs such as PNPM. The Generasi program was introduced in Pamekasan in 2007 and currently operates in eight of the thirteen total sub-districts. Pamekasan was chosen for its tremendous improvement in PNPM Generasi's health indicators reported in the MIS database. Although one *might* conclude that this is an exemplary and hoped-for side effect of the improved access afforded by the Suramadu Bridge, researchers encountered additional, more proximate causes that certainly contributed to Pamekasan's significant improvement in health service delivery over the past few years.

**Pandeyan  
Sub-district,  
Pamekasan**

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It takes a half hour along a wide and well-paved road to travel northward from Pamekasan town to the central market area of Pandeyan sub-district, where the puskesmas is located next door to a complex of sub-district government offices, including the PNPM office. The puskesmas has in-patient care facilities, and a complete staff including a full-time nutrition specialist who did her thesis research in Pandeyan. On the three separate days that the research team visited this puskesmas, the entire facility was bustling with both staff and patients. According to the head of the puskesmas, Pandeyan had the highest maternal and infant mortality rates in all of East Java, but after implementing an enforced "partnership agreement" between TBAs and midwives, there were impressive improvements (see Table 2). Although the puskesmas head attributes these improvements almost exclusively to the new rules and roles for TBAs in Pandeyan, the researchers came across a wide range of efforts across the health sector and PNPM Generasi that have also surely contributed to these favorable outcomes.

**Table 3: Reductions in Maternal & Infant Mortality in Pandeyan (2010 — 2012)**

	2010	2011	2012
Maternal Mortality	8	1	0
Infant Mortality	16	10	5

*Source: Data reported by Head of Puskesmas Pandeyan*

The FK for Pandeyan has a more manageable workload supervising 12 villages compared to Bonde’s 42 villages, but Pandeyan’s total population of 67,045 exceeds Bonde’s by more than 13,000. There are 83 active posyandu across these 12 villages, each with a complete staff of five trained volunteers, and this is due largely to inputs from Generasi.

**Badran Village, Pandeyan, Pamekasan:**

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The rocky landscape in Badran is not conducive to routine farming activities; many of the men work in a nearby quarry. The research team chose Badran as an exemplary “average” village relative to the impressive achievements in the neighboring village of Suruan. Instead, the researchers encountered a village still recovering from the disruptive aftershocks of a very close village election three years prior. Given the precarious political situation that prevailed in Badran, the supposed “average” nutritional health outcomes are nothing less than astonishing given so much adversity, with the former leaders working actively to spoil and sabotage the efforts of the new leadership, including their efforts to improve maternal and child health. After the election, the entire corps of posyandu volunteers (with one exception), and all of the PNPM actors (both Generasi and PNPM Rural) in Badran resigned. Not unlike the former leadership, the new regime installed close confidantes and family members in these vacant positions to restaff the posyandu and Generasi teams, but with an important distinction: nearly all sources interviewed agreed that the new leadership is invested in transparent village development that benefits the entire community and not just themselves. Just one example: even though Generasi pre-dated the new village leadership, there were only five posyandu for seven hamlets before the election, each with only a few volunteers, but now there are seven fully staffed and trained posyandu, one for each hamlet. Case Study #3 examines the details of Generasi’s role in this community going through this painful but productive transition.

**Suruan  
Village,  
Pandeyan,  
Pamekasan:**

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The agricultural village of Suruan grows tobacco, peanuts, soybeans, and rice. The most compelling reason for including Pandeyan in the research were the examples that the Pandeyan FK shared with the team referring repeatedly to the active midwife based in Suruan village (see Case Study #1). The Pandeyan puskesmas head confirmed the FK's reports, and suggested we visit Suruan. And yet, according to official puskesmas data, Suruan never achieves its projected health targets. Projected targets are based on population statistics, but Suruan's population, by some formal records but not others, includes the population of roughly 5,000 *santri* students that reside in one of Madura's largest *pesantren* (Islamic boarding school), which leads to skewed estimates such as projected childbirths. While including the *santri* in Suruan's population data has detrimental effects on projections in the health sector, in other sectors of Suruan's governance, the *santri* are a political benefit, providing a full sack (*kantong*) of votes for the candidate of their *kyai's* choosing in any election. Whoever the *kyai* backs for a village election will surely win, providing a strong measure of stability in Suruan's village politics, and in turn enabling the sustained implementation of long-term village development programs such as Generasi without significant local friction. While researchers heard stories of *kyai* in other parts of Madura who sought political gain by opposing public health programs, in Suruan the powerful *kyai* has not bothered himself with the health sector and village health matters are thus primarily managed by the village midwife and secondarily by Generasi actors.

# Thematic Findings

Dozens of interviews, group discussions, and direct observations of posyandu and other health-related activities and behaviors in the five villages described above generated a diverse set of recurring themes, discussed below under three sub-headers that roughly correspond with the research questions: “Chronic Undernutrition” addresses RQ1, identifying factors that improve or worsen maternal and child nutrition in Generasi villages; “Capacities and Involvement” addresses both RQ2 and RQ3, and examines the ways in which different stakeholders understand and interact with health providers and the Generasi program; and “Elite Control and Elite Capture” addresses RQ3, looking specifically at how formal and informal leaders at the village and sub-district levels implement and leverage nutrition-related services via either Generasi or health providers.



## RQ 1

Chronic undernutrition remains poorly understood and unaddressed within Indonesia's public health system, which responds more effectively to cases of acute malnutrition. National studies have estimated the prevalence of stunting in children at 37% (Riskesdas 2007). The following research findings suggest a diverse set of issues at the sub-district and village level that contribute to this persistent public health challenge.



### Generasi Food Supplements at Posyandu: Unintended Consequences

Informants in all five villages consistently reported what has generally been acknowledged as Generasi's biggest success: increasing posyandu participation and attendance, in part through the provision of food supplements. Food supplements at the posyandu, called "outreach supplements" because of their drawing power, are one of Generasi's most effective tools to reintroduce parents and their children to the front lines of public health service delivery in their own communities. In turn, increased attendance improves preventive surveillance of mothers and children at risk for undernutrition.

Nevertheless in all five villages, outreach supplements are always Generasi's largest health-related expenditure. Evidence for the effectiveness of complementary feeding strategies as a tool to prevent undernutrition is lacking (Bhutta et al., 2013), and since posyandu is a monthly event, the supplements do not actually address or prevent cases of chronic undernutrition. Furthermore, Generasi actors tend to purchase simple packaged products of questionable nutritional value such as biscuits that are easy to procure in bulk and do not quickly expire.

Some unintended side effects of Generasi's food supplements include:

**Reproducing What the Puskesmas Already Includes (or Should Include) in its Operational Budget:** In the best cases, such as what researchers found in Pandeyan, the village midwives coordinate with Generasi actors to ensure that no communities receive food supplements from both the puskesmas (or other government source) and Generasi. This can be an effective solution for puskesmas that are chronically underfunded and cannot meet the demand for their entire sub-district. In other cases,

researchers detected a slide toward complacency wherein some puskesmas choose to reduce their coverage area of food supplements, recognizing that Generasi can make up the difference. At the district level in Pamekasan, health officials told researchers that the annual budget for food supplements was removed and redirected toward financing the upcoming district elections. Indeed at the puskesmas in Pandeyan the nutrition specialist only had supplements for acute cases of malnutrition and there was no budget for outreach supplements to be provided at monthly posyandu activities, though they have had it in the past. Generasi, or the village communities themselves, provide it instead, and rather effectively. In the worst case scenario as in Bonde, puskesmas staff resent Generasi involvement in the business of food supplement altogether and refrain from monitoring underweight cases that receive assistance from Generasi. If the goal of Generasi is to stimulate demand for public services, in some instances the provision of supplements through Generasi has had the unintended effect of reducing supply-side accountability to communities.

**Producing Only a Temporary Demand:** One of the big successes of Generasi is improved attendance at fully staffed posyandu, and the volunteers and Generasi staff all credit the availability of food supplements that draw parents to attend with their children. In Bonde, where the annual Generasi budget has steadily decreased for the past three years, Generasi can no longer consistently provide food supplements for posyandu activities as they had in prior years, and volunteers notice that attendance has subsequently decreased.

**Removes Incentives for Community Initiatives:** A long-time posyandu volunteer in Bonde's Bena village noted that before either Generasi or the puskesmas offered food supplements for posyandu activities, the volunteers and village leaders procured their own food for the monthly posyandu. This posyandu in Bena used to attract parents to attend by holding *arisan* (revolving credit) activities every month at the posyandu. They would also purchase food for the monthly posyandu through communal cash contributions, something which the villages in Pandeyan, Pamekasan still do, but in Bena the prevailing attitude has changed to one of dependency on either the puskesmas or Generasi to provide the food that draws attendance. The Generasi district facilitator for East Manggarai recognized this as a side effect of the posyandu food supplement, and wondered if Generasi might better spend its budget on networking, lobbying, or advocacy activities that might stimulate a return to community-led initiatives.



## Local Diet

In Bonde, the dietary mainstay is referred to as “*makan segitiga*,” a “triangle diet” whose three points are water, vegetables, and salt (*air, sayur, dan garam*). The research team witnessed this as a daily mainstay in most households in Dantena and Bena (see Image 1 below). Either a local variety of squash or cassava leaves are boiled in salted water, and then poured over an enormous plate of rice. Interestingly, these were not households in extreme poverty. Most farming families own their own land; they are not sharecroppers. Most households keep chickens, and many also raise pigs and goats, but these are reserved for enormous social obligations known as *sida*, mandatory contributions of livestock (or money) when members of the extended family get married or pass away, or for sale at the market.

“We typically sell the livestock that we have in order to buy rice. Besides that, here [in Manggarai] we have a tradition called *sida*, where all members of an extended family must make communal contributions, so that when there are activities such as parties and celebrations, everyone must contribute. That’s why people in Manggarai cannot get ahead; their traditions mandate too many social contributions.”

(Village Secretary, Dantena)

“Our livestock is for income, not to eat.”

(Magdalena, Women’s FGD participant, Dantena)

“Even when we have chickens or pigs, it wouldn’t feel appropriate to eat it ourselves given that we still need money.”

(Yati, Women’s FGD participant, Dantena)

Despite their own livestock, most households in Bonde do not have a routine source of protein in their daily diet. By contrast, in Pandeyan, families in Badran and Suruan also eat meat rarely but they are surrounded by vegetarian sources of protein, especially peanuts, tofu, and tempe.



Image 1: “*Makan Segitiga*,” the “triangle diet,” in Bonde Sub-district, East Manggarai

The daily diet in most Bonde households features a local variety of squash or cassava leaves, boiled in salted water, and then poured over an enormous plate of rice. This particular meal shown in the photograph featured the addition of instant noodles in honor of the visiting researchers from Jakarta.



### Childrearing Practices

Wives and husbands in Bonde typically work in their gardens (primarily grooming and harvesting coffee, cacao, or clove trees in this mountainous region), sometimes for days at a time. Mothers either leave their young children with a relative in the village or take them along to the gardens, but in either case informants report that most parents are unable to prioritize either a nutritious diet or a stimulating social environment for their children. In empty homes, or alone up in their gardens, researchers observed children eating the same “triangle diet” as their parents, with very little direct engagement for integrated growth and development.



### Hygiene Practices

The complex problem of undernutrition also requires attention to local environment and hygiene practices such provision of toilets, access to clean drinking water, and handwashing promotion. Attention to environmental hygiene helps reduce inadvertent consumption of enteropathic bacteria, which stimulate a growth-suppression immune response (Humphrey 2009). Almost all children in Bonde, especially in Hamlet 2 of Dantena village, appear to live with minor but persistent respiratory infections, and they spend their days playing without shoes, frequently in open sewage areas (see Images 2 & 3 below).

Images 2 & 3:  
Poor Hygiene  
Among Children  
in Bonde Sub-  
district, East  
Manggarai



Left: A child with an upper respiratory infection in Dantena village plays around an open sewer.

Right: An underweight child in Bena village that receives food supplements with support from Generasi. His mother, pregnant with her second child, reports that his runny nose never goes away.



### Women Factory Workers

The research team came across a surprising side topic of relevance during the pilot phase in Ciperi sub-district of Sukabumi, West Java. In 2012, five out of the six cases of maternal mortality in Ciperi were women who worked in factories, drawing attention to the labor practices of factories and compliance with a minimum standard of maternity benefits and workplace provisions for pregnant employees. In response, the midwives at the Ciperi puskesmas have initiated biannual health exams for factory workers, and report a begrudging and minimal level of cooperation from the factory managers. Nevertheless, many ordinary residents in Ciperi, and even elsewhere in Sukabumi district, were quite aware of the maternity risks and other health issues faced by peri-urban factory workers, reflecting an uneasy relationship with the still recent entry of manufacturing industries into their community. As this issue presented itself during the brief pilot phase, and also because the health issues faced by factory workers was slightly outside the scope of research, the team could not pursue this surprising finding in more depth. The research team left Ciperi with a strong sense that this presents a compelling avenue for additional research, not least because it likely connects with the problem of chronic energy deficiency in pregnant women (see immediately below).



### Rare Acknowledgement of Chronic Energy Deficiency (KEK)

The cases of maternal mortality among factory workers in Ciperi draw attention to the nutritional risk of chronic energy deficiency (known as KEK in Indonesian, *Kekurangan Energi Kronis*) in pregnant women, who are far more likely to give birth to underweight infants who then grow up with a disproportionate risk of chronic malnutrition (Victora et al., 2008; Walker et al., 2007). The research team found an alarming lack of awareness of KEK at the village level, while midwives and health professionals rarely mentioned it on their own as a *nutritional* risk for mothers and their infants. Instead health professionals regard KEK as primarily a risk for pregnancy complications. When asked directly, most midwives could define KEK, and mentioned that arm measurements are a routine part of their pre-natal exams. As chronic malnutrition becomes an object of increased focus as Indonesia aims to improve maternal and child health, then education about and outreach to women with KEK must improve.

## Capacities and Involvement

RQ 2

+

RQ 3

### Generasi's Incentivized Block Grants

One of the sub-districts surveyed in this study (Bonde in NTT) received incentivized block grants since the start of the impact evaluation (the Treatment A group) in 2007, while the other two sub-districts started receiving their incentivized grants in 2009. All five villages should have been informed of these block grant incentives to achieve Generasi's target indicators since at least 2010. A surprising finding about the block grant incentives was the general lack of acknowledgement, awareness, or knowledge among village communities, including among some of the Generasi actors themselves. For example, one of the Generasi KPMD in Bena village in Bonde revealed a fundamental misunderstanding of how the incentivized grants work when she told interviewers she was disappointed to learn that the "incentive" or "bonus" for achieving target indicators was not a personal reward for Generasi actors themselves but rather for the whole community. While observing the posyandu in Dantena's Hamlet 2, interviewers asked the hamlet leader about Generasi's incentivized block grants, but he only shook his head and said he did not know about any bonus system. He looked suspiciously at the PK for Dantena, who was also a part of the conversation, and he too answered that he did not know much about an incentive system. Meanwhile in Pandeyan sub-district, the PK in Suruan village told interviewers that the incentive grants are discussed at the inter-village fund allocation meetings at the sub-district level (*musyawarah antar desa (MAD) alokasi dana*), and in Suruan and Badran at least, information about these incentives is not disseminated to the community. The extra funds may be reflected on the total budgets posted on public bulletin boards, but the budgets are not itemized to reflect the added reward for achieving annual targets, much less announced or promoted as such. The Suruan PK suggested that this was to prevent social jealousy between Generasi villages. Given this limited knowledge of the incentive block grants, it seems unlikely that these grants, whether awarded or not, have any incentive effect in achieving improved nutritional outcomes.



### Productive Collaborations

With so many different stakeholders involved in local nutritional outcomes, the very process of communication, coordination, and collaboration poses a multi-facted challenge. At least one central figure—the village midwife—consistently emerges as a focal point (see Case Study #1) through which Generasi and other stakeholders must interact when concerned with the nutritional status of women and their children.

**Between Local Health and Generasi Actors:** After a few days in Bonde, the research team encountered strained relations between the professional midwives and the Generasi program, whereas in Pandeyan there was routine

and close coordination. In fact, in Pandeyan the coordinating midwife at the puskesmas shared some of the same concerns about Generasi as the coordinating midwife in Puskesmas Bonde. They both lamented a lack of awareness or involvement in Generasi's activities in health domains usually under their purview.<sup>4</sup> What mitigates the situation in Pandeyan are the *village* midwives who work closely with village-level Generasi program managers, whereas in Bonde there were no full time midwives present in the villages, which short circuits the link between Generasi activities on the ground and health professionals at the sub-district level. In Bonde there were opinions and blame on both sides, but it seemed clear that users on the demand side did not benefit from these kinds of standoffs over issues such as who decides what constitutes correct food supplements (and perhaps more importantly, who purchases it).

**Between Midwives and Posyandu Cadres:** The difference in the level of coordination and collaboration between village midwives and the local volunteers who manage the posyandu leads to striking outcomes. In the Bonde sub-district of East Manggarai, posyandu cadres consistently report that the village midwife only attends special posyandu activities such as when there is Vitamin A distribution. Even though the midwives are typically absent, the cadres in East Manggarai are prevented from conducting critical outreach and detection activities (see 'Control and Protection of Specialized Nutrition Knowledge' section below), and feel disempowered to do anything other than carry out the mechanical functions of a posyandu clinic such as weighing babies and filling the register. Compare with observations in the Pandeyan sub-district of Pamekasan, where village midwives live in their assigned villages and coordinate closely with their posyandu cadres, fill out the registers together after every monthly activity, and encourage routine training activities for cadres so that they too may identify undernutrition and other health problems for referral in their communities.

**Between Midwives and Traditional Birth Attendants:** In Ciperi, Bonde, and Pandeyan, the research team heard about "partnership (*kemitraan*) agreements" between village midwives and traditional birth attendants (*dukun beranak* or TBA). The essential point of these agreements insists that TBA must no longer deliver infants on their own, and are instead given an incentive to arrange and accompany pregnant women in labor to a trained midwife, preferably at a health facility. In exchange, the TBA will receive somewhere between Rp20-50,000, almost always taken from the midwife's *jampersal* insurance reimbursement. These local agreements are based on a national policy framework published by MoH in 2011.<sup>5</sup> These guidelines describe how TBAs can support midwives and indirectly contribute to reduce maternal and child mortality. In the best instances, midwives know all of the TBA in their community, and encourage TBAs to be involved in pre-natal and post-natal care. But more commonly the research team found that midwives merely tolerated or openly scorned TBAs as an archaic nuisance; the "partnerships" are seen as a tool to sideline and eventually stamp out TBAs altogether.

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4. > Researchers cross-checked these claims against attendance records maintained by Generasi actors and learned that puskesmas representatives typically attend coordination meetings in both Bonde and Pandeyan sub-districts.

5. > <http://www.kesehatanibu.depkes.go.id/wp-content/uploads/downloads/2011/12/PEDOMAN-KEMITRAAN-BIDAN-DUKUN.pdf>

In Ciperi and Pandeyan, health professionals formally implemented these “partnership agreements” between midwives and TBAs. In Bonde there was talk about partnership, at least to make sure that the TBAs registered with the puskesmas were aware of the *Revolusi KIA* program (for more on *Revolusi KIA*, see below), but none of the TBAs that researchers interviewed in Bonde had heard of the program, nor of any partnership agreements. Despite the cultural sensitivity and practical breadth written into the national guidelines that acknowledge an important role for TBAs throughout the entire childbirth cycle, in local practice the main goal of partnership agreements is to prevent TBAs delivering babies on their own, and to encourage TBAs to refer pregnant women to trained midwives. Cooperative TBAs will make referrals and even accompany women to a health facility when they go into labor. In return, the midwife typically gives a small payment (usually around 40,000 rupiah, roughly USD4.00). Given this rather narrow interpretation and implementation of MoH’s broadly defined policy framework for TBA partnerships, Generasi has an opportunity to mobilize this underutilized and undercompensated village resource. (For more on TBAs, see immediately below.)



### Traditional Birth Attendants (TBAs)

Plenty of evidence suggests that TBAs persist as respected figures among women, not least because they provide advice and care throughout the entire childbirth cycle. While researchers found examples of TBA who still rely on questionable methods and knowledge, just as often they found others that were fully informed on aspects of nutritious diet and hygienic practices, suggesting that the persistence of TBAs in local communities presents an opportunity and not a nuisance for the health system (and to Generasi).

Each village surveyed had active TBAs in the community, and yet both Generasi actors and health professionals initially denied their presence when researchers asked about them. In retrospect this appears puzzling considering the aforementioned midwife-TBA partnership agreements sanctioned by MoH (see immediately above). When health officials and Generasi actors eventually acknowledged the existence of TBAs in their community, some described TBAs as an anti-modern institution that they are trying to eradicate. Other more culturally competent informants spoke of TBAs as respected customary figures in the community that are here to stay, and noted that the health system must learn how to work together with them. Nevertheless all health officials without exception described TBAs as *bandel*, which means recalcitrant, disobedient, or stubborn. The term is typically reserved for children and thus has deeply patronizing overtones. TBAs who are still *bandel* (and the mothers, also *bandel*, who continue to solicit their services) become the scapegoat for high maternal and infant mortality rates, which was how the head of the Pandeyan puskesmas explained the unacceptably high figures from a few years ago (see Table 2 above). Perhaps in response to this prevailing attitude toward TBAs and their users,



the partnership agreements, in addition to focusing only on referral to midwives for childbirth, typically rely upon a system of reward and punishments to ensure compliance. Punishments frequently invoke and include security actors (local police and military actors) to enforce them in an effort to scare TBAs and their clients into compliance. The head of the puskesmas in Pandeyan explained why:

“We still value and honor the TBAs in the villages, they are products of the local culture, but they require monitoring. So we conduct a ‘social audit,’<sup>6</sup> by inviting army officers from the Pandeyan sub-district command unit (*koramil*) and police officers from the Pandeyan precinct (*polsek*). The TBAs are afraid of them. Ideally we do a social audit with security actors. Their presence is important, to scare the TBAs. These are the social sanctions we have developed and implemented.”<sup>7</sup>

— Head of Pandeyan Puskesmas

Generasi typically has minimal involvement with village TBAs and the partnership agreements described here, with one notable exception. In Pandeyan, Generasi supported the puskesmas’ socialization of the new midwife-TBA partnership agreements, paying for two meetings at the sub-district level and followed-up with meetings in each village. Given their formulation and implementation, these new regulations might only euphemistically be called “agreements,” much less “partnerships,” instead of the top-down and martial directives that they are in practice. Rather than support this sort of partnership between midwives and TBAs, Generasi might explore a more inclusive and equitable interpretation of the MoH framework that explicitly encourages a persuasive and educative approach instead of compulsion.

As late as the 1990s, the health system had an accreditation program for TBAs, and some of the more elderly TBAs showed their training certificates to interviewers. But with or without training, TBAs persist as a local institution and community resource not least because women know them well, and trust them. As MoH guidelines acknowledge, TBAs are actively involved in the entire childbirth cycle, from confirming pregnancies, to various pre- and post-natal care practices, to spiritual guidance and pastoral care. The partnership agreements do not adequately compensate TBAs for their services to women when midwives are either unavailable or too busy to attend

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6. > The doctor did not explain how he interprets the term “social audit,” but he only mentioned it in reference to the inclusion of security actors on the implementation of Pandeyan’s partnership agreements between trained midwives and TBAs.

7. > The MoH policy guidelines encourage a multi-sectoral approach to the development and implementation of midwife-TBA partnership agreements. For example, the guidelines specifically mention the inclusion of sub-district health officials, civilian sub-district leaders, formal village leaders, informal community leaders and religious leaders, but the MoH document never mentions nor alludes to the inclusion of security actors from the police or military. Fieldwork from this research and at least one other PNPM-sponsored research project shows that the formal inclusion of security actors occurs variously and inconsistently at the provincial, district, or sub-district level.

to pregnancy needs that are not strictly medical. To be sure, some TBAs do rely on practices that may actively complicate the health of mothers and their infants, but many others certainly understand the basics of hygienic maternal and child health care and nutrition.<sup>8</sup> If the health system and Generasi do not involve the TBAs, it is a missed opportunity to mobilize an active, trusted, available and inexpensive community resource on behalf of improved health outcomes for women and their children.



### Normative Inclusion and Exclusion Criteria (Deservingness)

Questions surrounding “who deserves what,” or “deservingness,” have recently received attention in social science discussions around healthcare, recognizing that “moral conceptions of deservingness are foundational to all discussions of health-related attention, care, and investment,” but still remain “notably understudied and... poorly understood” (Willen 2012, p. 819). One reason is because assumptions of deservingness are typically *implicit* and taken for granted. As opposed to questions of universal, but abstract, health rights, typically expressed through juridical discourse, questions of deservingness require attention to “vernacular moral registers” that are “situationally specific and often context-dependent,... liable to shift and change” (2012, p. 814).

While conducting fieldwork, the researchers encountered several examples of implicitly articulated exclusion criteria that created local hierarchies of deservingness when discussing the Generasi program and nutritional outcomes for mothers and their young children. In Bonde, when Generasi actors, health officials, and several program beneficiaries discussed a recent maternal mortality case in Dantena village, no one failed to mention that the deceased mother of seven (formerly eight, one of her toddlers died one year before she did) lived with a mental illness. The extent of her exclusion from the community was readily apparent when many informants explained that they had not even noticed she was pregnant when she fell into a seizure during the seventh month of her ninth pregnancy. Dantena’s village midwife told researchers that she would not include this case in her routine data reports to the Bonde puskesmas specifically because she had a mental illness.

Another apparent example of a local hierarchy of deservingness from Bonde is discussed in some additional detail under the “Control and Protection of Specialized Nutrition Knowledge” header below, which notes the exclusion of Generasi beneficiaries who receive food supplements from follow-up monitoring by health officials. Through interviews with the puskesmas staff, the posyandu volunteers in Bena village, and Generasi actors, the research team discovered that if Generasi

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8. > While some of the better practices among TBA may be attributed to those who were old enough to participate in accreditation trainings when they were still offered in the 1990s and earlier, researchers could not discern any particular patterns that distinguished TBAs knowledgeable of best practices from those who were not. In general, TBAs credit their intuition garnered from their years of experience.

provided food supplements to households with undernourished mothers or children, then the puskesmas staff would exclude them from monitoring. In the explicit words of the midwife coordinator at the Bonde puskesmas, only families that receive food supplements directly from the puskesmas deserve follow-up care. The puskesmas staff argue that only they are empowered to determine who is and who is not undernourished. The Generasi actors and posyandu volunteers argue that it takes the puskesmas staff too long to make that determination when some families are clearly suffering, and so they go ahead and provide assistance. In these situations, the puskesmas staff then refuse to acknowledge and follow-up with these households.

In Pandeyan researchers encountered a different hierarchy of deservingness. Health officials, posyandu volunteers, and Generasi actors all bemoaned the ignorance of particular religious residents in their community who refused to access public health services. They blamed particular religious leaders who forbid their followers from using family planning services, immunizing their children, or attending posyandu. These non-users were described to researchers as “unaware,” “stubborn,” or “backwards” in their attitudes toward health services. This becomes an explanatory model that in turn allows Pandeyan’s lower health outcomes relative to other sub-districts in Pamekasan to persist without a sense of urgency. In Suruan, health officials and posyandu volunteers operationalize this local conceptualization of deservingness in at least two ways. First, instead of using a more persuasive approach (an example of which researchers found in Ciperi; see “Bu Haji” in Case Study #2), health officials and posyandu volunteers would ask religious families to sign a letter that explicitly acknowledges that they refused the services that were offered to them. While the refusal of services in Pandeyan is self-initiated by some of the more religious members of the community (or instructed by a third party, their religious leaders), the act of signing a letter becomes a literal act of “writing them off” their books, which leads to the second method by which the local hierarchy of deservingness in Pandeyan leads to concrete outcomes. After formally documenting the service refusers, health officials and posyandu volunteers restrict the distribution of food supplements to posyandu users only. One of the posyandu volunteers introduced the researchers to one of these non-user households in which the husband forbid his wife from bringing their children to posyandu. Some of the children were obviously unkempt and too small and thin for their age, but they are not eligible for food supplements.

These examples show some of the ways that prevailing conceptions of “deservingness” result in particular forms of exclusion of some members of the community not just from available health services, but also from the compilation of health data. Deservingness is a particular challenge because assumptions of who deserves what are embedded and naturalized in the communities where Generasi operates, and these prevailing beliefs include health and Generasi actors.



## The Revolusi KIA Program: Unintended Consequences

The so-called Maternal and Child Health Revolution (known as *Revolusi KIA* in Indonesian) in NTT province, has had some unintended consequences. Formally launched by the NTT governor in 2009, the stated purpose of the Revolusi KIA program is to provide assurance and protections to mothers and their infants through the provision of maternal and child health care services without discrimination.<sup>9</sup> The program aggressively addresses NTT's notoriously high maternal and infant mortality.<sup>10</sup> According to the NTT Department of Health, the sources of such high maternal and infant mortality are poor access to trained health professionals and properly equipped facilities. The Revolusi KIA program requires all pregnant women to deliver their infants in accredited health facilities and receives significant international donor support.

Particularly striking to the researchers during fieldwork was the aggressiveness with which the goals of Revolusi KIA were relentlessly pursued by health officials and providers to the detriment of the quality assurances and human protections that the program was meant to achieve. Whenever researchers broached the subject of Revolusi KIA with health officials, the first response was invariably laughter. The head of the East Manggarai district health office expressed skepticism about the program when he told his interviewers that "the people of NTT have been overly euphoric about Revolusi KIA," explaining that NTT's infrastructure, health facilities, and human resources are still inadequate to support the goals of the program. The result, he lamented, is that health officials have "adapted" (*disesuaikan*) the program's implementation to East Manggarai's conditions and available resources: "Revolusi KIA has been too hard to implement, so we develop our own versions of the program in each region."

How Revolusi KIA operates in the field does not accord with the program's technical guidelines. In Bonde sub-district, researchers detected that health providers at the puskesmas were under an extraordinary amount of pressure to deliver outcomes that demonstrate Revolusi KIA's success. There was evidence that midwives and program managers are producing "fictive" data in order to meet Revolusi KIA targets when researchers observed that the data contained in posyandu register notebooks did not match puskesmas reports on standard maternal and child health indicators. Indeed, in a discussion with Dantena's midwife, when asked about the recent maternal mortality case in her village after she told us there have been none during the past few years, she forthrightly explained that "I purposely decided not to mention that case..." because the mother had a mental illness, and this was her justification for not including her death in the puskesmas reports. "Otherwise," she explained, with visible emotion, "I would not meet my [Revolusi KIA] targets."<sup>11</sup> (see also Case Study #1)

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9. > Pasal 6, Peraturan Gubernur (Pergub) NTT No.04, Tahun 2009, tentang Revolusi KIA.

10. > Data from a 2004 national health survey reported that the maternal mortality ratio for NTT was 554/100,000 live births, versus a ratio of 307/100,000 for all of Indonesia. The infant mortality rate for NTT in 2007 was 57/1000 live births, versus 34/1000 live births for all of Indonesia.

11. > The researchers note, however, that other programs, including Generasi, run the risk of actors on the ground falsifying their data in order to meet targets.

### Local Leadership

Beyond the central role played by village midwives, the involvement of the broader community of local elites also appears to determine the success or failure of programs that support improved nutritional outcomes. Researchers met several formal and informal community leaders performing decisive roles in the success of *Generasi* and *posyandu* activities. In general, researchers discovered that *Generasi* provides opportunities for elites to retain and fortify their social standing. As brokers delivering CDD resources into their communities, local elites leverage *Generasi* to accumulate additional status for themselves. Without exception, every *Generasi* actor that the researchers met held other leadership roles in their community and maintained close ties with the local structures of village and sub-district governance.<sup>12</sup> Likewise, the more successful *posyandu* were led by local volunteers who also participated as leaders in other aspects of their community. Such a dynamic does not automatically call into question the altruistic motives of these leaders. The findings of this study support earlier research on PNPM by Dasgupta and Beard who concluded that “not all elites who had power were corrupt, a finding that highlights the important distinction between elite control and elite capture. Local elites were willing and able to contribute the time and know-how needed to facilitate community-level projects and governance” (Dasgupta & Beard, 2007, p. 244). One of the strategies that local elites use to maintain their *control* if not the *capture* of *Generasi* resources is by appointing members of their extended family or trusted confidantes in their personal network to manage *Generasi* activities. If the longer term goal of *Generasi* aims to break the cycle of poverty by generating demand for education and health services, in the short and medium term *Generasi* should recognize how elite networks leverage *Generasi* activities to consolidate their position in the local communities where they have influence, at the expense of some of the democratizing benefits that *Generasi* aims to facilitate.

A reliance on local leaders to ensure *Generasi*'s success also implies that *Generasi* activities risk failure when those leaders either opt-out of participation or participate counter-productively as spoilers to program success. The interesting question is whether and how local elites use this process of status accumulation via *Generasi* to generate beneficial outcomes for non-elites in their community, or to act as spoiler agents of elite capture. Case Study #2 demonstrates how these dynamics work through a collection of profiles in strategic leadership in the villages visited by the research team.

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12. > In an earlier evaluation of PNPM, David Mosse also found that village facilitators were typically drawn from privileged households in the community (Mosse 2008).



### Control and Protection of Specialized Nutrition Knowledge

In Bonde, the research team repeatedly discovered (expressed by both the demand and supply side) that health providers, midwives in particular, claimed and protected a specialized nutritional knowledge as a marker of professional expertise. This manifests in two specific ways:

**1. Determining who is malnourished:** Midwives in Bonde explained to researchers that the reason why there were so few cases of malnutrition despite the large number of posyandu records that show children “under the red line” (*bawah garis merah*) on their weight-for-age growth charts is because they do not meet the criteria for malnutrition. When an under-five child’s weight-for-age falls beneath the red line or if the child does not gain (or loses) weight three months in a row, then the midwife will make a referral to determine whether the child suffers from malnutrition. At the puskesmas, trained health professionals use the WHO/NCHS<sup>13</sup> standard for determining who is malnourished, and in Bonde *only they can do this*. Since midwives rarely attend the monthly posyandu in Dantena or Bena villages, the midwife’s posyandu register books (which someone else fills in for her) are sent back to the puskesmas for evaluation where she will inspect and look for the children who require referral. But researchers observed directly that these posyandu registers sit in a pile at the puskesmas, resulting in weeks or months of delay between data collection and detection. More often there is no detection at all because midwives never find the time to carefully go through the registers. Back in the villages, posyandu volunteers and Generasi actors have been told repeatedly that they are not even qualified to make referrals.

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13. > In 1999, WHO [the World Health Organization] defined severe malnutrition in children as a weight-for-height below -3 standard deviations (based on the NCHS [US National Center for Health Statistics] reference) and/or the presence of oedema.” (World Health Organization 2009, p. 3)

**2. Determining correct food supplements:** Likewise only puskesmas staff (preferably a nutritionist or midwife) may determine the correct food supplements that a child needs to recover once diagnosed with malnutrition. When the midwife does not attend posyandu or visit the village, communities go ahead and choose food supplements on their own via Generasi, leading to the strained relations described above between the puskesmas midwives and Generasi staff in Bonde. In fact, there are no significant differences between the supplements provided by Generasi and the puskesmas, typically a bulk purchase of biscuits and milk formula. Respondents in both Dantena and Bena villages reported that although they gratefully accept food supplements procured by the Generasi program, they would prefer their village midwives to assign the “correct” menu instead, because they too believe that only health professionals know how to prescribe a nutritious diet for underweight women and children. Furthermore, recipient communities argue that puskesmas staff will follow-up to ensure that the beneficiaries recover, whereas Generasi does not do specialized case management. But when Generasi purchases food supplements, the puskesmas then abdicates their monitoring responsibilities for the recipient community because they feel that their authority in matters of nutritional health has been sidestepped.

This attitude toward specialized knowledge in Bonde appears all the more puzzling when compared with what the research team found in Pandeyan, where posyandu volunteers had the training, knowledge, and confidence to recognize signs of undernutrition, and knew how to refer cases to the village midwife. The midwives in both Badran and Suruan villages lived in their communities for many years, and coordinated productively with the Generasi program to ensure that food supplements from either the puskesmas or Generasi were not overlapping.

# Case Studies

## Case Study #1:

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### A Tale of Two Midwives

#### Introduction

Two of the village midwives we met, one assigned to Dantena (in Bonde sub-district, East Manggarai, NTT) and the other to Suruan (in Pandeyan sub-district, Pamekasan, East Java) provided the Generasi nutrition research team with a study of astonishing diametrical contrasts in their attitudes and practices, their receptions in their host communities, and their collaborations with the Generasi program.<sup>14</sup> Both were born and raised in the regions where they work, each fluent in the local language, but neither come originally from the specific villages where they have been assigned to work. They may both be categorized as local elites in their respective sub-districts, but the similarities end there, because *how* they wield their elite status — whether or not they genuinely seek to improve the social welfare of the communities where they work — makes all the difference between an accomplished advocate and a neglectful spoiler.

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14. > Dantena and Suruan villages, and Bonde and Pandeyan sub-districts, are pseudonyms. All specific names of individual people have been changed as well.



### Suruan's village midwife, Ibu Nurhayati

When Ibu Nurhayati describes the work of outreach (*penyuluhan*) in Suruan where she has lived and worked as the village midwife since 1998, she flashes a wide knowing smile and sighs with resignation, "it's all about talking and talking (*bicara dan bicara*)... talking and talking... it never ends." Such an apparently Sisyphean task, however, has yielded impressive results over the past 12-13 years that she has worked in Suruan.

Ibu Nur explained many of the local beliefs in Pandeyan that informed women's resistance to come to her clinic. We verified these local perceptions of the midwife's clinic from several additional and varied informants. First, historically most women in Pandeyan manage their pregnancies at home, and traditional birth attendants (TBAs) come over to assist with deliveries. Second, any trip to a clinic would send a signal to the surrounding community that the mother is suffering from some kind of pregnancy complication. In such cases, the entire community typically accompanies the patient to the clinic and creates an embarrassing public drama for young mothers that they prefer to avoid. Third, and this is less intuitive to outsiders, is the local interpretation that pregnancy complications (or even painful deliveries in general) are a sign of shameful secrets (*aib*) within the household, so women not only avoid the clinic to prevent rumors from spreading, but they also try to keep quiet when they deliver at home. Fourth, perhaps related to the second point above, is a fearful association of the clinic with painful, invasive, and embarrassing procedures such as sitting exposed on a delivery table ("*disuruh nganggang*") or using a needle and thread to sew stitches ("*takut dijahit*") after delivering their babies. Finally, a widely held taboo prevents women from leaving their houses during the first 40 days after delivering their infants, precluding visits to the clinic for post-natal care.

For all these reasons, during the first four years that Ibu Nur worked and lived in Suruan, few women would voluntarily visit her clinic. Instead, she had to proactively assist with, or "intercept," deliveries by going directly to a mother's house while she was giving birth with a TBA. She recalls with grateful and historic clarity when the first mother delivered her baby at the village clinic in 2004:

“ Her name was Ibu S. She was the first to come on her own to give birth at my village clinic (*polindes*). It was Ibu S who promoted my services to the others, assuring them it was comfortable, that I provided a pain killer, that I ensured their privacy, that the recovery was quick, and that she was able to walk again only a day after giving birth. After that, one by one the women in Suruan would come to deliver their babies with me at the clinic. ”

— Ibu Nurhayati (Suruan’s village midwife)

Ibu Nur includes the local TBAs in her program of pre-natal, delivery, and post-natal care for mothers in Suruan. She not only makes sure that Suruan’s TBAs participate in the mandatory “partnership” between midwives and TBAs in the Pandeyan sub-district for the past two years, she also goes out of her way to make sure that every pregnant woman has a TBA that she feels comfortable using. All TBA that assist in the care of pregnant women receive Rp20,000 for simply being present and conducting the non-medical aspects of childbirth, and an additional Rp20,000 if they actively escort the mothers they assist to Ibu Nur’s clinic. If a mother comes to deliver her baby at the clinic without a TBA, Ibu Nur will ask her directly if she uses a TBA, and will then call to invite the TBA to assist in the delivery.

**Image 4: Suruan’s Village Midwife has Turned the Clinic into a Welcoming Setting**

**Ibu Nurhayati’s village clinic (*polindes*) in Suruan.**



All interview subjects in Suruan confirm that Ibu Nur attends every posyandu. One mother, a posyandu user, told us that when Ibu Nur conducts outreach at the posyandu, the participants wait to listen to her before they go home, and she holds question and answer sessions.<sup>15</sup> Ibu Nur's popularity suggests that respected members of the community can draw participants to the posyandu instead of depending upon food supplements. She spends a lot of time training the posyandu volunteers, and empowers them to identify families at risk and make referrals. When trainings for volunteers are offered by the puskesmas, Generasi, or other programs, Ibu Nur ensures that they each have their turn to participate. At the posyandu, she rotates the volunteers through the "five tables" system of tasks. After every posyandu, she sits with the volunteers to ensure that all the registers (and in Pandeyan they use a lot more register notebooks than in Bonde or Ciperi) are filled in correctly.

In addition to coordinating all aspects of the monthly posyandu in each of Suruan's five hamlets, Ibu Nur coordinates a number of other health activities in the community's *desa siaga*, a village health awareness program. She started a local blood drive, and even secured routine blood donations from the local *kyai* and his family who lead the large *pesantren* in Suruan. She also coordinates a voluntary donations program via the posyandu volunteers who manage the contributions every month. The money is used for emergency referrals, small gift packages with useful supplies for new mothers (talcum powder, baby soap, etc., see Image 5 below), and for blood type tests to accompany the blood donations. Ibu Nur maintains a list of blood donors and their blood type so that in the case of emergencies, she need not waste time finding the correct donor. She also keeps track of available vehicles in Suruan, with a list of their owners and phone numbers, that can be mobilized for emergency transportation.

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15. > To be fair, we must note that Ibu Nurhayati told us a conflicting version of how outreach runs at the posyandu. She has an acronym, D3K, which stands for "datang, ditimbang, dapat kue" ("come to posyandu, get weighed, receive a snack"). She complained that they just want to get through posyandu quickly, and rarely stay for outreach. The respondent who told us that everyone waits for Ibu Nur's outreach may have told us what we wanted to hear, with a normative response. Or, Ibu Nur, in her overall narrative about the challenges of outreach and change ("talking and talking") may have been self-effacing when describing the D3K phenomenon. What matters here, at least, is that mothers reported without hesitation their admiration for their village midwife, even if they embellished their active participation at the posyandu.



**Image 5: Voluntary Donations at the Posyandu in Suruan Support Gift Packages for New Mothers**

Bottom Left: a register book at each posyandu in Suruan keeps track of monthly donations.

Upper Half: a display of the supplies purchased with the monthly donations and given to new mothers.

Lower Right: a congratulatory message for new mothers, reminding them to feed their infants exclusively with breast milk for six months, to attend posyandu, and to make sure their infant receives immunizations.

Ibu Nur maintains a good relationship with the Generasi program, and several informants told us that the village facilitator always attends every posyandu together with Ibu Nur. She credits Generasi with the revitalization of the posyandu program in Suruan:

“I used to have to weigh the babies and fill in the register myself, with only one or two volunteers for each posyandu. But now every posyandu has five volunteers thanks to Generasi’s transportation allowance. ”

— Ibu Nurhayati (Suruan’s village midwife)

Generasi has also supported the purchase of new scales and five tables for each posyandu, and handheld loudspeakers, which the volunteers or hamlet leader use to announce the monthly posyandu. Generasi has also supported multiple trainings for both the volunteers and the users. But Generasi’s largest expense in Suruan, per usual, is allocated for food supplements. For this Ibu Nur is in charge of telling Generasi actors who should receive the supplements, and assists with the distribution. This kind of village-level coordination between midwives and Generasi easily bridges the kind of frictions between the health providers and Generasi that we observed in Bonde.

Ibu Nur reports delivering roughly 60 babies each year for a village population of about 3,014 people (not including the *pesantren* students, which raises the total to 6,089). In order to prove that she was meeting all her targets despite the expected “projection” figures (based on the *pesantren* population plus Suruan’s permanent residents), she had to conduct a village census of her own, with assistance from the posyandu volunteers, before the Pamekasan health officials would believe her.

During our interview with the Suruan village head, a close ally of the *kyai*, he told us: “I hand over all health matters to Ibu Nurhayati, her posyandu volunteers, and the Generasi program. Ibu Nur always coordinates with the village leadership and provides a monthly report. She is always ready.” He also mentioned that in 2008-09, the Pandeyan puskesmas received news that Ibu Nur would be transferred to another village. But “the community rose up in protest,” because “they know exactly how much she has done for us.”

The mother of an undernourished child who frequently consults with Ibu Nur also affirmed what the village head told us: “Everyone has Ibu Nur’s cellphone number, and she doesn’t mind receiving calls at any time... her husband is also socially-minded. He is a school teacher here and mixes well with the community.” Together this married couple of civil servants have earned a deep and abiding respect from Suruan’s residents where they serve.

### Dantena's village midwife, Ibu Nancy

A new village clinic was built in Dantena in 2010, but it stands empty on the hillside nestled between the village primary school and church (see Image 6). The clinic was built to house at least two full time staff, a nurse and a midwife. The village nurse, Ibu Wiwin, lives more than an hour away in the city of Ruteng, the capital of neighboring Manggarai district, and the village midwife, Ibu Nancy, lives 40 minutes away in the administrative center of Bonde sub-district, just a five minute walk from the puskesmas along East Manggarai's district highway. Both are supposed to live at the clinic full time, but they claim that the spirits from the cemetery behind the clinic scared them away. Instead, the nurse comes on weekday mornings, and the midwife is on call if anyone needs her (all the posyandu volunteers and village leaders have her cellphone number). The midwife coordinator at the Bonde puskesmas explained that she has reminded them of their duty to stay in Dantena full time, but she can not really force them to live there because in East Manggarai it would be too difficult to replace them with equally qualified personnel. Perhaps just as important, Ibu Nancy is married to an official from the Bonde sub-district office, who is also the PJOK (*penanggung jawab operasional kegiatan*) for PNPM Generasi and MP programs in Bonde, and it would be impolitic to replace Ibu Nancy and risk any repercussions.

**Image 6: Dantena's New Village Clinic Remains Empty**

Dantena's new village clinic (center, white building), built next to the primary school (left) and the church (right), and in front of the village cemetery (on the hillside). The photo was taken from across the village soccer field, on the terrace of the village head's office.



The Generasi nutrition research team interviewed several mothers, posyandu volunteers, TBAs, village leaders, and Generasi actors in Dantena to figure out how this community copes without easy access to maternal and child health care, including nutritional counseling. Many said this was why the TBAs are still active and in demand in Dantena:

When we interviewed Ibu Maria, she had just given birth three months earlier, and her mother-in-law, who is a TBA, assisted with the delivery: "My mother-in-law already has experience. She helped a lot of women before me. She's just as good as any midwife." When Ibu Nancy found out that Ibu Maria gave birth at home, she yelled

“I’ve seen some of the other mothers, when they want to deliver their infants, sometimes they have to wait for a really long time at the village clinic until Ibu Nancy comes. That’s why it’s more comfortable for us to give birth at home. If the midwife lived here and was reliably available at all times, I would have preferred to use the midwife when I went into labor.”

— Yulia, a mother in Dantena.

“The women here prefer to give birth at home with help from the TBA because the TBA responds quickly and with kindness. When we call the TBA (“mama dukun”), we only have to call her once and she comes immediately. When we call the midwife, we must wait, so the women prefer the TBA.”

— Dantena Village Secretary



**Image 7: Dantena’s Posyandu in the More Remote Hamlet 2**

at her and asked why she did not call her, and then (according to Ibu Maria) her mother-in-law yelled right back at Ibu Nancy: “How long would we have had to wait for you to get here? My daughter could have died!”

The “kindness” of TBAs mentioned by Dantena’s village secretary factored into other respondents’ unfavorable opinions of Ibu Nancy, who by many accounts treated Dantena’s women with sharp disdain. Dantena informants reported that the TBAs have wisdom, understanding, and patience. By contrast, Ibu Nancy forbids women from yelling out or crying during their labor, and it was even reported that she gets cross and was quoted saying things like “Enough already, stop crying! It was pleasurable enough when you made this baby, but now look who’s crying!”

The Generasi nutrition researchers were able to attend and observe both posyandu in Dantena, one in each of Dantena’s two hamlets, and Ibu Nancy did not attend either one. Dantena residents reported that Ibu Nancy only comes to posyandu during immunization and vitamin distribution months.

Before we heard any of these stories about Ibu Nancy, the Generasi nutrition research team met and interviewed her at her home near the puskesmas. Little did we know that much of what she told us turned out to be falsehoods. For example, she told us that she goes to her clinic daily, and that she not only attends every posyandu, but conducts a sweeping activity the day before to ensure that all women with children under five will attend, and another sweeping activity the day after to check all the mothers who did not come. She also told us that each hamlet’s posyandu in Dantena has 100% participation (later, we estimated it was less than 50%).

But we realized something was amiss when we asked Ibu Nancy if there were any maternal mortality cases in Dantena, and she said that there had not been any in years. In fact, one of the reasons why we chose to visit Dantena was because of a recent maternal mortality case just a few weeks prior to our arrival that both the Generasi staff and the midwife coordinator at the Bonde puskesmas described to us. Every person who mentioned the case remarked that this mother of seven children (formerly eight, one of her toddlers died a year before she did) had a mental illness, and that no one knew she was pregnant until she fell into a seizure during the seventh

month of her ninth pregnancy.<sup>16</sup> When we asked Ibu Nancy about the case during our interview with her, she looked surprised and asked if the midwife coordinator (her boss) already told us what happened. Her response was astonishing: “I purposely avoided mentioning the case to you because that woman had a disturbed psyche, and because her death would ruin our [*Revolusi KIA*] program targets.” Ibu Nancy followed this statement with a laundry list of excuses to explain how she and the entire Dantena community, failed to notice that she was pregnant. She also collected evidence from the hospital to defend herself when the health department conducts its required internal investigation into this death.

In Dantena’s Hamlet 1 we encountered another example of Ibu Nancy’s consequential neglect and disdain that had a closer connection to the subject of childhood nutrition, growth, and development. One mother in Dantena, Ibu Magdalena, was sure that her 16 month old daughter had some kind of undernutrition problem but could not get a diagnosis from the village midwife because Ibu Nancy never came to the village. Ibu Magdalena brought her daughter to the posyandu every month (the researchers verified this by inspecting her daughter’s growth chart, with data points for every month filled in). Indeed for the past three months, her daughter was “under the red line,” and researchers observed the child was only 7,4kg, had a weak disposition, and no appetite. When one of the posyandu volunteers informed Ibu Nancy about Ibu Magdalena’s daughter, she casually responded with “oh, then we will give her food supplements” without ever following up. Unlike in neighboring Bena village, the *Generasi* actors in Dantena still followed the puskesmas’ rule that only health staff can determine who receives food supplements, but Ibu Nancy never put Ibu Magdalena’s daughter on the list, keeping her in a state of uncertainty.

In Dantena, the *Generasi* nutrition researchers encountered a situation that might be described as overt “structural neglect.” Even Dantena’s village head lives near the highway, at the administrative center of Bonde, where he runs a small business, and leaves the management of daily affairs to his village staff. All of the formal village officials that work for him as well as Dantena’s *Generasi* team live in Hamlet 1, which has semi-finished road access to the highway, whereas Hamlet 2 is at a distinct infrastructural and economic disadvantage with only a recently built (by PNPM Rural) steep stone path accessible by only the sturdiest motorcycles.

While some of the posyandu volunteers in Hamlet 1 may be considered informal village elites (including one of the *Generasi* village facilitators), the same cannot be said for the volunteers in Hamlet 2, who have little say in the management of their posyandu and village affairs. Knowledge of *Generasi* was very low in Hamlet 2, and the volunteers only knew *Generasi* as the program that provided their transportation money for working at the posyandu, and sometimes food supplements. As of May

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16. > Dantena’s nurse, Ibu Wiwin, told her interviewer that the four-year-old child had fevers and diarrhea when she died. Her death is one more example of how the stigma of mental illness created a wall of invisibility that prevented Ibu Nancy, Ibu Wiwin, and the Dantena community at large from detecting the serious health risks in this woman’s household.

2013, there have been no “outreach” food supplements (snacks at the posyandu to increase participation) since late 2012. Individual recipients of “recovery” food supplements (mothers or children diagnosed with undernutrition) must walk up to Hamlet 1 to get it themselves when Hamlet 1 holds their own posyandu. The volunteer whose home has hosted Hamlet 2’s posyandu for more than ten years told me that he is tired of working at posyandu, and frustrated that he has received no compensation for offering his house over the years, but that village leaders would not give him permission to resign. For such a long-term volunteer at the posyandu, his record-keeping skills in the register were incomplete, and the register showed that there were no posyandu held for four months in a row in 2012.

Among health professionals in the public sector, and even among some posyandu volunteers, it is fashionable to blame parents in the villages for maternal and child malnutrition because they are lazy, ignorant, stubborn, or too busy with more pressing concerns. But at least in Hamlet 1 of Dantena, we discovered that mothers, TBAs, and Generasi actors were quite aware of the health problems they faced and were looking for solutions, but the available services failed to deliver the care they need. Ibu Magdalena’s example above reveals that she is trying to help her daughter gain weight and become healthier, but the village midwife failed to give her the care she requested. We also met a young mother who received and understood general nutrition tips from one of the village TBAs: “*Mama dukun* (the village TBA) told me that if I am not producing enough breast milk that I need to eat more vegetables and pork in order to produce more.” Another mother, Ibu Bernita, was quite aware of the risks she faced during her second pregnancy but was still rebuffed when she pursued the care she needed:

“ I had an operation during my first pregnancy, so I knew that my second pregnancy might be risky, so I tried asking the midwife. However I was unable to get an answer from her, so I decided to go directly to the puskesmas and ask. Would you believe that when I arrived at the puskesmas, they got angry at me? They said ‘Why are you coming here to ask us when you already have a village midwife?’ ”

— Ibu Bernita, resident of Hamlet 1 in Dantena Village

These are the voices of women who attended Hamlet 1’s posyandu, where Generasi hands over “recovery” food supplements to eligible families. Even without the midwife and nurse, and with a volunteer staff reluctant to conduct health outreach or referrals, these mothers still appreciated the availability of the posyandu:

“ Even though I gave birth at home, I still come to the posyandu so that my child will be healthy. I come to the posyandu because I want to know each month whether my child’s weight has increased or decreased.”



In the absence of professional health care in this setting of structural neglect, we found signs that the residents and leaders of at least Hamlet 1 are slowly adopting Generasi's cultivation of demand for services. The examples above show that many in Dantena are acutely aware of what the midwife and the puskesmas are *not* delivering to their community. In response Pak Stefanus, the Generasi PK for Dantena, told us that the village head sent a letter more than a year ago to the head of the East Manggarai Health Department requesting a new midwife, but he acknowledged the futility of their effort when he mentioned that the midwife's husband was the powerful PJOK for Bonde. In an effort to call the midwife's and nurse's bluff over their stated fear of the graveyard spirits behind the clinic, Pak Stefanus also told us that the village leadership will consider switching the locations of the village clinic and the village head's office (at the spot where Image 6 was taken with the author's camera). These preliminary efforts at holding the health system accountable to Dantena's needs may be partially credited to the Generasi program for supporting posyandu activities, showing the community how health services should be better than they are now, and empowering Dantena's leadership to demand a village midwife that actually lives in their village.

## **Conclusion**

In the constellation of village elites that can guarantee the success or failure of Generasi's efforts to improve demand for maternal and child health services, particularly related to nutrition, the midwife performs an outsize role among them all.<sup>17</sup> Since Generasi actors at the sub-district and especially at the village level may not be health experts (and are frequently perceived as unqualified to make health-related decisions), the presence, cooperation, and, in the best cases, collaboration of the village midwife makes all the difference, as the two contrasting examples from Pamekasan and East Manggarai illustrate. Clearly other factors such as human resource and infrastructure development have also contributed to radically different outcomes in the two communities where these midwives work, but when it comes to practical and proximate determinants of Generasi's success in the health sector, the village midwife is a crucial partner. At the puskesmas in both Bonde and Pandeyan, the midwife coordinator bemoaned a lack of "coordination" between Generasi and the puskesmas when it came to issues such as food supplements, but it was only in Bonde where such complaints led to tensions that had negative consequences for beneficiaries. The presence of full-time midwives in the villages in Pandeyan who *do* coordinate with Generasi had a reassuring effect on the midwife coordinator at Pandeyan's puskesmas even if she did not know specifically what was happening in each village, whereas in Bonde the lack of connection at the village level led to punitive recriminations back and forth.

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17. > For more on village elites in general, see Case Study #2.

When Ibu Nurhayati describes outreach as an endless exercise in “talking and talking,” she refers to the patience required to bring about change in health practices and local demand for health services. It took her 13 years to build the level of awareness that exists in Suruan today, whereas Dantena has never enjoyed the benefit of a full-time trained health professional living in their midst to even begin the long work of talking and talking to residents, with respect and dignity, about their health. Ibu Nurhayati’s example offers two tentative lessons to Generasi, one obvious and the other implicit. The obvious lesson is that Generasi’s work requires years of investment before nutritional outcomes and demand for health services improve. We believe that Dantena’s letter to the sub-district head, although essentially dead on arrival due to the current matrix of political elites in Bonde, represents a newfound awareness that health services ought to be available in their community, that the current state of structural and disdainful neglect should not be the status quo.<sup>18</sup> Although the posyandu in Dantena may not be functioning at ideal capacity (especially in Hamlet 2), without Generasi there might not be any posyandu at all. Generasi’s very act of supporting a routine posyandu, over time, provides an alternative for Dantena’s residents to conceptualize what minimum standards of maternal and child health care might look like, which then leads to tentative and hopefully more assertive demand. The implicit lesson may be that what Ibu Nur calls “talking and talking,” and what community driven development specialists might call “advocacy,” could be a productive pursuit for the Generasi program in the future instead of (or in addition to) its traditional focus on food supplements and volunteer incentives.

### **Epilogue from Dantena**

While preparing the profiles in Case Study #2 (below), a follow-up phone call to Ibu Dian, the Generasi KPMD and posyandu volunteer in Dantena village, revealed some interesting improvements since our visit in May 2013. It turns out that our team of three researchers from Jakarta, asking all kinds of questions about maternal and child health care from all kinds of informants, and coming right after a recent maternal mortality case, may have further increased what we detected was a slowly growing awareness of the acute shortcomings in Dantena’s maternal and child health care situation. After we returned to Jakarta, Ibu Dian reported that someone from the East Manggarai district level (unclear if it was from the health department or Generasi’s district facilitator) sent an official warning to Dantena’s village midwife, Ibu Nancy. Now Ibu Nancy answers her phone when Dantena residents call, and she arrives quickly on the scene when a medical situation requires her attention, even in the middle of the night. This strengthens our conclusion that there are productive possibilities for Generasi to engage in more advocacy work (see Recommendations, Section 4, below).

**See the Following Conclusions and Recommendations Drawn from Case Study #1: Conclusions: RQ1.2, RQ1.3, RQ1.6, RQ3.1, RQ3.2, RQ3.4 Recommendations: 2.2, 3.2, 4.5, 4.8]**

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<sup>18</sup> > Likewise, we argue in Case Study #3 that another village in our study, Badran in Pamekasan, is undergoing a similarly slow-but-sure transformation in awareness of what government services that actually serve the community might look like. In such a transformation, Dantena is still at a very early stage relative to Badran.

**Introduction**

This case study provides a cross-section of profiles in “strategic leadership” that illustrate with specific examples the general thematic findings described in the main body of this report under the header “Local Leadership.” The informants described below occupy both formal and informal positions of leadership in the communities where they live. Those who are directly involved with Generasi leverage the program to retain and fortify their elite status as brokers who deliver community driven development resources into their communities. One of the running themes of this report is to illustrate the difference between “elite control” and “elite capture” as described by Dasgupta and Beard in their evaluation of one of PNPM’s early programs in Indonesia (2007). Whether they are involved directly with the Generasi program or just volunteers at the posyandu, the profiles below all illustrate the ways in which village elites use their status to more effectively deliver benefits to their communities, which ultimately redounds back to them in the form of status retention or accumulation.

## Bu Haji in Ciperi Village, Ciperi, Sukabumi, West Java

Not unlike many Indonesians, Bu Haji speaks of herself in the third person. When we arrived at the posyandu in Ciperi's Middle Hamlet, Bu Haji explained everything that Bu Haji has contributed to Generasi's efforts in Bu Haji's neighborhood, where Bu Haji is the *ketua RT* (the neighborhood head). Bu Haji gave us a complete tour of Bu Haji's posyandu and Bu Haji's nursery school (PAUD) with infectious enthusiasm and pride.



**Image 8: Bu Haji Proudly Surveys the Healthy Children in Bu Haji's Village Pre-School**

After singing songs and other group learning activities, Bu Haji makes sure these PAUD (nursery school) students between the ages of three and five all attend the posyandu.

It may seem unusual that a single person assumes figurative "ownership" of a hamlet's posyandu and nursery school, but Bu Haji's claims on these institutions have a local historical basis. Before Generasi built the small maternal and child health post specifically for Middle Hamlet's posyandu, Bu Haji hosted the monthly posyandu in her garage. Then she made a charitable donation of her land (*tanah wakaf*) immediately next to her house to the village for Generasi to build the posyandu. The nursery school room shown in Image 8 is on the other side of Bu Haji's house from the posyandu, and the yard just outside the room has a small playground built with support from PNPM Rural. The nursery school classes are integrated with the posyandu, ensuring that the students who attend can walk over to the posyandu to have their weight *and also their height* measured every month (infants have their body lengths measured as well). Many parents lose interest in bringing their kids to posyandu after they have received all their shots, but the integrated approach ensures that the children in Middle Hamlet continue attending posyandu long after they have completed their immunization schedule. As a crucial indicator for assessing chronic malnutrition, the nutrition research team found it remarkable that out of the five villages surveyed for this report, only the posyandu in Ciperi kept routine statistics on the height/length of children/infants.



**Image 9: The Posyandu in Middle Hamlet, Ciperi Village Measures Height**

Out of the five villages surveyed in this nutrition research project, only the posyandu in Ciperi village kept height/length records of children/infants who attend. This photo was taken inside the posyandu building recently completed with Generasi support, built on land donated to the village by Bu Haji expressly for the posyandu.

In addition to serving as the de facto leader of the hamlet's posyandu and nursery school, Bu Haji holds several other strategic leadership positions in Ciperi. As noted above, Bu Haji is the head of her neighborhood, but she also leads the *Majelis Taklim* women's prayer group, and the women's savings and loan (*simpan pinjam perempuan*) group sponsored by PNPM Rural. Years ago she was also a fieldworker for the national family planning program. Before she retired, Bu Haji was a teacher at a teacher training school, and her husband is retired from the Sukabumi district Forestry Department.

Bu Haji does not hesitate to use her positions of leadership to persuade (or pressure, or gently "threaten") mothers to bring their children to the posyandu, and most women feel compelled to follow her lead, lest she decide to give them a hard time if they need her for something else (such as rice subsidies or ID card administration):<sup>19</sup> "I tell the mothers who do not bring their children to posyandu, 'bring your kids to the posyandu to measure their weight. If you don't come, then don't blame or complain to the volunteers if your children get sick.'" Bu Haji will criticize the parents of children who are undernourished; she usually asks them questions like "what do you feed your child at home?" and does not accept excuses from mothers such as "my child doesn't want to eat." She tells these mothers that they must find some way to make their children eat something. Bu Haji follows active feeding best practices but her skills—relying upon pressure or compulsion tactics—could use some refinement, including counseling skills.

In Ciperi there is a homegrown terminology unique to only a few neighboring West Java districts that refers to the more religious families in the community. They are called "ASPEK," derived from the phrase "anti-speaker," which appears to have its roots in a local fatwa that forbids mosques from using loudspeakers for the call to prayer, because there were no speakers during the time of the Prophet Muhammed.<sup>20</sup> Aspek colloquially refers to the Muslim families in Ciperi that do not watch television or use radios, where the women wear black clothes and cover their faces, and live exclusively amongst themselves. Historically in Ciperi the Aspek families avoid posyandu because husbands forbid their wives from using family planning and refuse immunization for their children. Unlike the posyandu volunteers in Pamekasan who tend to write off such families, Bu Haji uses her position as neighborhood leader and head of the local *Majelis Taklim* to personally approach these families.

She goes to their houses and uses a mix of persuasion and pressure to convince them to participate in posyandu. Bu Haji also uses the *Majelis Taklim* prayer meetings for women in Ciperi to conduct outreach on maternal and child health issues. She tells the other women about the importance of giving birth with a professionally trained

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19. > Unlike the other villages in our research, we did not see any fathers bring their children to the posyandu in Ciperi, nor were there any male volunteers.

20. > A search on Google for "aspek anti speaker" reveals a few articles and blog posts about the phenomenon and all examples appear to be from the Sukabumi-Bogor-Cianjur region of West Java.

midwife. Bu Haji concedes that most of the women in her prayer group are older women such as herself, because the young mothers are typically working in one of Ciperi's many factories, but these are the ways that Bu Haji makes use of her local elite status to spread health messages to some of the more obstinate residents in her community.

### **Ibu Dian in Dantena Village, Bonde, East Manggarai, NTT**

When Ibu Dian graduated from high school she tried attending college in Jakarta but dropped out after six months and returned home. In 1999, she left her home village of Dantena again, now with a husband, to live in Surabaya, where she worked at a shoe factory until 2004, when her husband died from poisoning. When she returned to Dantena with her son, she actively immersed herself in community activities, including Hamlet 1's posyandu. She won second place when the East Manggarai district health office held a posyandu volunteer contest. When Generasi began operating in Dantena in 2008, the community elected her to be one of the KPMD because of her active leadership in the posyandu. She is also the secretary for Dantena's PKK women's organization. For income to support herself and her son, she works on the administrative staff of a local private Catholic elementary school. They live with her parents who still manage a large coffee farm (the source of income that allowed this family to send their kids to college in Java). At age 38, Ibu Dian is now a candidate for the East Manggarai district assembly representing the newly formed National Democrat Party (*Partai NasDem*). The party is backing her campaign, hoping to harvest votes from the extensive social ties she has gained through her work with PNPM in Bonde.

Beyond the leadership roles that Ibu Dian has earned and maintained in Dantena, what the researchers also found refreshing was her matter-of-fact honesty about her own strengths and weaknesses as a KPMD for Generasi, and as a posyandu volunteer. She readily admitted that she finds it challenging to ensure maximal participation at both the PNPM village consultations (*musyawarah desa*, MD) and the monthly posyandu ("they come this month to posyandu, but then they are absent the next"), but that she always tries to encourage attendance. She listed by heart most aspects of her job description with Generasi and the posyandu, but then also admitted that she does not fully understand what KEK (chronic energy deficiency) means for women.

Ibu Dian understands the challenges faced by dietary and other cultural norms that prevail in East Manggarai, such as the inability to serve protein-rich foods because their livestock is destined for the market or special events. Readily available meat such as chicken and pork are reserved for special events and guests. "Guests," Ibu Dian told us, "are number one, but their own families are number two" when it comes to preparing healthy foods. "I can't afford those things, only vegetables," Ibu Dian says, imitating a typical mother's response when she tries to encourage them to diversify their diet. Babies' diets are another challenge in Dantena, where mothers are frequently too busy in their gardens to feed their infants under six months exclusively

with breast milk. When infants are left at home under the care of their grandparents or older siblings, they feed them bananas, rice porridge, or powdered milk.

Regarding food supplements purchased through the Generasi program, Ibu Dian lamented the inability to procure local food products because of purchase requirements (such as a stamped receipt). Instead, Generasi actors must purchase packaged, imported food such as mung beans (*kacang hijau*), powdered milk, and formula in Ruteng, the capital of the neighboring district, just over an hour away from Dantena. This is the largest expense of Generasi's budget in Dantena.

Ibu Dian's capacity for critical thinking and leadership appear to be based partly on her above average level of education and cosmopolitan experiences in Java compared to Dantena's ordinary residents, made possible by the income from her family's coffee farm. This marks her as a local elite in Dantena, an instance where land capital transforms into social and cultural capital. The village head, Ibu Dian's cousin (they share a grandmother), says that "no one else in the village could replace her." Dantena's posyandu and Generasi programs might not enjoy the limited success that they have had so far without her. Generasi has reinforced and even increased her village elite status in the community, propelling her forward and upward to contest the upcoming district elections.

### **Pak Mateo in Bena Village, Bonde, East Manggarai, NTT**

Out of the three posyandu that we observed in Bonde sub-district in East Manggarai, perhaps it is not surprising that the best organized and attended posyandu was hosted in the house of Pak Mateo, one of Bena's neighborhood leaders (*ketua RT*), just as the well-attended posyandu in Middle Hamlet of Ciperi is organized by their neighborhood leader, Bu Haji. Pak Mateo graduated from high school and hoped to become a government civil servant but discovered he could not afford the "entrance fee" (a bribe) required to join, so he became a full-time farmer instead. At age 47, Pak Mateo has been the *ketua RT* since the 1990s when Suharto was still president, and he became one of the posyandu volunteers shortly thereafter. The posyandu that he hosts at his house covers not just his own neighborhood, but two others that border his own. The day before each posyandu, he personally reminds the people in his own neighborhood to attend, and he sends work to the other two *ketua RT* to remind their residents as well. If one household persistently does not attend posyandu month after month, he will personally go to the house to ask why. Typically the answer is that the parents are too busy working on their farms, or they feel that posyandu is no longer necessary after they are older than two years of age. But thanks to Pak Mateo's efforts, attendance at his posyandu every month remains high.

Even when the assigned health officials do not show up to the posyandu, Pak Mateo ensures that the posyandu continues, and then he delivers the data register to the *puskesmas*: "they [the health staff] usually tell us they're not coming because they've 'changed the schedule' at the last moment, but even if they don't come, the volunteers

weigh the kids and I deliver the monthly results to the puskesmas.”<sup>21</sup> Nevertheless he says that only the midwife can diagnose malnutrition: “we just report the kids who are BGM [under the red line], and then the puskesmas decides who receives food supplements. However it takes them too long to deliver the food supplements, no faster than two months.” Likewise, only the health staff can conduct outreach to the families with young children: “the volunteers rarely do any outreach, that is the midwife’s job.” The so-called “outreach food supplements” that attract parents to attend posyandu are given only once in awhile from the puskesmas. They usually deliver rice, vegetables, eggs, and mung beans, which the volunteers must then prepare themselves: “I just accept the outreach food supplements for our posyandu, but if they don’t deliver any then we don’t dare ask any questions, we just accept it.”

Pak Mateo told us, “I have heard of PNPM, but I don’t know what it’s about.” Ibu Yati, profiled below, knew more about Generasi and explained the frictions between the Generasi program in Bena and the puskesmas in Bonde.

### **Ibu Yati in Bena Village, Bonde, East Manggarai, NTT**

Ibu Yati is Javanese, from a village near Semarang in Central Java, but has lived in Bena, her husband’s home village, since they married 20 years ago. They met through church-related activities when he was studying in Java. One of the first things she told us about her adjustment to life in Bena was how she absolutely refused the enormous *sida* obligations that keep people tied to their extended family networks through their contributions to extravagant ritual events but also have the effect of keeping people in an impossible cycle of poverty and debt. For example, in 2012 Pak Mateo (profiled above) had to contribute five million rupiah as his *sida* obligation to his brother-in-law. The drawback of refusing to participate in *sida* obligations is a kind of excommunication from family networks, but Ibu Yati has found other ways to integrate with the Bena community. For example, at her own house Ibu Yati hosts a nursery school (PAUD) similar to Bu Haji’s in Ciperi. The program receives support from the Department of Education. Her other social contributions recall what she learned from her mother’s active participation in PKK and the posyandu in her home village in Java. During the ten years that Ibu Yati has been a volunteer at the posyandu held at Pak Mateo’s house, she has contributed in many ways that come from following her mother’s example.

In 2004, Ibu Yati introduced food supplements at the posyandu paid for with voluntary contributions. Every household would contribute 500 rupiah (about US\$0.55 at the time) each month, and then all the posyandu volunteers and mothers would cook food together, with instruction on how to prepare nutritious meals. Some of the menu items, Ibu Yati explained, were based on her posyandu experience in Java, and

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21. > We knew, and so did Pak Mateo, that “changing the schedule” at the last minute is nearly impossible because the puskesmas sets the posyandu schedule a year in advance and is rarely flexible about changing it in order to avoid scheduling conflicts with other puskesmas activities.



still new to the community when she introduced them in Bena: “Before then, vegetable soup and mung bean porridge (*bubur kacang hijau*) were unknown in this community.” But when the puskesmas began providing food supplements around 2007, followed by an international NGO that introduced kitchen gardens (*kebun gizi*), and then Generasi’s food supplement program, the neighborhood-initiated program that Ibu Yati had introduced stopped, and has not been active since then.

Ibu Yati also introduced a rotating credit program (*arisan*) to the posyandu, another activity she learned from her mother’s activities in PKK, as an incentive to attract more parents to attend. Typically, each participant would contribute 5000 rupiah each month and up to 60 people joined. The program worked from 2004 until 2011. The reason why the *arisan* stopped is because typically the first person to receive the money was the health official who formally managed the posyandu on behalf of the puskesmas. Since the health staff are frequently rotating through their positions, they never kept their assignment with the posyandu in Bena long enough to repay their credit. Then when another health official was assigned, he or she would again be the first recipient of the rotating credit. It eventually dawned upon the increasingly disappointed Bena residents that giving health staff the honor of receiving credit first was resulting in a net loss for the community, and the *arisan* activities, which had been an effective tool to attract posyandu attendance, ended as well.

Ibu Yati knew much more about the Generasi program than Pak Mateo. One reason Pak Mateo might not know about Generasi, Ibu Yati hypothesized, is because posyandu volunteers are rarely invited to attend the Generasi planning meetings, and Generasi actors only come to posyandu to ask for data. Nevertheless, before Generasi the puskesmas typically only had enough funds to support three volunteers for every posyandu, but now Generasi supports a full staff of five volunteers. The first signs of tension between the puskesmas and the Generasi program became apparent when Generasi supported the recruitment of these additional volunteers. Whenever the puskesmas held training activities for posyandu, only the original volunteers were invited to attend, and Generasi made up the difference by providing trainings for only the new volunteers.

“The Generasi program and the puskesmas have never found a common ground here,” Ibu Yati explained. When Generasi began providing food supplements, the puskesmas stopped providing guidance on what menu items to procure and how to prepare them. Puskesmas staff would tell the posyandu volunteers in Bena “it’s up



**Image 10: Ibu Yati Maintains A Detailed, Organized Posyandu Register**



to you, those supplements are from PNPM,” which made the volunteers confused because they have always been told that they are not qualified to make decisions on what constitutes a nutritional diet for undernourished mothers and children. “We volunteers don’t know the nutritional standards. That should come from the nutritionist at the puskesmas.”

In fact, there is very little difference in the types of food provided by the puskesmas and Generasi. Biscuits, powdered milk, formula, mung beans, vegetables, eggs, and so on, are the same whether they are procured by the puskesmas or Generasi, but the difference is that the puskesmas typically provides recipes with measurements, and Generasi does not. To save their own time, without the guidance of a recipe, the posyandu volunteers give the raw food supplements directly to the families instead of preparing it in advance. Ibu Yati concluded that “if the volunteers cook up some mung bean porridge and the kids do not like it, the parents will just give it to their pigs.”

### **Pak Bukhari and Ibu Raihan in Suruan Village, Pandeyan, Pamekasan, East Java**

On our first visit to Suruan village, while we waited in front of Ibu Nurhayati’s clinic to meet her, it was Pak Bukhari and his wife Ibu Raihan who welcomed us enthusiastically and warmly to the Suruan community and explained the Generasi program that they manage together. Pak Bukhari is the Generasi PK, and his wife is one of the KPMD. Ibu Raihan comes from a city in Kalimantan, but she moved to Pamekasan in 1988 to study at the famous pesantren in Suruan. Three years later, she married Pak Bahri, who is the son of one of Suruan’s former hamlet leaders. When his father retired in 1996, the Suruan *klebun* (Madurese: village head) appointed Pak Bahri to replace him. When a new *klebun* was elected in 1999, all of the other hamlet leaders either resigned or were replaced (as is common in Madura, see Case Study #3) but the new *klebun* asked Pak Bukhari to stay. The first PNPM program’s (PPK) arrival in Suruan coincided with the election of another new *klebun* in 2006. Once again, the new *klebun* asked Pak Bukhari to remain as one of the hamlet leaders, while all the others were replaced, but Pak Bukhari decided to resign in order to become the head of Suruan’s PPK. Formally, Pak Bukhari was elected, but informally the *klebun* directed the community to vote for Pak Bukhari. When the Generasi program was introduced in 2008, Pak Bukhari once again was elected as PK by acclamation at the village meeting.<sup>22</sup> Pak Bukhari illustrated the paramount importance of village leaders in rural Madura when he said things like:

“The process of becoming PK is through village consensus (*musyawarah desa*), but decided by the *klebun*,”

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22. > These local dynamics in which Pak Bukhari is repeatedly nominated for leadership positions (inside and outside of PNPM) “by acclamation” and the determining role of the *klebun* (and behind the scenes, the *kyai*) in community-based decision making processes are specific instances of what David Mosse evocatively calls “facipulation,” or manipulative facilitation (Mosse 2008, p. 7).

“My election can not be separated from the faith placed in me by the current klebun, who has continually given me his trust. The klebun and the entire community trust me.”

Ibu Raihan’s leadership role in Suruan rose alongside Pak Bukhari’s. When he first replaced his father as the hamlet leader, Ibu Raihan automatically assumed leadership of the hamlet-level PKK group. Even though her husband is no longer the hamlet leader, she is still active in PKK. She did not expect to get involved with PNPM, but when the village leadership changed in 2006, one of the village facilitators for the original PPK program resigned in solidarity with the outgoing klebun. The way Ibu Raihan recalls the history also illustrates the determining role of the klebun in village affairs, including PNPM:

“She is a friend of mine, and she didn’t think it was appropriate to stay on as a PPK village facilitator because there was a new klebun. So in the end my friend resigned. She is a relative of the former klebun. She asked me to replace her, and the new klebun agreed.”

After a year with PPK Ibu Raihan then became KPMD for Generasi.

Although neither Pak Bukhari nor Ibu Raihan had formal schooling beyond elementary school, out of all the communities we visited, they were by far the most knowledgeable, practical, and actively involved of all the village level Generasi actors we met during our fieldwork. At our first meeting, Ibu Raihan quickly listed all of Generasi’s twelve indicators. For her exemplary efforts over the years, Ibu Raihan was selected to be one of only two KPMD from Pandeyan sub-district to attend a special KPMD training in Malang in 2012. Together with the village midwife, Ibu Raihan not only plans yearly trainings for all the posyandu volunteers on various subjects such as nutrition and book-keeping, she also attends them. Generasi also supports monthly exercise classes for pregnant women and occasional child-rearing classes (including cooking and diet) for mothers with young children, and Ibu Raihan attends all of these events. Together with the village midwife, she also attends every monthly posyandu in every one of Suruan’s hamlets (we verified this from multiple respondents). She explains why: “I’m happy to be able to attend the posyandu and learn about the daily lives of mothers. I also want to know why this child’s development progresses, or why that child’s development does not.”

On her husband’s political navigation across three village administrations, which is quite unusual in Madura, Ibu Raihan says Pak Bukhari is the type of guy who can “go with the flow” (*mengikuti arus*): “whoever becomes the new klebun, Pak Bukhari always gets along with him even when the others don’t. He is trusted by all the klebun. Others resign whenever there is a new klebun, but Pak Bukhari doesn’t join them. He gets along and is always trusted.”

In many ways, Pak Bukhari is the classic village broker figure (Geertz 1960; James 2011; Wolf 1956). He not only navigates village politics with ease and takes a leading role in PNPM projects, he is also a *calo*, an agent or broker, who helps the other villagers navigate the government bureaucracy to fulfill ordinary household administrative obligations to the state, such as procuring identity cards, family or household identity cards (*kartu keluarga*), and driver's licenses. Finally, we also noted that Pak Bukhari enjoys a close relationship with the kyai who leads the large pesantren in Suruan, and who, as we noted elsewhere, plays a determining role in village elections (as hundreds, if not thousands, of his students are registered voters in Suruan, and the added demographics bring some additional benefits to the community). Pak Bukhari's access to the pesantren's kyai is another form of brokerage that Suruan's village leaders value, and hence, one after the other, they each want to keep him in their political inner circle.

Another reason why Pak Bukhari and Ibu Raihan can be so dedicated to managing so many details of the Generasi program in Suruan is because they never had children of their own. They have taken wise counsel (*hikmah*) from their fate by dedicating themselves wholesale to village activities. This may be why the residents of Suruan do not complain about some of the obvious opportunities they might have to benefit personally (or unethically) from their joint involvement in PNPM. Once in awhile, Ibu Raihan hears comments from people in Suruan to the effect of "oh it must be nice to *both* be involved in a project," but she sees the positive side, noting that they work well together, and can help each other to better complete their tasks with information that they can each cross-check among members of the community. If village "whispers" (*bisik-bisik*) and rumors about their outsized roles in Generasi spread, they simply remind the community that their (s)election (by the *klebun*) was through the village consensus process. Pak Bukhari sees the positive as well, and does not admit that there might be a conflict of interest: "Whenever there is a problem, we just have to speak with and help one another. For example, if we need a note-taker, I ask my wife to keep the minutes of our meetings, but in general we each have our tasks, and I don't get involved in my wife's business. She prepares the reports, and I'm involved with the budgets. I know how to manage the money." Indeed, for the past few years, PNPM has asked Pak Bukhari to audit the books for Generasi projects throughout Pandeyan sub-district.

## Conclusions

One of the cornerstones of PNPM is the community decision making process, the *musyawarah desa/dusun*, or *musdes/musdus*, in which Generasi actors are elected and program goals are decided. But when we asked the Generasi actors profiled in this case study (among the many others we met) how they came into their roles, invariably the answers turned upon a nexus of elite social connections in the village. Ibu Dian is the village head's cousin and comes from a family of relative means; Pak Bukhari is the son of a hamlet leader and a close confidante of the Suruan pesantren's

powerful kyai and successive village leaders. Their quotes (above) point to these kinds of relationships that brought them into their strategic leadership positions.

Once in these roles, they see their job of organizing musdes and musdus as a numbers game to maximize attendance. Sometimes Pak Bukhari has to give Suruan villagers 5,000 rupiah in order to ensure their attendance at PNPM planning meetings. But rarely do the program audits inspect the *quality* of these consultation sessions. Instead, Generasi program decisions further rely upon the nexus of village elites, and in the best cases include committed village midwives such as Ibu Nurhayati in Suruan. Pak Bukhari told us that one of the most satisfying aspects of working with Generasi was getting to know Ibu Nur over the years and learning all about the work she does for maternal and child health in Suruan, a subject he honestly knew very little about before Generasi. In Suruan, Pak Bukhari and Ibu Raihan closely follow Ibu Nur's suggestions, which carry far more weight than musdes or musdus decisions. But there are more suspect situations, such as when Pak Bukhari was still working for PPK and the village head named him as the "contractor" for a PPK-supported village road project. When Ibu Raihan prepares a procurement plan, and then her husband Pak Bukhari manages the agreed-upon budget to implement the plan, there must surely be tempting opportunities for conflicts of interest. Likewise, one could ask where the line between public and private falls in Ciperi when PNPM Rural builds a playground for Bu Haji's nursery school, on her own land on one side of her house, and Generasi builds a posyandu clinic on the other side, but on land that Bu Haji formally donated to the village but still informally claims as her own.

The point here is not to accuse Pak Bukhari, Ibu Raihan, Bu Haji, or any of the other formal and informal leaders profiled here of egregious corruption. On the contrary, the contributions they have made through Generasi (or closely affiliated with it) have led directly to improvements in maternal and child health services, in some instances quite dramatically, in their communities. Our fieldwork left us with no doubt, for example, that when a neighborhood head (*ketua RT*) such as Pak Mateo or Bu Haji also hosts the monthly posyandu, the community participation rate will be higher. These profiles show how various kinds of village elites leverage their leadership strategically on behalf of their communities in ways that ultimately redound to their benefit as well, primarily by reinforcing or improving their stature in the community (and perhaps secondarily through less transparent but minor acts of elite capture).

[See the Following Conclusions and Recommendations Drawn from Case Study #2:  
Conclusions: RQ1.4, RQ1.5, RQ2 Recommendations: 1.3, 1.4, 2.4, 2.5, 4.4, 4.7, 4.8]

### Case Study #3:

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#### Generasi Accompanies a Pamekasan Village in Transition

Immediately upon introducing himself at the start of our interview, Pak Subandi, the *pamong* (Madurese: hamlet leader) of one of Badran's seven hamlets, announced to me with a sardonic chuckle that "we are right in the middle of the Golden Triangle."

"What kind of golden triangle? What's in it?" I asked.

"This is the stronghold of the old *klebun* (Madurese: village head), who lost the most recent village election, nearly three years ago, by only three votes." He went on to define the three points that draw Badran's Golden Triangle: in the first corner is the household of the old *klebun*, in the second corner there is a small *pesantren* (Islamic boarding school) led by a *kyai* (religious leader) who supported the old *klebun*, and in the third corner is the household of Pak Subandi's predecessor, the former *pamong* who also supported the old *klebun*. Inside the triangle are the old *klebun*'s supporters, mostly members of his extended family, and they have persistently and consistently tried to sabotage all matters of village governance, including PNPM infrastructure and Generasi health projects, since they lost the election, especially in this hamlet: "The law of the jungle still prevails here." Pak Subandi has been an important source of intel for the new *klebun*, reporting the concerns and activities in this part of Badran nightly, either by text message or by clandestine visits to the new *klebun*'s house after midnight. Even our visit, as Generasi program researchers, posed a security risk that Badran's new regime tried to avoid. So when Badran's Generasi PK realized that we were determined to visit *posyandu* volunteers and ordinary residents in several hamlets and not just the village leaders, he had to carefully lead us on a circuitous route to Pak Subandi's house in order to avoid passing in front of the old *klebun*'s house. Pak Subandi nodded in approval when the PK described our route.

As I learned the arcane and sordid details of Badran village's micropolitics, I was still skeptical that this dramatized clash between old and new village elites could have consequential knockdown effects on seemingly innocuous public health programs such as the *posyandu*. But as I spoke with Pak Subandi, a second researcher (Nelti) held an FGD with four of the hamlet's five *posyandu* volunteers and learned that when the old *klebun* lost the election, all but one of the *posyandu* volunteers across Badran resigned en masse, and so did all of the Generasi program actors. These new volunteers are all distant relatives of the new *klebun*.

Village elections in Madura typically follow this pattern whenever there is a change in leadership; mass resignations ensue and the new village administration must recruit an entirely new staff, without any handover of records and assets. Learning from this

bitter and disruptive turnover in Badran, PNPM staff at the kecamatan level in Pandeyan published a letter addressed to all village facilitators and leaders urging them, in the event of a change in leadership, to retain the current facilitators and postpone any resignations until at least the end of the annual project cycle.

Under the new klebun's leadership, and with support from Generasi, Badran has increased the number of posyandu from five to seven (one for each hamlet now), and each one has a complete staff of five trained volunteers. But all sources in Badran reported that for at least a year after the village election posyandu attendance dropped precipitously. While attendance has improved with the promise of food supplements provided at each posyandu with support from Generasi, attendance in Pak Subandi's hamlet in particular remains a problem, confirmed by an inspection of the detailed records maintained by the village midwife at her public village clinic. Out of more than 50 households with children under five years of age, only about 20 show up every month to this hamlet's posyandu. Some of the families that do not attend are relatives of the former klebun, and when posyandu volunteers visit their houses to encourage their participation, they refuse with statements such as "my child doesn't need to be weighed, he's healthy!" Other families would like to attend the posyandu, but they fear retribution from members of the old klebun's family if they go. Shortly after the election, one household had their public water supply pipes cut after they were threatened to avoid the posyandu but attended anyway. Many people in the community suffer verbal abuse when they try to attend the posyandu:

"One of the neighbors once complained to me. She said she was afraid to come to the posyandu because when she tried to go previously, members of the old klebun's family would tease and yell at her when she passed by their house, shouting 'Hey! You're going to the posyandu huh? Don't you have enough to eat at home?' because they know we provide food supplements at the posyandu."

— posyandu volunteer in Badran's "Golden Triangle"

"They even tease and yell at us whenever we hold a posyandu. They say things like: 'Your kid is already fat! You still have to bring him to posyandu?'"

— posyandu volunteer in Badran's "Golden Triangle"

In Badran's "Golden Triangle," posyandu volunteers do not feel safe monitoring children with known risks for malnutrition among the non-users in the community. When Nelti asked if she could visit the nearest home of an undernourished child, the volunteers appeared nervous: "It's too risky to go there because the house is surrounded by the old klebun's family." When Nelti persisted, and they went to visit after all, the mother in this obviously impoverished household verified what the volunteers reported: "we are afraid of the hostile members of the old klebun's family." At three and a half years of

age, her son still could not walk, and he had some obvious developmental impairment, unable to move one side of his body on his own. Her husband did not allow her to have their son immunized. Isolated from available health services by both her husband and her “hostile” neighbors, she visits a traditional healer who massages her son’s body.

We discovered that although Badran is clearly going through a harrowing political transition, our interviews with the new klebun, his wife, the village midwife, the posyandu volunteers, and the PNPM (Rural & Generasi) facilitators in Pandeyan all confirm that the new leadership in the community is working hard to earn the support of the old klebun’s supporters, and this includes a transition in health service awareness and utilization. The kecamatan facilitators in Pandeyan reported that the new klebun is more serious; he keeps better records, actively monitors PNPM programs, and attends every planning meeting. The village midwife has also played an instrumental role in this difficult transition period. In a good faith effort to increase posyandu participation in all of Badran’s hamlets, the village midwife accompanied the new klebun’s wife going door to door to encourage people to attend posyandu. This has included visits to the old klebun’s relatives, who forthrightly shouted insults at the new klebun’s wife. Remaining above the political fray, the midwife helps the klebun’s wife to be patient, let the insults drop, and move on to the next household. *The village midwife and the new klebun’s wife both attend every posyandu.* The klebun’s wife works with the volunteers of each posyandu to prepare the food supplements to be distributed at posyandu, paid for with Generasi funds. The midwife informs Generasi actors which families require extra food supplements, and then the klebun’s wife takes care of it with the posyandu volunteers. During months when Generasi funds are not available for food supplements, the klebun’s wife and the village midwife pay for it themselves. (Outside the health sector, the new klebun himself conducts other kinds of outreach to the supporters of his former opponent, outreach that comes partly out of the late night strategy sessions with Pak Subandi.) In areas such as the “Golden Triangle” where mothers do not feel safe publicly attending the posyandu, the midwife reminds them they can attend the posyandu in the neighboring hamlet instead or make a private visit to her clinic (and some of them do). The new generation of posyandu volunteers freely admit that they used to give birth with TBAs (still relatively common in Madura), but in the last two years they are aware of the new “partnership” arrangement between TBAs and midwives, and recognize the importance of pre-natal exams and giving birth with the village midwife.

We interviewed the one posyandu volunteer, Ibu Sita, who did not quit after the village election in Badran three years ago to find out how she survived the pressure to resign. Ibu Sita is a young, college-educated mother who teaches at the village elementary school. She is the daughter of a well-to-do Badran business owner and has chosen to stay in Badran and raise her family there. She believes that her family’s stature and her higher education protected her from the hostile pressures from the old klebun’s family that forced all the other volunteers to resign. Ibu Sita claimed no loyalty to either the old or the new klebun, and insisted that she did not want to know the details of how PNPM and other village development programs work. “Whether it’s the old or the new klebun,



neither are transparent. We never see any purchase inventories and expenditures for food supplements.” Nevertheless Ibu Sita confirmed that the PK personally shows up to every posyandu and gives transport money to the volunteers, and he purchases the food supplements for the klebun’s wife and the volunteers to prepare and deliver. As long as the program runs effectively, she does not raise questionable issues such as the involvement of close members of the klebun’s family running Badran’s Generasi program (the klebun’s sister is one of the Generasi facilitators, and his brother-in-law is the PK) or the lack of transparency in program expenditures. As in neighboring Suruan, Ibu Sita explained that all the posyandu volunteers are empowered to monitor for malnutrition and high risk pregnancies in their communities and make referrals to the midwife.

## Conclusions

A new regime of elites has taken over the administration of Badran, and to deliver results the new klebun must stick with close members of his family that he trusts to get things done in the face of so much hostile micropolitical intrigue. Based on our own observations and Ibu Sita’s relatively neutral assessment, we left Badran with questions about Generasi actors’ transparency with the Badran community in managing their budgets.<sup>23</sup> PNPM is a crucial tool for the new regime to consolidate their credibility as leaders in the wake of a highly contentious and hostile election. The results of the Generasi (and PNPM Rural) program, among other government programs that they administer, legitimize their status in the eyes of both supporters and former opponents. While some members of the community may slip through the cracks, such as the isolated families living in Badran’s “Golden Triangle,” an oft-repeated refrain during our interviews in Badran were variations on “little by little, awareness is growing.” Broadly speaking, this refers to growing awareness of what government services can provide to the hamlets in Badran, as the old regime was characterized as a thuggish group of minor kleptocrats who never delivered services that inspired confidence in local government. But more specifically, “awareness is growing” refers to an increasing utilization of health services, a transition from TBAs to the midwife, and a more active group of posyandu volunteers who have learned skills to monitor nutrition in their community and refer at-risk cases for examination. The emphasis on “little by little,” however, remains important given the spoilers in their midst engaged in active resistance to any efforts that improve the image of the new regime. Generasi’s outreach does not improve demand and accountability overnight, but it has assisted and accompanied Badran through its slow and challenging transition to improved governance.

[See the Following Conclusions and Recommendations Drawn from Case Study #3: Conclusions: RQ1.2, RQ1.4, RQ3.1, RQ3.2 Recommendations: 1.3, 4.4]

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23. > We would emphasize here that the PNPM facilitators and the UPK office at the Pandeyan sub-district level complimented the (new) Badran Generasi actors for correctly submitting their budget and expenditure reports, and always attending sub-district meetings. The lack of transparency raised here is downward toward the Badran community.

# Conclusions

In light of the thematic findings and case study examples, the following conclusions respond to the specific research questions posed at the start of this report.

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## RQ 1

### Associations With Improved or Worsened Nutrition Indicators

Given that the social and biological factors that lead toward improved or worsened nutritional outcomes interact in such complex ways at the community level and become manifest in such diversely specific ways at the household level (Dettwyler 1993), a brief qualitative study of this nature can only identify factors that present clear *associations* with nutritional outcomes rather than proven causative pathways. The following observations from the thematic findings and case studies stand out:

**1.1** Although a more controlled epidemiological study may be warranted, researchers found that *Generasi's current system of food supplement procurement and distribution does not appear to be associated with improved nutritional outcomes*, and certainly not to such an extent that justifies the enormous budget allocations for it.

**1.2** *Generasi, by its very active presence in local communities, provides communities with the tools to imagine alternative possibilities of what health services might provide that contrast with the status quo.* Compelling evidence from Badran (Case Study #3) and Dantena (Case Study #1) villages suggest that *Generasi* activities over the years have increased awareness of what communities should expect from their health services, which translates into a slow transformation of demand. This suggests that *Generasi* might productively refocus some of its programmatic efforts and resources toward advocacy.

**1.3** *An active and engaged midwife that lives in her assigned village full time and treats her clients with dignity and patience may be an unattainable ideal in many cases, especially in regions with limited human resources, but Ibu Nurhayati's example in Suruan village proves that such figures do exist within the health system, and their contributions ensure that undernourished women and their children do not slip through the social safety net.* A full time village midwife also ensures more active management and supervision of posyandu activities with ongoing support and education for the volunteers. When the puskesmas has a full time midwife in the village, health administrators are less likely to be wary of *Generasi* efforts in these communities. Village midwives have the knowledge, time, skills, and status

to become productive collaborative allies with Generasi actors. Their support and advice to Generasi actors lends Generasi additional legitimacy in its health activities on the ground. Villages with neither an active nor present midwife, in contrast, leave posyandu volunteers without a direct supervisory figure, reduces surveillance capacity in the villages, and leaves Generasi actors without a direct link for coordinating with health service providers.

**1.4** *Strategic community leadership participation in posyandu and other maternal and child health outreach activities and services indirectly encourages (or softly compels) wider community service utilization and demand.* Each of the case studies illustrates this clear association in a variety of ways featuring broadly defined networks of formal and informal village leaders and the positive influence they have in community utilization of health services.

**1.5** This study also highlights how *elite practices of strategic control and capture refer not just to material and monetary resources, but also to information and knowledge dissemination, which may disempower community and household efforts to improve health outcomes.* It was a bitter irony to discover in Bonde sub-district that the World Health Organization's NCHS standard for determining malnutrition was wielded as an exclusive tool, only at the puskesmas and only when the midwives had the time to examine the charts (a kind of elite capture of knowledge), sadly resulting in delayed diagnoses and recriminations between health and Generasi staff. The puskesmas in Bonde expressed deep aversion to sharing their maternal and child health knowledge with the posyandu volunteers and other local leaders in the villages, whereas in Pandeyan the village midwives actively empowered their posyandu volunteers with maternal and child health knowledge so that they would be better equipped to conduct informal surveillance in their home communities and make referrals to the midwife as needed.

**1.6** *Local conceptions of who is more or less deserving of maternal and child health services lead to differential access to care and outreach.* The maternal mortality case in Dantena village in 2013 and the death of this woman's daughter in 2012 were persistently qualified with "...but she had a mental illness," even by Generasi actors, suggesting that psychiatric health differentially qualifies individuals and their families for health services. In Pandeyan, households that subscribed to particular interpretations of Islamic practice that forbid women and children from accessing biomedically oriented health services were deemed less deserving of active outreach. When researchers encountered similar beliefs in Ciperi, local leaders still persisted with a more persuasive approach whereas in Pandeyan health actors effectively wrote these households off. Deservingness is a particularly difficult challenge to address because local understandings about who is more or less qualified to receive care tend to be based upon a set of shared and naturalized beliefs among local decisionmakers that include health service providers and Generasi actors.

**1.7** *Monotonous, protein-poor diets are associated with poor nutritional health among mothers and their children.* Again Dantena, and to a lesser extent the slightly more prosperous Bena villages in Bonde sub-district, with their daily “triangle diet” of vegetables boiled in water, poured over rice, featured children with poorer nutritional status than the villages surveyed in Ciperi and Pandeyan, which had better access to a more diverse supply of affordable and nutritious food, including soy-based protein sources such as tofu and *tempe*. It bears emphasis that Bonde’s monotonous daily diet is not strictly a function of poverty, but is also associated with the social organization of resource allocation toward outsized family obligations, and local economy that emphasizes production of agricultural commodities such as coffee and cloves over subsistence farming.

**1.8** *Public and household hygiene practices have direct consequences upon maternal and child health, including nutritional health.* Dantena village, which had minimal infrastructural waste maintenance and where every child had an upper respiratory infection contrasts strongly against the other four villages that the research team visited in this study.

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## RQ 2

### Effectiveness of Generasi Incentivized Block Grants

*In the villages, formal and informal leaders, ordinary residents, and even some Generasi actors themselves showed limited understanding of the incentivized block grants.* In fact, this lack of knowledge may illustrate another aspect of elite control of information in which Generasi program managers do not adequately share information about how Generasi works. The FK in Suruan village forthrightly explained that while Generasi actors in Pandeyan do the work of allocating annual rewards based on achievement of target indicators, they do not itemize or promote these bonuses at the village level. Whether this exemplifies merely a patronizing attitude toward Generasi beneficiaries in the villages or an obfuscation of more sinister efforts at elite capture could not be proven with the limited fieldwork conducted by the research team. Suruan was arguably the top performing village in this study, whose Generasi actors demonstrated impressive mastery over how the entire PNPM program operates. In Suruan, the FK made a strategic decision to withhold itemized information about the reward system for achieving Generasi targets, but in general, the research team concluded that the lack of knowledge about the incentivized block grants is but one symptom of a larger issue of proper socialization of policies developed in Jakarta about how Generasi works in the villages. Unlike the KPMD in Suruan (the FK’s wife) who understood all the mechanics of how Generasi operates, in Bena village the KPMD had a fundamental misunderstanding of how the incentive system works, could not recite Generasi’s twelve indicators, and had difficulty explaining how Generasi monitors and addresses malnutrition. Her lack of knowledge was indicative to researchers of how much more work Generasi needs to do in order to ensure the mechanics of the program are understood in sensible terms and implemented correctly in the villages.

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## RQ 3

### Generasi's Effect on Health Volunteers and Health Service Providers

**3.1** *One of Generasi's biggest successes has been the revitalization of village posyandu, and this includes Generasi's support for the posyandu volunteers. In Badran village, for example, prior to Generasi there were only five posyandu to serve seven hamlets, and each posyandu had only two or three volunteers. After Generasi, there are now seven active posyandu, each with a full staff of five routinely trained volunteers. Each posyandu has the equipment it needs such as tables and scales, and even a loudspeaker to announce posyandu activities throughout the neighborhood as a way to boost attendance. But even in the more resource-poor villages in Bonde sub-district, especially in the absence of full-time health providers in the villages, Generasi's support for the posyandu in Dantena and Bena has the less obvious and longer term effect of raising awareness in these communities of the services that the puskesmas in Bonde ought to provide them.*

**3.2** *When a village midwife is present and active in Generasi communities, there are opportunities for mutually beneficial collaborations between health services and Generasi. Village midwives manage and supervise posyandu activities, so by definition Generasi must coordinate with them. In Suruan and Badran villages in Pandeyan sub-district, each village midwife maintained positive relationships with Generasi actors, and they actively contributed to Generasi programs, sometimes as an informal advisor, and sometimes as a co-organizer. It would be hard to conclude whether Generasi holds these midwives accountable to their communities or inspires them to be more active, but researchers observed an obvious positive synergy at work between health services and Generasi activities in these two villages.*

**3.3** *When a village midwife is not present and active in Generasi communities, there are opportunities for miscommunication and misunderstanding of Generasi's activities, leading to resentment or even abdication of responsibilities among health service providers. This was the major finding from Dantena and Bena villages in Bonde sub-district, where puskesmas staff thought that Generasi was encroaching on their turf and lacked proper qualifications to conduct health-related activities in these villages. The contrast between Pandeyan and Bonde sub-districts convinced researchers of the importance of having village midwives for Generasi actors to coordinate with because they act as a crucial link between Generasi activities in the villages and the health administrators who work at the sub-district puskesmas. When the puskesmas has a representative of their own in the village, the administrators may still complain that they do not fully know or understand Generasi's work in the villages, but they are reassured that their village midwives probably do instead.*

**3.4** *Generasi has little or no direct effect on the knowledge and practices of TBAs in the villages where Generasi works, but the findings from this study suggest that Generasi should view the TBAs as an untapped human resource for future maternal and child health education and advocacy activities (see Recommendation 3 below).*

# Recommendations

The following list of recommendations has been developed in light of the thematic findings, case studies, and conclusions described above. The recommendations are divided into four sections: food supplements, posyandu, traditional birth attendants, and advocacy.



## 1. Food Supplements

By far Generasi spends most of its health-related expenses on food supplements, and although they certainly do encourage increased posyandu attendance, their impact does not seem proportional to their expense. In some cases, such as in Bena village, the nutrition researchers observed that food supplements—whether from the puskesmas, from Generasi, or a third party NGO—had the unintended effect of dampening local initiatives to increase posyandu attendance such as the *arisan* (rotating credit group) and the neighborhood’s own contributions to preparing food supplements for the monthly posyandu. The following recommendations may be considered with respect to food supplements:

**1.1.** *Put limits on the food supplement line items in Generasi’s health-related budgets.* Savings may be allocated for other activities such as advocacy and increased support for posyandu volunteers or TBAs (see below), while a more limited budget for food supplements may prioritize treatment for acute cases of malnutrition (see 1.4 below) instead of the low-impact “outreach” supplements used for the posyandu.

**1.2.** *The quality of food supplements could be improved by requiring Generasi to purchase from local vendors of fresh food instead of packaged products from the cities.* Most sub-district and village level facilitators choose the simplicity of bulk purchasing milk and biscuits, in some cases enough for an entire fiscal year. Generasi actors claim this is not only easier, but also meets accountability and audit requirements because urban vendors have the tools to submit tender proposals, provide stamped receipts, and so on. But the nutrition researchers saw that this method of procurement also offers opportunities for easily disguised forms of elite capture of cash resources,

whether by midwives who receive commission for recommending particular brands of milk for Generasi to purchase<sup>24</sup> or by Generasi actors themselves who may collude with urban vendors.

**1.3.** *A transparent mechanism needs to be devised that enables purchase of local food products from within rural farming communities, but that also meets Generasi's accountability and audit requirements.* In Pamekasan and Sukabumi, Generasi actors appeared to be purchasing at least some of their food supplements such as eggs and vegetables from local suppliers, but the PKs were not forthcoming with information about their procurement procedures for these local products. The tradeoff from this lack of transparency in Pamekasan was the facilitators' assertions that the village head would pay for posyandu supplements out of his own pocket if Generasi funds were not enough to cover the expenses, but this informality does not scale up.

**1.4.** *A flexible mechanism needs to be in place for rapid treatment of identified cases of acute malnutrition with food supplements.* In Bonde, the puskesmas was not following up in a timely manner when potential malnutrition cases were identified by the posyandu volunteers. In one village (Bena), Generasi actors tried filling this gap by providing food supplements, but to the chagrin of the puskesmas, while the other village (Dantena) waited for the puskesmas to make their diagnosis. But even in Bena, Generasi actors were constrained by budget cycles and procurement procedures that did not allow for the rapid procurement of food supplements when they were needed. If Generasi actors had more flexibility to rapidly procure local sources of food supplements for acute cases, then they might also be able to more actively ensure that parents are using it to feed their children (instead of giving it to their pigs, as Ibu Yati warned) on a daily basis, instead of dropping off bulk items of milk and biscuits several weeks after cases have been identified.



## **2. Posyandu**

The posyandu remains a village-level institution with great potential, but researchers observed radically inconsistent variations in its implementation across the five surveyed villages in this study. Generasi can support the continuation of posyandu and its development with more than just food supplements. Generasi already supports minimal incentives for the posyandu volunteers, and in many villages also provides additional training for them. In short, the findings of this research recommend an increase in both, while also taking advantage of the posyandu as a village-based institution for disseminating health messages to parents with young children.

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**24.** > The fairly recent ban on midwives marketing baby formula to mothers with infants under six months of age appears to have encouraged the marketing of other milk formulas specially designed for pregnant women and children over six months of age. Many Generasi communities readily take up these marketing suggestions and purchase them.

**2.1.** Generasi has partly revitalized posyandu by providing incentives to the volunteers, thus ensuring a complete staff of five volunteers for every posyandu. *Volunteer incentives should be increased in exchange for performance accountability.* Some examples: many midwives, Generasi actors, and posyandu volunteers complained that few among them had the time, interest, or knowledge to prepare nutritious food supplements for the monthly posyandu. With an increased incentive to participate, volunteers may be asked to spend time preparing fresh food the night before or the morning of each monthly posyandu. The examples from Suruan and Badran show that when the village midwife actively includes the volunteers in the compilation and analysis of posyandu data, and empowers the volunteers to identify risk cases for referral, the volunteers then share a greater sense of ownership in their posyandu. Increased incentives may be tied to these reflective and analytical tasks at the end of each posyandu event. In short, as volunteer capacity improves (see next recommendation 2.2), so should their incentives.

**2.2.** Generasi supports routine training for posyandu, and this could be increased. For many parents, the posyandu volunteers are their first contact with public maternal and child health services. Instead of being told by health professionals (as in Bonde) that they are not capable of performing anything but the mechanical functions of the monthly posyandu, *the volunteers should be trained and empowered to identify signs of malnutrition, infections, pregnancy risks, and even mental health disorders for referral to trained health professionals.* Pamekasan provided many excellent examples of how the volunteers receive routine training and work collaboratively with the village midwife. An important caveat: Generasi should take care not to simply replicate (or worse, replace) the posyandu volunteer training curriculum already established by the puskesmas. While Generasi's advocacy activities should ensure that the puskesmas fulfills its obligations to correctly and completely train their posyandu volunteers without cutting corners (see 4.1 below), Generasi may *supplement* the puskesmas training with particular skills not already covered by the puskesmas curriculum.

**2.3.** Related to recommendation 2.2 immediately above, but important enough to stand alone on its own, *wherever Generasi operates, posyandu volunteers must be trained and required to measure the lengths of infants and the heights of toddlers and young children under five.*<sup>25</sup> This requires inexpensive inputs such as tape measures and measuring sticks (preferably against a wall), and one or two training and practice sessions that includes how to measure lengths and heights, and how to modify the registers to include this data. Some health professionals, such as the midwife Ibu Nancy in Bonde, argued that measuring length/height is not yet part of the puskesmas standard operating procedure, and they may only do this once a year for the annual village health survey, but researchers observed that the posyandu volunteers in Ciperi, Sukabumi could easily integrate length and height measurement into their monthly routine (see Image #9). These measures provide the raw data for

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25. > Additional training on how to correctly and consistently measure weight, as well as how to calibrate hanging scales and floor scales would improve posyandu data validity across Indonesia.



monitoring stunting in Indonesia. A critical mass of Generasi communities integrating length and height measures into posyandu will be an invaluable advocacy tool for bringing about changes in standard posyandu operating procedures more quickly. *This recommendation may require modifying the Generasi health indicators to include stunting.*

**2.4.** As a front-line maternal and child health service in villages, *posyandu has the potential, with support from Generasi, to provide more effective monthly outreach to parents.* In Suruan, for example, Generasi supported activities for parents such as cooking classes for mothers and aerobic exercise for pregnant women. But these activities were not integrated with the posyandu. Generasi could simultaneously promote posyandu as a desirable and visible village institution and save money on expenses such as nutritious snacks (instead of providing them twice at separate events) by conducting these training activities at the posyandu.

**2.5.** In order to reduce dependency on Generasi (or the puskesmas) to provide “outreach” food supplements, or snacks, at the monthly posyandu, *Generasi should advocate for and empower neighborhood associations to assume responsibility for their own posyandu “outreach” food supplements and other incentives such as arisan activities to improve participation rates.*



### **3. Traditional Birth Attendants**

As with the posyandu, Generasi should not overlook the role and untapped potential of TBAs (*dukun beranak*) in the villages. Researchers found that many mothers, especially at the social margins or at great distances from professional health services, are still using TBA services throughout the entire pre- and post-natal childbearing cycle. TBAs have more time to attend to these women than health professionals, so it is important that TBAs have training in the best practices of village-based maternal and child health care and referral. Many puskesmas have already implemented partnership agreements with village TBAs, but these are based on a narrow and vertically directed interpretation of guidelines set forth by MoH focused strictly on ensuring that TBAs refer women to midwives for childbirth. Given that these guidelines actually acknowledge and specify a more broadly inclusive and equitable role for TBAs across the childbearing cycle, Generasi has an existing model, consistent with national health policy, to develop and advocate for a redefinition of these partnerships. Some recommendations include the following:

**3.1** *TBAs should not be exempt from the kinds of trainings that Generasi supports for posyandu volunteers.* Many TBAs already have the experience and intuition to know what constitutes best practices for maternal and child health and nutrition, while some could use a persuasive correction of various practices that may complicate the health of mothers and their infants.

**3.2** *Generasi should develop and advocate for more inclusive and equitable midwife-TBA partnership agreements based on MoH national guidelines.* The MoH guidelines distinguish between the technical role of the midwives and the non-technical contributions of the TBAs that educate and empower mothers and local communities such as:

- a. Empowering women, their families, and the entire community on maternal and child health issues.
- b. Highlighting local traditions that empower and reinforce best practices in maternal and child health.
- c. Discouraging traditional practices that may lead to pregnancy, childbirth, and childrearing risks and complications.<sup>26</sup>

In promoting more equitable partnerships with TBAs, the MoH guidelines mention inviting TBAs to sit in and observe midwives at their clinics and providing financial incentives, contingent upon monitoring and evaluation activities that ensure TBAs adhere to best practices.<sup>27</sup>

Based on these general MoH guidelines, *Generasi* might consider some of the following suggestions. For example, if *Generasi* actors and posyandu volunteers are too busy to routinely check in on mothers or to prepare and deliver fresh food supplements to undernourished mothers and their children, for a minimal investment the TBAs can be trained and incentivized to do these monitoring and outreach activities as informal community health workers. As trusted members of the local community, TBAs are ideally situated to monitor, identify, and refer high risk pregnancies and undernourished mothers and children for medical diagnosis. TBAs can also encourage and teach mothers to improve nutrition in their household diet and promote exclusive breastfeeding. TBAs should be rewarded for upgrading the skills that they already employ, and that mothers already solicit.

**3.3** Existing partnership agreements currently focus exclusively on how to ensure that “*bandel*” TBAs no longer deliver infants on their own rather than how TBAs may be recruited as a community resource to support and ensure optimal maternal and child health. *Generasi should strictly avoid supporting so-called partnership agreements that employ scare tactics and punitive approaches that stigmatize and further marginalize the TBAs as an enduring village institution.* This disciplinary approach to sidelining TBAs from maternal and child health care comes out of a patronizing attitude toward these women who are invariably seen as backward pillars

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**26.** > These recommendations are summarized from page 8 of the MoH document cited in footnote 6 above.

**27.** > pp.14-15 in the MoH guidelines cited in footnote 6. In the partnership agreements that researchers learned about during fieldwork, TBAs were indeed invited to participate in the non-technical aspects of childbirth at the clinic and were given a small incentive (never more than \$5), typically drawn from the national childbirth insurance scheme for midwives (*jampersal*).

of pre-modern Indonesian society, without conducting a thoughtful inventory of the knowledge and practices of TBAs, nor examining the social and economic reasons why women still solicit TBAs for their services. If MoH in Jakarta has developed a less judgmental understanding of the role of TBAs in local communities, then Generasi should not only avoid supporting regulations that reinforce stigma, but also actively advocate for the destigmatization of TBAs so that MoH's more inclusive approach to midwife-TBA partnerships described above might someday be realized in practice.



#### **4. Advocacy**

During a recap of our visit to East Manggarai with a team of Generasi actors, the district facilitator wondered aloud whether Generasi might benefit from spending its budget on activities such as networking, lobbying, or advocacy that might stimulate community-led initiatives for better health services. The list of advocacy recommendations here reflect upon his suggestion, and they may be possible financially if Generasi places limits on budget allocations for food supplements.

**4.1** In some communities such as Bonde, *Generasi should avoid doubling or replacing training activities that fall under the puskesmas' purview and instead advocate and support the puskesmas to conduct these activities in full and for all intended stakeholders.* For example, Generasi relied upon the puskesmas' three-day basic training curriculum for posyandu volunteers. The puskesmas conducts this training annually, but it only lasts one day, whereas when Generasi conducts the same training, the volunteers attend a full three-day event. Rather than conduct the training twice, Generasi might instead advocate for the puskesmas to do it once, in full, perhaps with a little extra support to ensure that all volunteers can attend for all three days.

**4.2** Similarly, *Generasi should transition away from providing "outreach" food supplements at the posyandu because this too falls under the purview of the puskesmas. Instead, Generasi could conduct advocacy work to ensure that the puskesmas demands and receives a budget for posyandu food supplements from the district health office and then correctly administers it.*

**4.3** For a program that prioritizes health, Generasi does not have many health experts working at the district and sub-district levels. This reduces Generasi's bargaining power with health service providers. Trained health professionals make it clear in both subtle and direct ways that Generasi actors are unqualified to implement and monitor health-related activities in the villages. *Generasi might consider hiring district-level and/or provincial level facilitators with recognized health credentials in order to conduct more convincing advocacy work with health service providers.*

**4.4** Following upon 4.3, the general lack of expertise on health issues within Generasi means that sub-district and village level actors have radically inconsistent levels of health knowledge that depend on prior education and self-initiative rather

than a uniform *Generasi* standard. Compare Ibu Raihan, the KPMD in Suruan, with one of the KPMD the researchers interviewed in Bena. Ibu Raihan attends every training and every posyandu, and has all the health indicators memorized, but the Bena KPMD could not even give her interviewers a consistent understanding of the warning signs for malnutrition, nor could she list any of the *Generasi* indicators. *All Generasi actors should be required to confidently appraise the risks and symptoms of undernutrition and understand the tools at Generasi's disposal to address malnutrition in their communities.* As with recommendation 2.1 to reward posyandu volunteers for increased capacity, so too should *Generasi* reward KPMD mastery of the health concepts and program mechanics that are essential for effective village facilitation.<sup>28</sup>

**4.5** *Generasi's sub-district and district facilitators should more explicitly conduct outreach activities in the villages to inform families about health policies and services that meet their needs such as the national (and/or regional) health insurance schemes (jamkesmas and/or jamkesda) and the pregnancy and childbirth health insurance scheme (jampersal).* Apart from health insurance schemes, *Generasi* can also more proactively inform local communities about what they should expect from their puskesmas, their village midwife, and their neighborhood posyandu, and then provide the tools and support for seeking redress when these expectations are not met.

**4.6** In some communities, women and men are actively involved in managing and attending the posyandu, while in others these activities are dominated almost exclusively by women. Whether the health domain and the posyandu in particular are dominated by women or not, *Generasi should conduct active family health outreach to men in the villages, particularly fathers,* because in many communities (such as in Pamekasan) all household decisions, including for health care, require the permission of men even when they are ultimately carried out by women.

**4.7** Bearing in mind the insights on strategic leadership described in Case Study #2, *Generasi might consider identifying and then supporting some of the formal and informal leaders in the villages such as Bu Haji, Pak Mateo, and Bu Yati, who show potential to become maternal and child health "spokespersons" in their communities.* *Generasi* may creatively pursue options to leverage the status of local leaders in the community that benefits both the community and the chosen spokespersons.

**4.8** As many of these advocacy recommendations may be outside of the scope of program's core mandate, *Generasi should explore outsourcing advocacy work to local civil society organizations concerned with health and governance issues.* This advocacy work may be shared with existing institutions such PKK, a women's group in every village led by the village head's wife that is technically a stakeholder in the implementation of posyandu activities but in general has historically left posyandu in the hands of the health sector. A model for outsourcing advocacy work to local NGOs is currently underway in Lombok Barat where *Generasi* is working together with the ACCESS program.

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28. > Recommendations 2.1 and 4.4 point to a more general need to creatively think of ways to conditionalize the performance of *Generasi* actors at the village level.

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# Appendix 1: Fieldwork Itinerary and Activities

PNPM Generasi Qualitative  
Nutrition Study Fieldwork  
Itinerary and Activities  
Sukabumi District (Pilot  
location) \*

April 30-May 3, 2013  
and Manggarai Timur and  
Pamekasan Districts \*  
May 5 - June 1, 2013

Date	Activity	Location
April 30, 2013	Leave from Jakarta to Sukabumi	Sukabumi
	Meet with Faskab PNPM GSC	Sukabumi
May 1, 2013	Meet with Kabid Promkes-Promosi Kesehatan Dinkes (Health Promotion section)	Sukabumi
	Meet with Kasie Yankes-Pelayanan Kesehatan Dinkes (Health Services section)	Sukabumi
	Meet with GSC Actors in Ciperi Sub District (FK, PL, PJOkec, KPMDs from all villages in Ciperi)	Ciperi, Sukabumi
	Observation on Taman Gizi, Ciperi, Hamlet 1	Ciperi, Sukabumi
May 2, 2013	Posyandu Observation in Taman Posyandu Ciperi, Hamlet 2	Ciperi, Sukabumi
	Meet with village midwife	Ciperi, Sukabumi
	Meet with Puskesmas staffs (Midwives Coordinator, Nutrition Staff, Sanitation Staff)	Ciperi, Sukabumi
	Meet with The head of Puskesmas	Ciperi, Sukabumi
	Meet with Traditional Midwife	Ciperi, Sukabumi
	Meet with TPK, Community leader	Ciperi, Sukabumi
	Meet with with Village apparatus (The head of Village, Village secretary, The head of Hamlet)	Ciperi, Sukabumi
	Meet with female factory worker and female Posyandu Cadre	Ciperi, Sukabumi
May 3, 2013	Leave from Sukabumi to Jakarta	transit
May 4, 2013	Rest Day	Jakarta
May 5, 2013	Leave from Jakarta to Kupang	transit
	Meet with AIPMNH	Kupang
May 6, 2013	Leave from Kupang to Ruteng	Ruteng
	Meet with GSC actor- District Facilitator	
	Meet with BPM, District Manggarai	
May 7, 2013	Meet with Dinkes in Manggarai District	Ruteng
	Meet with Dinkes Manggarai Timur	Borong
	Meet with FK GSC Bonde	Ruteng

May 8, 2013	Meet with Pokja Kesehatan dan Pokja Pendidikan GSC actors, UPK Bonde	Bonde Sub-district
	Meet with Puskesmas Bonde	
	Team meeting for village selection	
May 9, 2013	Meet with Village midwife in Dantena	Dantena Village
	Meet with village leader	
May 10, 2013	Meet with GSC actors (KPMD, TPK, PK) and Village leaders in Dantena	Dantena
May 11, 2013	Posyandu observation and Meet PLKB	Dantena Hamlet 1
	Posyandu Cadres	Dantena
	Transect and Meet with Posyandu user-Hamlet 1	Hamlet 1
	Meet with traditional midwife, Hamlet 2 Dantena	Dantena Hamlet 2
May 12, 2013	Writing Up	Ruteng
May 13, 2013	Meet with Village Secretary	Bena Village
	Meet with KPMD Bena Village	
	Meet with Traditional Mid wife	
	Meet with Mother of Malnourished Child	
May 14, 2013	Meet with GSC beneficiary	Bena
	Meet with the Head of Susteran BKIA Bena	Bena
	Observation in Posyandu Bena and FGDs with Posyandu users	Dantena
May 15, 2013	Meet with Puskesmas Staff in Bonde sub-district	Bonde
May 16, 2013	Observation on Posyandu activity in hamlet 1 Bena	Bena
	Meet with Posyandu users	Bena
	Debriefing with GSC Actors Faskab Manggarai, FK, PL, Pokja Kesehatan & Pendidikan GSC Bonde	Ruteng
May 17, 2013	Trip Ruteng to Labuan Bajo	Labuan Bajo
May 18, 2013	Writing up and Team meeting	
May 19, 2013	Writing up	
May 20, 2013	Leave from Labuan Bajo to Madura (via Denpasar and Surabaya)	Transit
May 21, 2013	Meet with Faskeu Pamekasan district	Pamekasan
	Meet with the head of BPM, PJOKab	
May 22, 2013	Meet with Dinkes Pamekasan	Pamekasan
	Meet with FKs	
	Meet with FK Pandeyan	
	Team meeting for Kecamatan/Village Selection	
May 23, 2013	Meet with UPK staffs Pandeyan	Pandeyan Sub-district
	Meet with the head of Puskesmas Pandeyan	Pandeyan
	Meet with Health and GSC Actors in Suruan Village	Suruan Village

May 24, 2013	Meet with Suruan Village Leaders	Suruan
	Meet with Posyandu users in Hamlet 1	
	Meet with Traditional Midwife	
	Meet with Village midwife	
	Meet with Posyandu Cadre	
	Meet with Mother KEK	
	Meet with Faskab	
May 25, 2013	Interview with Posyandu Cadre Hamlet 2	Suruan
	Interview with Male Posyandu Cadre	
	Interview with User Posyandu	
	Interview with Non User Posyandu	
May 26, 2013	Writing up	Pamekasan
May 27, 2013	Meet with Village Leaders and KPMD GSC	Badran
	Meet with FK in UPK	Pandeyan
May 28, 2013	Meet with Village Midwife Assistant	Badran
	Meet with Posyandu Cadre in Hamlet 1	
	Meet with Posyandu Users	
	Meet with The head of PKK	
May 29, 2013	Meet with Posynadu Cadre in Hamlet 2	Badran
	Meet with Village midwife	
May 30, 2013	Meet with Midwife Coordinators and Nutrition section staff	Pandeyan
	Debriefing with Faskab and FK	Pamekasan
May 31, 2013	Travel to Surabaya and Writing up	Transit
June 1, 2013	Leave from Surabaya to Jakarta	Transit

\* The sub-district names of Ciperi in Sukabumi (West Java), Bonde in Manggarai Timur (NTT), and Pandeyan in Pamekasan (East Java) are pseudonyms. Likewise, the village names of Dantena and Bena in Bonde, and Suruan and Badran in Pandeyan are also pseudonyms to protect the confidentiality and honesty of a full variety of PNPM Generasi stakeholders in these communities.



### Contextual Topics

1. Political Economy: District-level elections have effects on the type of pro-poor health policies enacted. Example: District governments that rely on populist campaign messages may respond more actively in office to the needs of poor constituents (Rosser & Wilson 2012).
2. Presence of other nutrition programs: NTT is well-known for the abundance of nutrition improvement programs promoted by international agencies, NGOs, and government health initiatives. To what extent do chronic malnutrition indicators benefit from the presence of these programs (concurrent with PNPM Generasi) at the village level?
3. JamKesMas & JamPersal: Related to the previous question, to what extent do decentralized health insurance policies (JamKesMas, jaminan kesehatan masyarakat), including new forms of pregnancy and delivery insurance programs (JamPersal, jaminan persalinan) lead to a differential impact on chronic malnutrition status?
4. Poverty and Malnutrition: Much of the anthropological and social epidemiology literature on malnutrition report that poverty is rarely the primary cause of malnutrition (e.g. Dettwyler 1993). To what extent are these conditions correlated in NTT and Java? Are BCC messages only targeted toward particular socio-economic groups, and if so, is that a bias?
5. Double burden of malnutrition: To what extent does our research detect the double burden of malnutrition (i.e. the co-existence of overweight and underweight) in Generasi communities? Are communities and service providers aware of this issue?

### Supply-side Topics (health services)

6. Health bureaucracy and administration: How are health policies and services coordinated between district, sub-district, and village levels? Are sub-district clinic staff conducting routine outreach and surveillance in the villages? What data collection methods are employed at each level and what are their indicators? Do specialists in nutrition, hygiene, midwifery, and nursing work with PNPM facilitators? Do these specialists keep tight controls over their program information?

7. Behavioral Change Communication (BCC): How do targeted BCC messages vary across Generasi villages, and are there differential effects? What role do the *promkes* officers play?
8. Supplementary feeding (PMT Pemberian Makanan Tambahan): Does the use of supplementary feeding or MMN (Multiple Micro-Nutrient supplements), either for urgent cases (PMT pemulihan) or longer term care (PMT penyuluhan) make a difference in the chronic malnutrition indicators. In particular, do pregnant women use these supplements (food or MMN) and then as a result give birth to healthier babies at less risk for stunting? What role did PNPM Generasi play in the selection and procurement of PMT or MMN?
9. Surveillance improvements: Did Generasi have an impact on local community and service provider capacity to improve surveillance and detection of malnutrition? Could such improvements account for the increase in chronic malnutrition indicators?
10. Village midwives and posyandu volunteers: How does front line service delivery work in the villages?

#### **PNPM Generasi**

11. PNPM Generasi Bureaucracy and Administration: How do PNPM Generasi staff coordinate at district, sub-district, and village levels? Are village facilitators conducting routine outreach and surveillance in their communities? What data collection methods do PNPM facilitators employ at each level and what are their indicators? Do PNPM facilitators coordinate and work with health specialists in nutrition, hygiene, midwifery, and nursing?
12. PNPM Generasi's Menu of Options: Each Generasi village may choose from a menu of options most appropriate for their communities. What gets implemented and how? Are some villages choosing options that have differential effect on nutritional status? For example, if a disproportionate number of Generasi villages in Java focused exclusively on education items on the PNPM menu, might these education benefits come at a cost to nutritional status? Note: how much can we learn about this in advance from the MIS data?

13. PNPM Facilitator Dynamics: How involved are local facilitators in assisting Generasi villages to make informed decisions about how to choose the most appropriate programs? Do facilitators know how to develop awareness of the needs of the most vulnerable in their communities? Do facilitators provide enough information (about the types, risks, and presentation of malnutrition for example) to help Generasi villages make informed decisions? Do facilitators map out and explain local service capacities in order that communities will make decisions that reflect the greatest service needs?
14. Generasi Beneficiary Inclusion and Exclusion Criteria: How do Generasi villages, together with their PNPM facilitators, set the parameters for defining the target beneficiaries of their selected programs? How do the Generasi villages and their PNPM facilitators perceive and enact the distribution and equity of resources in their own communities. Local Knowledge, Attitudes, and Practices (KAP)
15. Community and household sanitation/hygiene: Observational indicators such as presence of soap, open defecation (rivers, behind houses), well-constructed gutters (saluran) to carry waste away from houses, presence of acute respiratory infections, children with bare feet and/or runny noses, access to household or village MCK facilities, etc. Will also pursue personal knowledge of best hygiene practices during interviews.
16. Household Diets: How have families' knowledge, attitude, and practice of household diets changed since the introduction of Generasi into their village? Particular issues to focus on include exclusive breastfeeding to infants up to six months, the diversification of dietary intake for children between six and twenty-four months, and mother's diet both during and after her pregnancy.
17. Community Perceptions & Taboos: What perceptions and taboos related to food and MCH do respondents report in Generasi communities, and have these changed at all since the introduction of the program?





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