THE IMPLEMENTATION OF KADER DESA PEDULI AIDS PROGRAM IN DENPASAR: WHAT LESSONS CAN BE LEARNED?

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ABSTRAK

Kader Desa Peduli AIDS (KDPA) merupakan program pencegahan HIV berbasis masyarakat di Bali. Denpasar sebagai Kota dengan prevalensi HIV tertinggi di Bbali telah menyelenggarakan program KDPA sejak tahun 2008. Namun, evaluasi terhadap program KDPA belum pernah dilakukan. Penelitian ini bertujuan menggali implementasi program KDPA dari perspektif pelaksana program. Penelitian ini menggunakan rancangan deskriptif. Data dikumpulkan melalui wawancara mendalam dengan 10 orang kader dan 2 orang pengelola program KDPA, survey melalui telepon dan review dokumen. Analisis data dilakukan dengan analisis deskriptif dan analisis tematik. Seluruh desa di Denpasar telah memiliki kader terlatih akan tetapi terdapat ketidakseimbangan dari segi gender yang didominasi oleh kader laki-laki. Pelaksanaan program kurang optimal dan kinerja kader lebih rendah dari harapan program. Kader yang tidak aktif cukup banyak yang terutama diakibatkan oleh mekanisme rekrutmen yang lemah. Faktor-faktor pendukung program yaitu pengelola program yang berkomitmen dan kolaborasi yang baik dengan LSM lokal. Kurangnya dukungan sumber daya pendukung program berdampak pada kurangnya insentif, monitoring dan supervisi serta pelatihan penyegaran. Komitmen Desa untuk mengalokasikan sumber daya untuk pencegahan HIV juga dinilai masih rendah. Implementasi KDPA masih kurang optimal. Upaya untuk meningkatkan partisipasi masyarakat, penyediaan sumber daya serta keterlibatan pemerintah desa dan pemangku kepentingan terkait perlu ditingkatkan.

Kata kunci: Implementasi, Kader Desa Peduli AIDS

INTRODUCTION

HIV and AIDS has caused major health, social, and economic burdens globally including in Indonesia (1-3). The first case of AIDS in Indonesia was noted in 1987 and since 2001, there has been a rapidly increasing trend of HIV and AIDS in Indonesia (1, 2, 4). Bali is one of the provinces in Indonesia that has suffered from a highly concentrated epidemic of HIV (5, 6). As at 31st

March 2010, Bali was in the second position among 33 provinces in Indonesia with HIV prevalence of 48.55 per 100.000 population (7). Heterosexual intercourse is the major mode of HIV transmission in Bali (5, 8). The rapid, uncontrollable growth of illegal sex trade in Bali has been indicated out as a major contributor to the epidemic growth (9). The high prevalence of HIV and AIDS in female sex workers (FSWs) and clients is made worse by the increasing trend of HIV in pregnant women and their babies which is a warning sign of an HIV epidemic extension into the general population (6, 8-10).

Many efforts have been made to alleviate the growth of HIV epidemic targetting high risk population particularly female sex workers (FSWs). Unfortunately, most of these efforts have not been proven to be effective in alleviating HIV transmission because of the power imbalance of FSWs and their clients due to economic dependency and unsupportive environment (3, 11). Considering the above issues, it is argued that intervention should not only address high risk groups but also general population, assuming that FSWs and their clients are inseparable part of the community (6). Community-based interventions targeting the whole community regardless their risks of HIV, are crucial to alleviate the HIV epidemic in Bali. Therefore, The Governor of Bali endorsed Governor’s decree number 443/1311/B Kesra, on 23rd December 2010, recommending The Kader Desa Peduli AIDS (KDPA) or village AIDS cadres program to be established in all vilages in Bali (8). The KDPA program is a top down, vertical or disease-specific intervention using community leaders as community health workers, dubbed as ‘cadres’, as an extended hand of the health system to scale up HIV prevention and treatment. There is no evaluation has been conducted regarding the KDPA program since the program started in year 2010.

METHODS

This research is primarily a process evaluation of KDPA program, with some examination of early impact to help establish how well the program has been implemented. A descriptive design, as described by Ovretveit (2002) which is exploratory in nature is employed in this research as KDPA program do not have any predetermined target or benchmarks to be compared with. Qualitative data was collected through in-depth interviews with 10 cadres from 10 villages in Denpasar and two KDPA program staff. Informed consent was sought from the respondents prior to the interviews. Quantitative data was gained through short telephone survey to 43 villages in Denpasar exploring the existence of village decree of KDPA program and also HIV related activities that have been conducted in each village. Document review to KDPA program and villages' documentation was also conducted. This research employs RE-AIM framework for evaluating interventions which was developed by Glasgow (1999). Therefore, this research explored five domains of RE-AIM, namely reach, effectiveness, adoption, implementation, and maintenance (12, 13). Thematic analysis was used to analyse the qualitative data. Quantitative data was analysed descriptively, by calculating the percentages and ratio.

RESULTS

The reach, appropriateness and acceptability of the KDPA program

Interviews suggest that all 43 villages in Denpasar have been reached by the KDPA program. Based on the program's database, 598 people from 43 villages have been trained in HIV as at February 2012. The number of cadres trained from every village was varried from 4 to 18 persons, resulted in a wide variation of cadres to population ratios ranging from 0.3 to 4.3 per 1000 population (see fig. 1). According to the Bali Governor decree, representatives of adult male, female and youth should be included in the KDPA program. However, in practice, there are wide variations of KDPA organisational structures. In the majority villages, male cadres are predominant and there were five villages do not have trained female cadres, indicating the lack of gender sensitivity in KDPA program. Based on the program's database, there are 419 (70.1%) male and 179 (29.9%) female cadres in Denpasar.

Recruitment of cadres was not on a voluntary basis but by appointment of head of villages. The majority of cadres were selected because of their structural position in the village such as head of the hamlets, village staff, and women organisation's members. Representatives of youth organisation are rarely included. Convenience, capability and cooperativeness were other considerations in recruiting cadres. For ease of administrative arrangements, the KDPA organisational structure in many villages also includes village staff who have not yet been trained in HIV. Although all villages have been trained for a year or more, there are only about half of the villages with a village decree of the KDPA program.

The existence of the KDPA is not widely known by the community in some villages due to a lack of program dissemination. All respondents note that the KDPA program is appropriate to local HIV situation. In communicating HIV prevention messages, talking about sex is often unavoidable. Most respondents stated communicating messages regarding sex is not taboo in their community, even to youth. However, some respondents still considered discussing sex in relation to HIV with the opposite sex group as uncomfortable and less appropriate.

> *"Honestly, I never communicate those things (sex education messages on HIV) to women because I feel uncomfortable to talk about that to them."*
> [Male, 41 years old, head of KDPA]

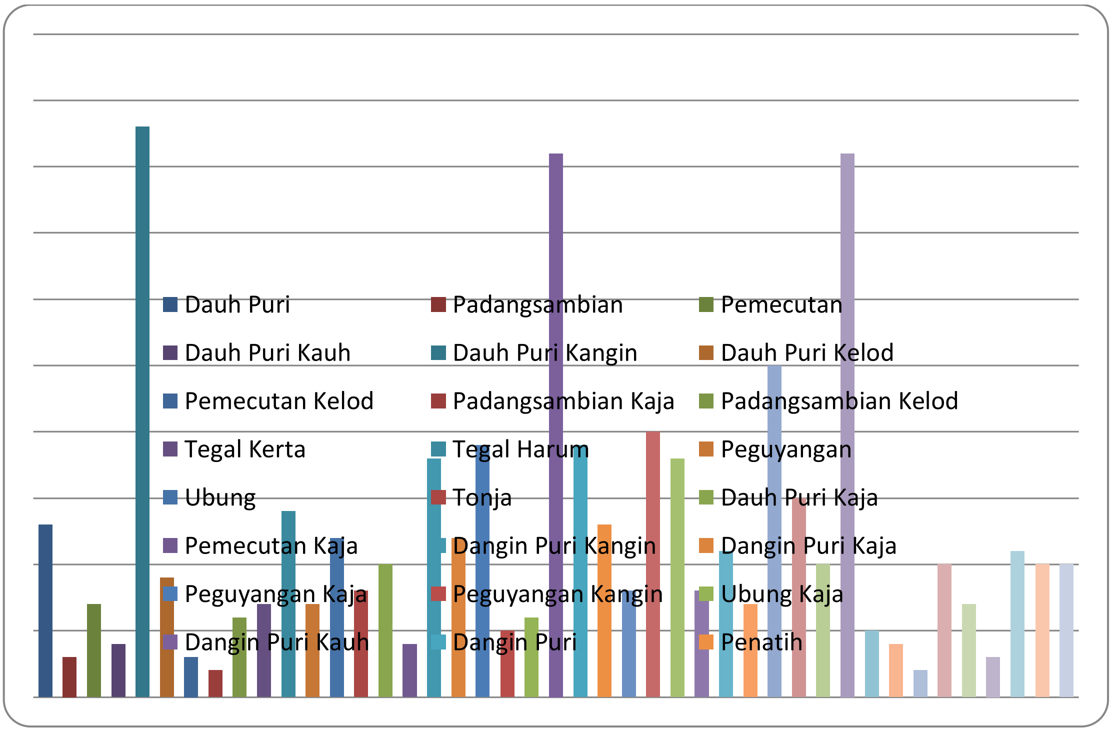

Figure 1. The ratio of cadres per 1000 population in 43 villages in Denpasar (per February 2012)

The implementation of the KDPA program

Data from the short telephone survey revealed that only 19 out of 43 villages (44.2%) have conducted formal HIV education sessions. Unavailability of a village decree and competing interests in the village have been highlighted as disabling factors. In formal education sessions, the majority of cadres as took on a role as coordinator or conduit between the community and the DDAC. Sources of information were health professionals from NGOs and police who were provided by the DDAC. Most of respondents did not feel confident to deliver HIV education in formal sessions due to their lack of in-depth knowledge. Moreover, they claimed their non-medical background leads to a lack of credibility and in turn a lack of community confidence towards them.

> *"We can provide general information but they (the community) possibly will not believe us because we are not from medical sector."* [Male, 46 years old, member of KDPA]

Most respondents mentioned health professionals as being more credible and trusted by the community in delivering HIV information. Almost all of the respondents said that they have inserted HIV information in their daily interactions, including in social traditional events like wedding ceremonies or funeral ceremonies. Difficulty in reaching youth was experienced in most of the villages since routine events for youth are rarely held and youth organisations are not well-functioning.

Some respondents mentioned that although their community has known that they are cadres and they can provide assistance to community members who need helps regarding HIV, no one has contacted them. They cited that fear of status disclosure and shame when asking for assistance about HIV from people who is from their own community as inhibiting factors. Several respondents mentioned that it was too risky for them to undertake the role to identify and follow-up HIV suspected cases in their community as it could risk jeopardising their relationship with those community members.

Cadres of the KDPA program do not receive any routine payment for their work. However, travel allowances were given for them to attend training. Non-monetary incentives in the form of t-shirts with the KDPA logo were also provided for them. Some respondents cited the knowledge they received from training as incentives they have received from being cadres.Some respondents said that financial incentives were not their main motive to conduct their role as cadres. The desire to contribute to alleviating HIV in their community and also the trust that has been placed in them as cadres, were their primary motives. However, respondents did not deny the fact that the lack of incentives would potentially contribute to many inactive cadres. Most of the respondents highlighted a lack of non-monetary incentives such as supportive supervision and capacity building as more discouraging factors that affected cadres' performance.

Most respondents mentioned that there is lack of supervision and monitoring of KDPA activities. There is also no routine reporting mechanism of cadres' activities to the DDAC so the program does not have complete data regarding what activities have been undertaken by the cadres. Program staff realise the importance of monitoring and evaluation activities to measure the progress of the KDPA program. However, lack of human resources to match workload prevents them from undertaking monitoring and supervision. A weak data management system was also observed during evaluation process. Program databases are spread widely among different locations and are difficult to trace.

Supporting and inhibiting factors of the KDPA program

The DDAC staff state that there is a strong commitment from the Denpasar district government to support this program as evidenced by an increasing budget allocation for HIV prevention activities. There is also a strong commitment of DDAC staff which is reflected by their commitment to support the village with facilities needed for HIV prevention activities. A strong collaboration with locally- based NGOs working on HIV issues, the Kerti Praja Foundation and the Citra Usadha Indonesia Foundation, is also a major supporting factor for the program implementation. These NGOs have not only facilitated cadres' capacity building process, but also assisted cadres in conducting HIV prevention activities. The existence of committed and influential cadres provides a strong support for the program implementation.

Despite increasing budget allocation for HIV prevention activities, funding is still limited and it prevents the DDAC from conducting refresher training and providing incentives for cadres. Unavailability of incentives for cadres also discourages the DDAC from reinforcing program implementation by cadres. Additionally, a lack of human resources, particularly staff to manage the KDPA program, has caused staff burnout and prevents them conducting supervision and monitoring.

Cadres were chosen from people who are holding important positions in village. Therefore, the majority of cadres have other responsibilities and work to do that inhibits them to performing optimally as cadres. The non-voluntary nature of the recruitment process leads to selection of cadres who are possibly not committed. The weak recruitment process has resulted in many inactive cadres which has consequently undermined the program's performance and created a burden for those cadres who are committed.

> *"The reality is among those selected cadres, there are only few people who do the works so they are overburdened by those works."* [Female, 26 years old, member of KDPA]

Furthermore, a lack of commitment from the head of the village as the supervisor of the KDPA program is cited by some respondents as a challenge to develop a village decree, and to initiate and expand on HIV prevention activities.

> *"I have tried to communicate this plan (plan of HIV education session for youth) to the head of the village but he kept saying that he is busy so the plan cannot be realized."* [Male, 57 years old, head of KDPA]

The Adoption and Maintenance of the KDPA program

Local NGOs, particularly the Kerti Praja Foundation, have actively participated in and supported the KDPA program. Active involvement in capacity building and also cadres' activities, through provision of source persons and also supporting facilities such as leaflets, stickers and condoms have been documented in interviews. Efforts to engage related stakeholders have been done through inter-sectoral meetings. However, to translate inter-sectoral commitment into real practice is still a challenge.

The DDAC provided a stimulant fund for every village in Denpasar to establish the KDPA program. In some villages, it was noted that no activity is conducted once the fund was finished. The majority of respondents said that it is difficult for the program to be sustained without adequate funding support from government. Only a minority of the sample villages have allocated their village budget and expenditure for HIV prevention activities. Complex administrative procedures for the arrangement of village budgets discourage villages from allocating their budget to HIV prevention.

DISCUSSION

In general, problems encountered by the KDPA program are typical of problems for top-down programs in developing countries which are removed from lack of community participation and hampered by lack of resources (14, 15). Community participation is not only about recruiting community health workers, but also about having the community involved in the planning, implementation and evaluation of a program (14).

In term of reach, the KDPA program has reached all villages in Denpasar with training of cadres in HIV. However, there is inequity in the cadres' composition in terms of sex and age groups, with domination of adult males in most of the villages. This gap should be addressed since it could potentially be a source of inequity in access to HIV prevention for youth and female groups.

Task shifting, which involves the delegation of tasks and responsibilities from health professionals to lower level personnel who are capable to do the tasks, has not been successfully undertaken in the majority of villages (16). Based on the objectives of this program, cadres are expected to be able to deliver HIV information to the communities. However, cadres are still simply performing the role as a conduit between the DDAC and community, instead of being community educators. A lack of confidence in their knowledge due to a lack of training is a major contributing factor in addition to their non-medical background. Despite this, most respondents stated that they had communicated HIV prevention messages in their day-to-day interactions with the community. However, community perspective to confirm the cadres' statement was not explored in this evaluation.

There is no consensus of ideal length of training for community health workers since it is varied and based on the type of interventions which should be delivered by cadres (17, 18). However, it is agreed that refresher training is as important as initial training (17, 18). Without continuous training, the knowledge gained from the initial training may be diminished (14, 18, 19). Moreover, the inability of the KDPA program to conduct refresher training may prevent cadres from improving their knowledge and skills to meet the program expectations.

The evaluation findings indicate a lesser preference for the community to seek for assistance regarding HIV from people within their own community due to shame and fear of status disclosure. The above findings are consistent with previous studies in Bali and rural Uganda which demonstrate that the community preference is to receive HIV information and counseling services from health professionals, or at least people whom they do not know in person (20-22). Therefore, the expectation of cadres to be able to function as counselor or outreach worker should be revisited. The community's opinion should be taken into account in determining future expectations of the KDPA program.

Underutilisation of the KDPA program is documented in the evaluation which might be caused by lack of program dissemination. This might raise the question of whether HIV prevention activities are being perceived as a 'community demand', which is a prerequisite for a sustainable program (13).

The evaluation findings indicate that the majority of cadres are inactive due to various reasons, which contributes to sub-optimal program implementation. The recruitment process is an important gateway for successful program implementation (14, 19). Recruiting cadres from community leaders can bring benefits in term of ease community mobilisation using their influence. However, conflicting responsibilities and workloads of the cadres discourage them from performing their roles optimally. A lack of commitment to undertake cadres' roles might also be due to non-voluntary recruitment method. The literature suggests that greater participation of the community in selecting CHWs will result in better acceptance and performance (14, 23). However, as experienced in many of the settings, the KDPA's cadre recruitment is based on the appointment of the village bureaucrat (head of the village) (14, 23).

High attrition rate of cadres can lead to inefficiency and lost of investment (14). Incentives are crucial for maintaining cadres' retention rate (18). Financial incentives are proven to be effective in improving retention rates (14, 18).

However, since the KDPA program has not been supported by sustainable funding, providing routine payment will cause negative impacts once the funding is stopped (18). There is no consensus of best form of incentives for CHW since it depends on community characteristics which should be explored by program planners (14, 18). In contrast with common CHW programs that use poor and disadvantaged members of the community, the KDPA program uses people with a relatively high social status in the community. Interviews suggest that some cadres prefer to be ‘helpful volunteers’ rather than ‘low-paid workers’. Therefore, non-financial incentives may be more highly valued than money for these cadres. Lessons learnt from other settings in applying preferential treatment, such as exemptions of cadres from village contribution, or priority in accessing health services, may be appropriate for KDPA’s cadres since those kinds of incentives do not require external support so they are feasible and more sustainable (18). However, supervision is required in preferential treatment delivery to avoid misuse (18).

Strong participation and commitment of local NGOs in supporting training and cadres’ activities reflects the strong adoption of this program. However, a low level of commitment from village authorities to allocate resources, and a lack of program implementation, reflect the notion that KDPA has not been a part of villages’ core business.

It is important to note that CHW programs are not a ‘panacea for a weak health system’ or a ‘cheap option’ for scaling up access to health services (14). Many CHW programs have experienced a failure in the past due to unrealistic expectations, a lack of planning, and also underestimation of resources required to make these programs succeed (14, 19, 24). Similar issues are highlighted from the evaluation findings of the KDPA program. Therefore, necessary modifications have to be conducted to prevent program failure.

CONCLUSION

The limited implementation represents a major weakness of the program to date which in turn limits the capacity of the program to achieve its objectives. Therefore, improvement in community participation since the planning, implementation, monitoring and evaluation of the KDPA program should be made. Provision of resources, program management and intersectoral collaboration with related stakeholders are also important to be improved to optimize the achievement of KDPA program's objectives.

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