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CHILD SURVIVAL-PLUS TWO (CS-P2) PROJECT
LOMBOK ISLAND, WEST NUSA TENGGARA PROVINCE, INDONESIA

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MINISTRY OF HEALTH
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in collaboration with

PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH (PATH)
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Introduction

This is the first annual report of the AID-funded Child Survival-Plus Two (CS-P2) project. The report highlights project inputs and outputs for the first year of activities (October 1, 1990 to September 30, 1991), linkages with other health and development activities, the health information system, lessons learned, progress in sustainability, and the workplan and budget for the second year of activities (October 1, 1991 to September 30, 1992).

Background

The CS-P2 project is a model service delivery project that aims to integrate selected maternal and child survival interventions into the EPI delivery mechanism on the island of Lombok, Indonesia. CS-P2 conforms with the Government of Indonesia (GOI) long term development policy and strategy to decentralize the provision of health services from sub-district health centers (puskesmas) to village health sub-centers (puskesmas pembantu) and integrated health posts (posyandu) in the hamlets. CS-P2 pilots an integrated model for delivering child survival services for the GOI. By testing various service delivery mechanisms, the project aims to achieve quality service delivery within the existing infrastructure of the Ministry of Health (MOH). The project also aims to identify obstacles and mechanisms to integrating key maternal and child survival interventions into the EPI service delivery system in a cost-effective manner. The CS-P2 project emphasizes collaboration with government agencies and local nongovernmental organizations (NGOs) providing health programs on Lombok.

I. Changes in project design

I-A. Project objectives

The project objectives have not changed since the DIP.

I-B. Project location and size of the priority population living in the project impact areas

The launch of phase I activities was delayed by one month due to local religious customs. Lombok is predominantly a Muslim society. No training or orientation sessions could be conducted in the fasting month and the week after Ramadhan (March to April 1991). Due to this delay, project targets for Year I are slightly lower than the number mentioned in the DIP. The revised targets are 1900 newborns (instead of 2250), 2300 pregnant women (instead of 2750), and 1900 lactating women (instead of 2250). No changes in the project location were made.

I-C. Health problems which the project addresses

The project is addressing the same health problems outlined in the DIP.

I-D. Child survival interventions

In addition to the child survival interventions described in the DIP, three new interventions will be tested and assessed as follows:

- a. Promotion of handwashing with soap prior to breastfeeding and distribution of soap to mothers of newborns during the home visit. This intervention is being supported by a private sector collaborator (P.T. UNILEVER Indonesia).
- b. Development of a low-cost "Safe Birth Kit" and test market study among pregnant women and TBAs in CS-P2 project sites. The kit consists of (1) sterile razor blade and cord tie, (2) bar of soap, and (3) sheet of plastic. This intervention is also supported by contributions from P.T. UNILEVER Indonesia.
- c. Feasibility study of local distribution and marketing of prepackaged cereal-based ORS. This intervention will be undertaken in cooperation with an international company (Galactina) and selected local ORS distributors and retailers.

I-E. Strategies for identifying and providing services to individuals at higher risk

The project strategies are the same as those described in the DIP.

II. Human resources and collaboration

II-A. New staff

No changes.

II-B. Technical assistance

Several government departments, private voluntary organizations (yayasan), professional associations, and individuals have provided technical assistance in support of CS-P2 project activities. These include the Communicable Disease Control and Community Health Directorates of the MOH, Yayasan Keluarga Sehat Sejahtera Indonesia (YKSSI) and Yayasan Hati Sehat (YHS), the Society for Perinatology, and others.

The CS-P2 project is guided by a National Steering Committee composed of six officials of the MOH and chaired by the Head of the Indonesian EPI program. The national team is able to provide guidance on national policies and support on project logistics given the availability of funding from the GOI budget. At the provincial level, technical oversight is provided by the Head of the MOH Provincial Health Office (Kanwil) and a provincial team consisting of medical and public health experts. The provincial project team and the district teams supervised and coordinated field activities and provided on-site technical assistance.

The PATH program manager, based in Jakarta, provided technical, administrative, and financial assistance to the Project Team. She was backstopped by the Finance and Administrative Departments of PATH Headquarters. Staff from the PATH Technology Assessment Department provided technical guidance on various project activities including the introduction of PATH technologies to the field. A senior program officer from the same department visited the PATH Regional Office in Jakarta and the project site, Lombok, and provided on-site technical assistance. The CS-P2 technical coordinator recruited and coordinated all technical input to the project from various sources and liaised with relevant Ministry of Health Departments and NGOs. Both the program manager and the CS-P2 technical coordinator made several visits to Lombok.

The CS-P2 counterpart project officer provided on-site technical assistance to the project and liaised with MOH and other relevant government officials at provincial, district, and sub-district levels, local and international NGOs as well as various professional groups.

The Hepatitis B Model Immunization Program counterpart project officer established a computerized data monitoring and reporting system. He assisted in the analysis of the baseline coverage and KAP survey and the survey concerning vital registration systems. A microcomputer was purchased for a local PVO, Yayasan Keluarga Sehat Sejahtera Indonesia (YKSSI), which is collaborating with PATH and the MOH on the baseline survey, follow-up surveys, and the CS-P2 database.

The training advisor, assisted by the provincial team, the CS-P2 technical coordinator, and the CS-P2 counterpart project officer, developed training plans and training and IEC materials for the project. She trained local master trainers in training methodologies and skills. The social marketing/training expert contributed to the project through training members of a local NGO, YKSSI, in interviewing techniques, FGD methodology, and pretesting techniques. YKSSI thereafter assisted the provincial team in conducting the baseline survey and in pretesting training and IEC materials. The YKSSI anthropologist and the PATH research consultant collected qualitative information on various aspects of community life. This information allows the project staff to develop culturally sensitive IEC and training materials.

Two non-governmental organizations, Yayasan Hati Sehat (YHS) and Yayasan Kusuma Buana (YKB), piloted field trials for introducing PATH technologies into CS-P2 project areas. The Indonesian Society for Perinatology (Perinasia) and the Indonesian Obstetric and Gynecology Association (POGI) also provided technical guidance on various perinatal and antenatal care issues.

II-C. Community activities

The CS-P2 project design relies heavily on existing local community structures and resources. The reporting/recording of vital events that is essential for the identification of the priority target population is initiated at the hamlet and village levels. In CS-P2 program areas, village volunteers, hamlet chiefs, village leaders, and other village administrative staff were oriented towards project goals and interventions and were trained in accurate notification of vital events. They also motivated pregnant women and mothers with children under five years of age to visit the integrated health post (posyandu) and/or health sub-centers for vaccinations, antenatal care (ANC), and other health services, which supports and speeds up the policy set up by the MOH. Additionally, project staff worked with members of the PKK (Women's Welfare Movement) at the hamlet and village levels and at the sub-district and district levels to strengthen the existing community infrastructures where needed.

II-D. Linkage with other health and development activities

Overall, the project conforms with the long-term development policy and strategy of the GOI to decentralize the provision of health services from sub-district health centers to village health sub-centers and integrated health posts in the hamlets. The strategy of the project involves strengthening and upgrading the quality and range of preventive health services provided by village nurse/midwives (bidan desa) based in health sub-centers. Most of the CS-P2 interventions are integrated into the MOH routine services and are delivered at existing health service posts at the hamlet and village level, including home visits.

Considered essential for delivery of basic health services to the community, the project initiated a needs assessment of basic equipment in the health sub-centers (see Table 1).

Table 1: Status of Medical Equipment and Supplies at Health Sub-centers in CS-P2 Core Villages

District	Number of Villages	Number of Sub-centers	Number of Sub-Centers with at Least One Usable Piece of Medical Equipment				
			Stetho- scope	Sphygmo- manometer	Weighing Scale	Baby Scale	Fundus Cup
West Lombok	6	6	4	4	4	6	6
Central Lombok	6	6	2	0	1	2	3
East Lombok	<u>6</u>	<u>6</u>	<u>1</u>	<u>1</u>	<u>4</u>	<u>1</u>	<u>3</u>
TOTAL	18	18	7	5	9	9	12

CS-P2 staff carried out the needs assessment and provided the provincial and district health offices with detailed information on where essential equipment was missing or broken. As a result of the assessment, the MOH has replaced the missing or broken equipment. Prior to the launch of CS-P2, only 9 of 18 health sub-centers assessed had a weighing scale, 7 had a stethoscope, and only 5 had a sphygmomanometer that was functioning. As a result of the survey, only one health sub-center is still waiting for some of its essential equipment. The MOH also provided steam sterilizers with canister inserts, needles, and syringes to 50 percent of CS-P2 health sub-centers. Since the program start, dual-function refrigerators have been allocated by the MOH for use in health sub-centers which are situated far from the health center. Among the 18 CS-P2 core villages, 14 satellite centers are now able to store vaccines. The extension of the vaccine storage capability to the health sub-center enables the village nurse/midwife to provide services at the village/hamlet level on a daily basis, thereby reducing the number of missed opportunities.

Prior to the launch of the CS-P2 project, in only 7 of the 19 health sub-centers (37%) were regular ANC and family planning (FP) services provided on a weekly or bimonthly basis. Because of the CS-P2 project and the provision of detailed information on the availability of ANC and FP services in the CS-P2 areas, the provincial and district MOH motivated the health center doctors/midwives to provide regular ANC and FP services to all their health sub-centers. Since May 1991, the MOH has established ANC and FP services in all health sub-centers in CS-P2 core villages. Midwives from the health centers rotate to the outreach clinics and the health sub-center to provide ANC and FP services. The first group of bidan desa have finished their one-year training program, and four of them were deployed to health centers in the CS-P2 project area. Currently a new group of village midwives is being trained. Upon completion of their training, several will be posted in health sub-centers in CS-P2 villages.

In collaboration with two Indonesian local NGOs, YKB and YHS, small-scale field trials for evaluating the acceptability and appropriateness of the PATHstrips were initiated in urban and rural health clinics in September 1990 and July 1991, respectively. PATHstrips^{TM*} are simple, low-cost, reliable dry chemical test strips used to detect proteinuria and to identify pregnant women at risk of pre-eclampsia. Women identified by simple urine screening can be promptly referred for more complete diagnostic evaluation (blood pressure and clinical symptoms). Eclampsia is the third most common cause of maternal death in Indonesia. By introducing PATHstrips for screening as a routine part of ANC, earlier detection, more targeted use of diagnostic measures, and better care of pre-eclamptic women will reduce maternal and perinatal morbidity and mortality. Proteinuria is also an indicator of urinary tract infection (UTI), a condition that also can have serious consequences during pregnancy and requires proper diagnosis and treatment.

*PATHstrips is a trademark of the Program for Appropriate Technology in Health (PATH)

Since September 1990, PATH has worked with YKB on an informal small-scale PATHstrips trial in one of the clinics. The clinic is run by midwives and serves a low-middle income neighborhood primarily for FP services. Prior to the start of the trial, the CS-P2 technical coordinator conducted a survey at the clinic regarding ANC services, provided training to the midwives, and collected data periodically.

Forty-eight pregnant women were tested using PATHstrips from the period of September 1990 to June 1991 in this clinic. Twenty-seven pregnant women were tested using PATHstrips with the first generation color panel in 1990. Eighty-five percent showed positive test results. A portion of these were attributed to false positive due to reported difficulties in differentiating a "0" reading and a one plus (+) reading using the old color panel as well as other factors. All patients with positive test results had normal blood pressure and were retested with negative results.

Twenty-one pregnant women who attended the YKB clinic were tested during the first six months of 1991 using PATHstrips with a second generation color panel that Indonesian midwives found easier to read. Fifty-two percent positive results occurred. Of the seven pregnant women with test result as (+), all but one had normal blood pressure. These patients were re-tested within one to two weeks and showed negative test results. The one with elevated blood pressure was referred to a hospital for follow-up. A complete urinary test was offered to pregnant women with >(++) and normal blood pressure. Patients with test results indicating urinary tract infection were treated with antibiotics. Three of the four positive had urinary infections as the presumed cause of the proteinuria. This suggested that many "false positives" can be attributed to urinary infections of these pregnant women. The patient with (++++), and elevated blood pressure was immediately referred to the hospital. She was diagnosed with pre-eclampsia and the fetus died consequently.

Midwives at the clinic found that PATHstrips were very easy to use after training. They also noted some practical problems when using the strip. A guideline for follow-up patients after their initial testing was developed in consultation with the POGI and YKB clinic doctors. These guidelines are currently used in the clinic.

Results from this preliminary experience showed that PATHstrip proved to be user-friendly among YKB midwives. Over the last year, they have been able to correctly use PATHstrips and provide appropriate consultation and referral based on patients' test results. By using PATHstrips, these midwives were able to identify pregnant women at risk of pre-eclampsia and refer the patient accordingly, thereby enhancing the quality of ANC service provided at the clinic. Based on this experience, PATH is planning to introduce PATHstrips to the CS-P2 project service delivery system, given the existence of referral systems in some villages. Health center doctors, midwives, and health sub-center staff will be able to utilize PATHstrips to screen pregnant women more effectively and enhance the quality of ANC.

To date, the outreach of laboratory services needed to perform this test are only at the sub-district health center level, which now uses the conventional

wet test. These were found to be under-used and not practical for field and village activities.

In collaboration with YHS, a small-scale field trial in rural areas in West Lombok was initiated in July 1991 in order to get better insight into the acceptability of PATHstrips and to identify possible problems introducing PATHstrip in rural areas. Within the field trial, PATHstrips are being used during ANC visits at outreach clinics, in the health center, and in health sub-centers in the six CS-P2 core villages in West Lombok. Results of the field trial will be used to develop a strategy and the software for introduction of PATHstrips into 42 CS-P2 villages in project Years 2 and 3.

Table 2: BIRTHweigh Field Trial Results from Six West Lombok Villages, April to July 1991

	<u>Number Weighed</u>	<u>Low Birthweight (<2500g)</u>	
		<u>Number</u>	<u>Percent</u>
Within 24 hours	46	3	6.5
8 to 40 hours	87	6	6.9
>40 hours	<u>141</u>	<u>9</u>	<u>6.4</u>
Total	274	18	6.6

BIRTHweigh^{TM*} is a hand-held, color-coded scale for identifying low birth-weight (LBW) newborns. Combined with locally made cloth slings, BIRTHweigh gives traditional birth attendants and primary health care workers a simple, portable, and accurate way to assess a newborn's weight. The scale has been extensively field tested in Egypt, Malawi, Yemen, and Zambia, but had not yet been used in Asia. A small-scale field trial was initiated in West Lombok to determine the acceptability and usefulness of BIRTHweigh in CS-P2 project areas and to identify possible problems in introducing BIRTHweigh on a larger scale (see Table 2).

Six nurses from health sub-centers in the core villages in West Lombok were involved in the trial. Between April and July 1991, 274 infants were weighed. Of the 46 infants weighed within 24 hours of birth, 3 (6.5%) were LBW, i.e., less than 2500 grams. The exact number of neonates weighed within 24 hours of birth cannot be determined because records were only kept on the date of birth and the date the weight was taken, but not the time of either event. Since all weights were taken during the day, it is possible that those babies born before midnight were weighed at 8:00 a.m. the next day, which would appear in

*BIRTHweigh is a trademark of the Program for Appropriate Technology in Health (PATH).

the records as the second day of life. It is for this reason that a category of 8 to 40 hours has been included to denote those infants who may have been weighed within the first 24 hours. The third category of >40 hours represents infants weighed on the second day after birth and up to and beyond 15 days. Because information was not kept on premature births, some of the infants who were still under 2500 grams at 15 days may have, in fact, been premature and would still not have reached term birthweight. While the sample size is small, the percentage of LBW infants in each of the three categories was between 6.4 and 6.9 percent. There was no gender difference between the LBW infants.

Since the people of Lombok are very receptive to messages given by religious leaders, PATH is collaborating with the provincial Ministry of Religious Affairs, the provincial Ministry of Health, community religious leaders, and international organizations in Lombok in preparing health educational materials used in the mosques and at religious meetings. These materials are being finalized and will be distributed to the religious leaders by the end of this year. Appropriate training will be provided accordingly. PATH is also evaluating the tetanus toxoid (TT) vaccination program for brides-to-be together with the above-mentioned agencies. Channels of collaboration to improve the coverage are being discussed.

Experienced interviewers from YKSSI, a private nonprofit health foundation on Lombok, assisted the provincial team in conducting the baseline KAP survey and the survey evaluating existing vital registration systems. They will also assist the provincial team during the midterm and final evaluation surveys. YKSSI also assisted PATH and the provincial team with the development and field testing of various IEC training materials and radio messages as well as in the evaluation of training sessions.

Since May 1991, a small scale ethnographic study has been conducted in the CS-P2 program area in East Lombok. Field workers from YKSSI, in consultation with PATH's research consultant, are collecting data concerning local perceptions, beliefs, and practices, for identifying cultural barriers and entry points for CS-P2 interventions. Additional resources for expanding the field work will be made available by a non-USAID-funded international NGO working in the same area on a community development project. Moreover, an Australian anthropologist (Ph.D. student), working in one of the CS-P2 core villages in East Lombok, has also provided qualitative information concerning various health related aspects of community life to the project.

In collaboration with UNILEVER, a private consumer goods manufacturer, health education materials concerning personal hygiene for mothers are being prepared for distribution during the home visit. UNILEVER donated 4000 bars of soap for distribution to the mothers of newborns during the home visits. During the home visits health education is given concerning personal hygiene. After stressing the importance of using soap when washing hands, a bar of soap is given to the mother of the newborn.

In addition to PATH, other international organizations will also provide technical and financial inputs in the CS-P2 project area. For example, the MOH, in collaboration with UNICEF, is currently developing a special

surveillance system for tetanus, which will be piloted in Nusa Tenggara Barat (NTB) throughout the province including the CS-P2 project area. The World Bank Health Project III will allocate additional resources to cover the operational cost for the health sub-center in the CS-P2 project area.

The international NGO described above as working on a community development project in 2 sub-districts in East Lombok will provide additional resources needed for CS-P2 related health services, training activities, and/or for upgrading health sub-centers in areas that overlap with the CS-P2 project.

III. Progress in health information data collection

III-A. Baseline surveys

Baseline KAP and EPI coverage survey

This survey was undertaken by PATH, MOH, and YKSSI to establish a baseline on the current knowledge, attitude and practice (KAP) of mothers of infants and children aged 0 to 23 months with respect to antenatal care, immunization, breastfeeding, acute respiratory infection, and family planning. This survey was also performed in February 1991 and in the 18 core evaluation villages of the CS-P2 program. The standard EPI cluster sampling method was used to gather information from respondents. The total sample size included 384 mothers with infants ranging in age from 0 to 11 months and 248 mothers with children 12 to 23 months of age.

It took one week to translate and pretest the survey instrument in the local Sasak language and to refine the questionnaire based on pretest results. The actual field work took 14 days. On average, one interview lasted 30 to 40 minutes. The survey was financed with CS-P2 project funds and cost \$3,132.

Valuable technical assistance in questionnaire design was provided by Dr. Michael Linnan, the USAID/Indonesia Child Survival Consultant, and in preparation for data entry by a private research firm, Survey Research Indonesia (SRI).

The computer arrived in Lombok in June 1991. Three different malfunctions kept the computer out of operation until September. Despite these constraints, entry of the baseline KAP survey data has been completed and is attached. Detailed analysis of the data set will be undertaken in late November and early December with technical assistance from Dr. Michael Linnan. Preliminary analysis of the data set is included in the attachment entitled, "Child Survival Plus Two Baseline Survey Preliminary Analysis." The baseline survey instrument is attached as Appendix 1.

Key preliminary findings include relatively high levels of mothers reporting antenatal examination (83 percent) with the majority of these examinations taking place at village integrated health posts (Posyandu), health sub-centers (puskesmas pembantu), and sub-district health centers (puskesmas). Among women not having antenatal examinations, the major reason cited was the attitude that antenatal examinations are not necessary if the pregnant woman is not sick. This finding has highlighted the need for an information and

education program aimed at educating mothers about the benefit of antenatal care. The survey also identified relatively low levels of educational attainment among respondents of which about 42 percent had no formal schooling. Fifty-six percent of respondents were also found to be illiterate. A surprising number of respondents, however, owned radio/cassette recorders (39 percent) and television sets (9.5 percent), and an even larger percentage of respondents claimed to sometimes listen to radio (82 percent) and watch TV (63 percent) indicating the potential for use of the mass media to reach target mothers with CS-P2 information and education. This information is currently being used to guide the development of an IE&C campaign for CS-P2.

The results of the baseline immunization coverage survey can be seen in Table 3.

**Table 3: Child Survival Plus Two Project
Baseline Immunization Survey, Lombok, February 1991
(Children N = 265; Women N = 391)**

<u>Vaccines</u>	<u>N</u>	<u>%</u>	<u>Mean Age in Months</u>
DPT1	224	85	2.9
DPT2	223	84	4.5
DPT3	217	82	6.0
BCG	223	84	4.4
Polio 1	224	85	2.8
Polio 2	223	84	4.3
Polio 3	217	82	5.8
Measles	214	81	10.0
Completely vaccinated Children with Card	173 185	65 70	
TT1	117	30	3.9**
TT2	92	24	2.7**
Women "protected"*	71	18	
Women with Card	119	30	

*TT - TT2 interval of at least 1 month

**Months before birth of child

Although immunization coverage data for childhood vaccinations of DPT, polio, and measles are relatively high, only 65 percent of the children were completely vaccinated before 12 months of age. Hepatitis B immunization coverage data are not included, as not all villages were enrolled in the Hepatitis B Model Program in the period from which these data were collected.

TT coverage data for pregnant women were very low; only 30 percent of the women with a child 0 to 11 months of age received at least one TT vaccination and 24 percent received two TT vaccinations during their last pregnancy. Figure 1 shows that immunization coverage in the CS-P2 core villages is somewhat lower than that of the Hepatitis B Model Program core villages. The baseline mean age (months) for immunization among children in CS-P2 core villages was also lower than that of the Hepatitis B project area (Table 4).

Figure 1: Routine EPI: Coverage Survey Results, Hepatitis B and CS-P2 Core Villages, Lombok, February 1991

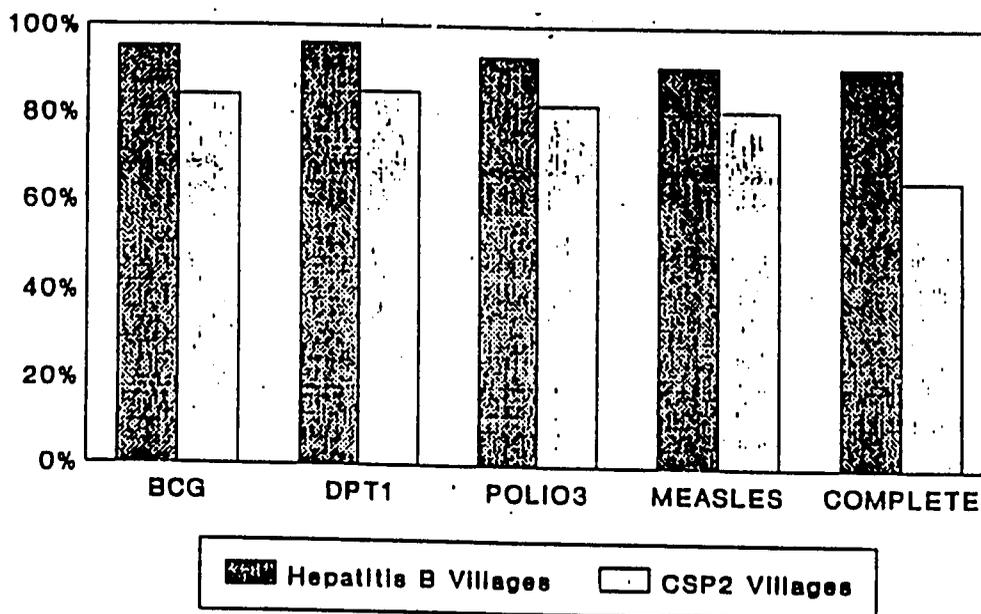


Table 4: Routine EPI: Mean Age (months) at Immunization, Child Survival Plus Two Core Villages, Hepatitis B Project Core Villages and Non-Project Areas, Lombok, February 1991

	<u>DPT</u>	<u>Polio 3</u>	<u>Measles</u>
CS-P2 Core Villages	2.9	6.0	9.95
HB Core Villages	2.3	5.1	9.90
Non-Project Area	3.7	7.0	10.40

The results of the baseline immunization coverage survey were discussed with provincial and national team members. These results confirm the original assessment of the need to improve TT vaccination coverage and coverage for childhood vaccinations. Other preliminary baseline KAP data are attached Appendix 3.

Evaluation of vital registration systems.

Although births and deaths are required by law to be reported within 48 hours, in practice this is neglected. The Hepatitis B Model Program has designed a local vital registration system.

In March 1991 the vital registration systems in the Hepatitis B Model Immunization Program area on Lombok were evaluated (see Appendix 2 for survey instrument and results). Vital events data in the 18 core villages of the hepatitis project and in the 18 core villages of the CS-P2 project were collected in a door-to-door survey using the WHO cluster-sampling method. The number of dwellings visited per cluster ranged from 42 to 262, with 7039 domiciles being visited in total. The entire field work was completed in 15 working days. One interview took on average 10 to 15 minutes. The survey was budgeted for by the Hepatitis B Model Immunization Program at no cost to the CS-P2 project.

A Canadian intern, supervised by the Model Program counterpart officer and assisted by the CS-P2 counterpart officer, designed the questionnaire and sampling methodology and analyzed the data. Interviewers from YKSSI and the provincial health office and district health office were involved in the field work.

Two hundred and thirteen pregnant women were surveyed in the CS-P2 core villages; 26.3 percent of their pregnancies were recorded in the hamlet records and 34.7 percent of pregnancies were recorded in the health center records. Of the pregnancies recorded in the hamlet records more than 60 percent were also recorded in the health center records.

Data were collected on a total of 395 births that occurred during the previous year. In the hamlet records, 23.5 percent of the births were noted, while 73.7 percent of the births were recorded in the health center records. More than 90 percent of the births reported in the hamlet records were also noted in the health center records.

The results show that recording of vital events at the village/hamlet level is far from optimal. The main constraint is the illiteracy of PKK cadre, hamlet chiefs, and other people who are involved with this reporting/recording system. Despite PKK literacy programs, many people are not able to record various vital events. This brought up the need to develop appropriate recording forms for illiterate or semi-literate people. Once births/pregnancies were recorded in village/hamlet records, the events were very likely to be reported and recorded to health officials, stressing the importance of adequate reporting/recording at the hamlet/village level (for details see the attached report). The survey results were discussed with provincial and national team members and with the master trainers for recording/reporting training at the hamlet/village level. No changes in the program were considered, based on the result of this survey.

In the CS-P2 project villages, hamlet leaders, village leaders, village administrative staff, and village volunteers received a one-day refresher training in which the importance of a timely birth/death and pregnancy

reporting as well as the reporting/recording mechanism for national development planning including health development programs was extensively explained. The survey results were used during the training sessions. In October and November 1991 all TBAs in the CS-P2 project villages will also be trained to assist in timely reporting/recording.

Baseline and on-going mortality survey

Since April 1990 data in maternal, perinatal, and infant death have been collected in the 18 core villages. Mothers and/or family members of the deceased are interviewed by village nurses/midwives using verbal autopsy methodology. The interviews last 20 to 30 minutes. The provincial team and the counterpart project officer designed the questionnaires and trained the interviewers. The model program counterpart officer assisted the CS-P2 counterpart project officer in establishing a computerized system for the data entry and analysis.

Approximately 320 neonatal and 20 maternal verbal autopsies have been completed since April 1990. Data collection will be continued throughout the life of the project. The mortality data from April 1990 to April 1991 will serve as baseline mortality data for the project. These data are currently being entered in the computer and will be analyzed in the coming months. Of the ten maternal verbal autopsy forms received to date, very preliminary results indicate problems of bleeding, both antepartum and postpartum. Further data analysis will guide development of possible intervention for future consideration. This ongoing data collection will be analyzed bi-annually. Feedback will be given to the appropriate districts as well as to health (sub-) centers. In the CS-P2 project areas the MOH, in collaboration with UNICEF, will start a pilot tetanus surveillance program, applying the CS-P2 verbal autopsy form for case finding. Each infant death suspected as caused by tetanus will be followed and analyzed by the midwife from the health sub-center, and appropriate measurements, including training of TBAs in safe-cord care, will be carried out accordingly.

III-B Routine data collection

A. Reporting/recording of vital events at the community and health sub-center

The success of the CS-P2 program depends upon a timely reporting of pregnancies and births. The Hepatitis B Model Immunization Program developed a special birth notification system at the community level in areas that overlap with the CS-P2 project. This system has been upgraded and strengthened in CS-P2 program areas. The system is initiated at the hamlet level by village volunteers, who are members of the PKK. In Indonesia, the PKK is playing a key role in social mobilization for outreach clinic activities, including the delivery of EPI vaccines as well as for other community/hamlet level activities. In the CS-P2 program areas, the PKK and TBAs provide oral notification of pregnancies, births, and deaths to the hamlet chief, who in turn will record the vital events and report to the village leader. Births are required to be reported to the village leader within 48 hours, while deaths and pregnancies are reported on a weekly basis. The village nurses/midwives (health sub-center staff) collect this information

from the village chief every week. TBAs, village volunteers, hamlet chiefs and families are also encouraged to report births directly to the health sub-center staff.

Data from each newborn, postpartum woman (if not yet recorded during pregnancy), and pregnant woman are recorded in the hamlet record book (buku dusun) which is kept in the health center or health sub-center. Services provided are recorded on the child's and maternal Road to Health card and on the daily records (form B4.1 and B4.2) and later copied into the hamlet record book. These routine records were slightly changed in the CS-P2 project areas in order to be able to record all services delivered to the target population. The new reporting/recording system ensures that pregnant women can be identified and motivated to attend ANC services at the health sub-center and/or outreach clinics. This system also identifies defaulters for vaccinations and allows village volunteers and hamlet chiefs to motivate mothers and families to bring their children to the integrated village health post (posyandu) for vaccination and other health services. LBW infants will also be identified for referral and follow-up services.

B. Monitoring community health workers and reporting/recording activities

The daily vaccination and CS-P2 program activity records are collected on a monthly basis. These records are to be verified every 3 months, using hamlet record books. On time reporting/recording and delivery of CS-P2 interventions will be monitored regularly. Health center staff will evaluate the reporting/recording with the village nurses/midwives and village leaders. Village leaders and nurses/midwives will then provide feedback to the village volunteers and hamlet chiefs on their performances.

C. Program outcome and impact indicators

Apart from project inputs and outputs, several process and impact indicators will be collected. Among them, accurate reporting of pregnancies, births, and deaths is a key indicator that determines how successfully the program is reaching the target populations. In the beginning of the project, hamlet chiefs and village volunteers were oriented towards the importance of timely reporting of vital events and were trained in how to report/record vital events. However, in many areas their performance was far from optimal. Inaccurate reporting puts the burden on the village nurses/midwives, who have to actively look for pregnancies, newborns, and deaths. To solve this problem, sub-district, health sub-center staff, and village PKK leaders will provide more intensive supervision to the hamlet chiefs and village volunteers. Given the fact that pregnant women often seek help from TBAs, TBAs will also be trained October 1991 in reporting pregnancies and births.

As a result of an existing immunization reporting/recording system, data will be collected every month, computerized, and evaluated quarterly. The baseline immunization coverage data will be compared with data collected at midterm and final evaluations. The routine EPI vaccines administered in 18 CS-P2 core villages between May to August are shown in Table 5.

Table 5: Routine EPI: Vaccines Administered in 18 CS-P2 Core Villages, May to August 1991

<u>Vaccines</u>	<u>Doses Administered</u>	<u>Coverage Rate %</u>
HB1	1,724	100%
HB2	1,516	88%
HB3	1,201	70%
DPT1	1,533	89%
DPT2	1,348	78%
DPT3	1,239	72%
BCG	1,347	78%
Polio 1	1,528	89%
Polio 2	1,353	78%
Polio 3	1,237	72%
Measles	1,300	75%
TT1	1,197	57%
TT2	1,040	49%

*Population data used to calculate the initial targets were based on a projected number of births and pregnant women of 3% (1500) and 3.8% (1833) of the population respectively. The number of births in the project area is higher than expected, hence a coverage rate of 115% of the project target births. The 3% was originally chosen because of data from the hepatitis core villages.

**Since the number of births in the target area is at least 15% higher than the initial target, the project target for pregnant women has also been raised by 15%. Thus, the targets used for calculating coverage here are 1,724 births and 2,108 pregnant women. These are maximum coverage estimates since they assume that no babies missed their HB1.

Table 6 shows the preliminary data on CS-P2 Phase I activities in the 18 core villages during May to August 1991. This data suggested an initial success was achieved in the 18 core villages.

**Table 6: CS-P2 Phase I Activities Coverage in
18 Core Villages May to August 1991**

	<u>Projected Target*</u>	<u>Number Achieved</u>	<u>Percent Target</u>
<u>Newborns</u>			
HB1	1,724	1,724	100%
OPVO	1,724	1,404	81%
<u>Post partum women</u>			
Vit. A (200,000 IU)	1,724	1,318	76
TTM	1,724	1,318	76
Health Education	1,724	1,318	76
<u>Pregnant Women</u>			
TT1	2,108	1,197	57
TT2	2,108	1,040	49

*As in Table 5, the targets used for calculating percent of target here are 1,724 births and 2,108 pregnant women.

Using verbal autopsy methodology, mortality data at the 18 core villages are being collected. It is expected that the program will have an impact on selected cause-specific mortality figures, e.g., neonatal tetanus mortality and mortality due to acute respiratory infection (ARI). The routine reporting and recording of stillbirths and maternal and infant deaths is, however, far from complete. The village nurses/midwives who are conducting the verbal autopsies consider updating the list as well as retrieving reliable information from the families of the deceased very difficult. Incomplete reporting/recording of deaths will hinder the use of mortality data as an impact indicator. Intensive supervision is provided to the village nurses/midwives and a refresher training is planned for this year.

Data on mothers' KAP regarding several topics were collected during the baseline KAP survey and will be repeated during the midterm and subsequent final evaluation.

Health service utilization will be evaluated as one of the outcome indicators in the second-phase activities, namely ANC, screening for high-risk pregnancies, and ARI case-detection and management. Pregnancy and ANC services received at outreach clinics and health (sub) centers will be recorded and evaluated. Data on the overall proportion of mild and severe cases of ARI being treated at the health center will also be collected.

D. Monitoring service performance and sustainability indicators

The provincial team, district teams, and health center staff will visit the field to monitor the quality and quantity of services provided by the village nurses/midwives monthly. Hamlet, village, and health sub-center records will also be evaluated regularly. Village nurse/midwife and/or staff from the health center will visit every hamlet at least once a month. Performances of village volunteers and hamlet chiefs will be observed and evaluated during the monthly integrated health post. Moreover, birth/pregnancy reporting/recording and village volunteers' motivational skills will also be evaluated in a post-hoc manner quarterly by analyzing vaccination coverage and timing of the first home visit. One of the highest health manpower priorities of the GOI is to create the health sub-center at the village as the backbone of primary health care in Indonesia.

The project assisted establishing the health sub-centers by developing their manpower and improving their infrastructure. Intensive training in various child survival interventions was provided to the health sub-center staff. Equipment was redistributed to reach the needs of the target population. This enables the health sub-center to continuously provide integrated services and quality care to the target population after the termination of the project.

E. Surveillance activities

No disease surveillance activities as such will be undertaken in the CS-P2 project. However, by following up of all infant and maternal death reports, cause-specific deaths per village/area will be defined and appropriate interventions can be initiated. The MOH in collaboration with UNICEF is currently developing a special surveillance system for tetanus, which will be piloted in the CS-P2 project area, using the verbal autopsy forms developed by PATH for casefinding. The midwife from the health sub-center will analyze each infant death caused by tetanus. Appropriate follow-ups, including training of TBAs in safe-cord care, will be carried out accordingly.

Starting in October 1991 all TBAs in the CS-P2 project villages will be trained in weighing newborns and identifying LBW infants as well as in adequate home care and/or referral of the LBW infants. The TBA will report the LBW infants to the health (sub) center. The village nurse/midwife will provide home visits.

F. Collection, compilation, and analysis of data

The health center doctor will be responsible for collecting all vaccination records, health sub-center records, and completed verbal autopsy forms and sending the forms to the district health office. The records will be compiled in the provincial health office monthly and forwarded to the PATH Lombok office for computerization and analysis. Analyzed data will be periodically reported to the MOH/national team.

G. Quality control of HIS systems

The reporting/recording systems are monitored through frequent supervisory visits of provincial and district team members and the PATH counterpart project officer. Once-a-month reporting/recording forms are sent to the district health offices and forwarded to the provincial health office and the provincial team. Cross-checking is done at the district and provincial health offices. Also, the number of vaccines given according to the records will be compared with the number of vials of vaccine distributed to the different health (sub-) centers. The daily vaccination/CS-P2 program activity records (B4.1 and B4.2) are computerized. Every three months these records/data will be cross-checked and verified using the hamlet record books.

H. Feedback of information collected to project areas

The provincial team and PATH will prepare quarterly progress reports, showing project outputs, outcomes, and impact indicators per village and per district. The findings will be discussed at provincial- and district-level meetings. Doctors of the health centers involved in CS-P2 project activities will attend these meetings and give feedback to their staff, including the village nurses/midwives. The feedback will then pass to the village chief, hamlet leaders, village volunteers, and TBAs by village nurse/midwife. The first quarterly report (May to July) is in preparation.

I. Expenditure on HIS systems

Approximately 7 percent of the program expenditure has been spent on the project's health information systems.

IV. Improvements in program quality and technical effectiveness

IV-A. Lessons learned in implementation of CS-P2 project activities

- * Commitments from the central government as well as from the local government at all levels are the key to successfully implement the program and to sustain program activities after project termination.
- * Orientation of local government officials and intra-sectorial and inter-sectorial departments towards the goals, objectives, and strategies of the program is essential for the success of the project. They need to be continuously involved and updated regarding progress, constraints, and modifications of the program.
- * Various governmental and nongovernmental organizations have provided considerable support to the project. Collaboration with governmental and nongovernmental organizations is essential for the long term success of the community-based preventive care approach of the project.
- * It is most important to take local circumstances and cultural constraints into consideration when adapting national policies to project designs.

- * Appropriate training and orientation materials are essential for all levels of staff and government officials involved in the implementation and supervision of the program activities. Supervision of the training sessions is crucial to assure adequate transfer of knowledge and compliance with the training objectives. Careful planning and sufficient time must be budgeted for training local master trainers in training methodologies and skills.
- * All training and orientation materials should be extensively field tested and adapted to local circumstances. The local language and pictorial material should be used in the development and pretesting of health education and training materials.
- * In areas where community organizations are weak, the delivery of community oriented services are not fully implemented as planned. Intensive training and supervision needs to be given to these areas in order to strengthen community structures and increase community awareness.
- * New technologies need to be extensively field tested before introduction to determine the local acceptability, usefulness, and appropriateness of the materials. Prior to the introduction, the new technologies also need to be evaluated in the context of availability of similar technologies locally. The product performance and costs of these technologies also need to be taken into account.

IV-B. Activities undertaken for strengthening technical quality of health programming

Experience gained from the training activities and project activities in the Year 1 villages will be used to modify the training curricula and to improve the effectiveness of the training in the Year 2 and Year 3 villages as well as the refresher trainings for the Year 1 villages. A new trainer adviser has been identified and will be based in Lombok starting in September 1991. She will develop appropriate training and IEC materials for the project, working directly with the provincial team, the counterpart project officer, and master trainers. She will also assist the project team in preparing the training plan for project Year 2 and Year 3. Alternative training methodologies are being explored to improve the quality of training and to reduce the burden of the provincial and district teams. In collaboration with YKSSI, a mobile team of trainers/supervisors could be contracted for full time training and supervision in the field.

More frequent supervisory visits to the project sites are necessary to provide on-site technical assistance to the village nurses/midwives, hamlet chiefs, and village volunteers. The health center staff will be more actively involved in supervising the health services performed by the health sub-center staff. District and provincial team members will make more frequent joint field visits to identify problems in the field and to strengthen their collaboration in the project.

V. Work schedule

V-A. Problems encountered

Reporting/recording of vital events

In some areas community organizations are rather weak. In those areas, the drop-out rate of community volunteers is high and hamlet chiefs are less active in reporting/recording. As a result, the task of identifying pregnant women, newborns, and postpartum women is shifted to the village nurses/midwives and vaccinators. Intensive supervision from health sub-center staff and sub-district PKK leaders is required to improve the notification of vital events at the hamlet/village level and to prevent late encounter for CS-P2 interventions. The community will also be involved in updating the notification system when the monthly outreach clinic is held at the hamlet. The MOH has also recommended the development of stricter criteria for cadre selection. In October and November 1991, TBAs in the CS-P2 project areas will be trained in, among other things, reporting of births and pregnancies. Further, PATH, in collaboration with YKSSI and a non-USAID-funded international organization, is currently preparing radio messages targeted to parents and TBAs on the importance of timely reporting of births.

Application of new reporting/recording forms

Although guidelines and training were given when introducing the modified forms for recording project interventions, the village nurses/midwives still had difficulties using the forms correctly. Continuous technical assistance is given during supervisory field visits. In addition, all village nurses/midwives will be invited to attend a two-day refresher/evaluation session in October. Reporting/recording mechanisms will be discussed and explained in this session.

Logistics concerns

Transportation for home visits and other outreach services is a main constraint to the project, especially in villages with dense population and/or large areas to cover. As not all health sub-center staff own a motorbike, some have to walk or take a horse cart when visiting newborns in their homes. Additional resources for transportation may be available through World Bank funding. In one area of East Lombok, a non-USAID-funded international NGO has agreed to provide financial support for the health sub-centers in their project areas that overlap with CS-P2 project areas.

Medical devices necessary for project activities are still far from sufficient. In many health sub-centers the lack of sufficient needles, syringes, and sterilizers hinders the provision of adequate health services and could potentially create a health hazard. This equipment will be redistributed to the health sub-centers from the national, provincial, and district existing stocks after the field assessment.

Marketing of project activities

Although in all CS-P2 health sub-centers ANC and FP services are initiated, the services are not yet fully utilized. This may be attributed to the insufficient marketing of these health services among the target population. Economic, geographic, and cultural constraints may also prevent pregnant women from utilizing these services. To address this problem PATH, in collaboration with YKSSI and an international NGO, will develop radio messages to promote ANC services in the project area. By strengthening vital events reporting/recording at the hamlet level, village volunteers and hamlet chiefs will be involved in motivation of pregnant women to utilize ANC services. TBAs will also be trained to advise and refer their clients to attend ANC services at the health sub-center.

Time constraints

In the past, members of the national, provincial, and district teams have been distracted from program activities because of their commitments to parallel projects. Many of them are playing multiple roles in various projects. In the CS-P2 project area, one major project that requires attention from the provincial team is in the final evaluation stage. Upon completion of this project, provincial and district team members will be able to devote more time to the CS-P2 project.

Inter-sectorial collaboration

As described in the DIP, the leadership of this project is shared among several governmental departments. Therefore, inter-program and inter-sectorial collaboration is essential for the success of the project. In the past, lack of sufficient collaboration between departments delayed the decision-making process. As a result project activities were not fully implemented as planned. More inter-program and inter-sectorial meetings are planned to improve communication and collaboration among the government departments involved.

V-B. Major activities for fiscal year 1991 and 1992

See Appendix 4.

VI. Changes in project expenditure and justification for budget changes

A. Procurement

The national and provincial teams have requested that we procure 500 ARI timers to be used by village health workers (cadres) for ARI case detection and referral in CS-P2 project areas. We have identified a supplier of ARI timers which is based in Singapore (Diehl Pte Ltd.). The unit cost of the timer is US\$4.41. The timers were developed according to UNICEF specifications and have been pretested in the Gambia and Nepal and were found to be of high quality.

Sufficient funds exist from the Year 1 Procurement line item to cover the cost of the ARI timers for Year 2 activities. The Annual Report Form A is attached.

VII. Sustainability

VII-A. Recurrent costs

As project interventions are integrated into the MOH routine services, and the information systems and management training will be institutionalized within the MOH routine operations, it is therefore expected that the activities will continue as a national program and will not be terminated after project completion.

Continuous supply of vaccines, needles, syringes, and vitamin A capsules will be needed for the outreach services. Reprinting of health educational materials and reporting and recording forms are also required for continuation of the project activities. Operational costs will be needed for maintenance and gasoline for the motorcycles to be used during outreach services. Funding for supervision visits from various administrative levels is also required for monitoring performances after project termination.

VII-B. Strategies for reducing sustainability concern

The CS-P2 project design relies heavily on existing community structures and resources. The project provides training, supervision, and feedback at the hamlet/village level to strengthen the community structures and to raise the community awareness concerning health problems.

New knowledge and skills are transferred through extensive training to the village nurses/midwives. They are therefore empowered to provide quality care to the community.

The project strengthened and upgraded the vital events reporting/recording systems. This system can be the foundation for any new health intervention at the community level in the future.

PATH provided training in financial management skills and organizational development to YKSSI and YHS, local PVOs on Lombok. These PVOs provide technical assistance in various project activities.

VII-C. Cost recovery activities

Cost recovery methods will include those described in the DIP, as well as new methods generated through test market studies of the "Safe Birth Kit" and cereal-based ORS products.

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1991 COUNTRY PROJECT PIPELINE ANALYSIS: REPORT FORM A
PVO/COUNTRY PROJECT: PATH / INDONESIA CHILD SURVIVAL-PLUS TWO

HEADQUARTERS	Actual Expenditures to Date (9/30/90 to 9/30/91)			Projected Expenditures Against Remaining Obligated Funds (10/1/91 to 9/29/93)			Total Agreement Budget (Columns 1 & 2) (9/30/90 to 9/29/93)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
COST ELEMENTS									
I. PROCUREMENT									
A. Supplies			0			0			0
B. Equipment			0			0			0
C. Services/Consultants									
1. Local			0			0			0
2. Expatriate			0			0			0
SUB-TOTAL I	0	0	0	0	0	0	0	0	0
II. EVALUATION /SUB-TOTAL II	0	0	0	0	0	0	0	0	0
III. INDIRECT COSTS									
Overhead on HQ/HO (%)			0			0			0
SUB-TOTAL III	4,056	9,757	13,813	17,913	15,805	33,718	21,969	25,562	47,531
	4,056	9,757	13,813	17,913	15,805	33,718	21,969	25,562	47,531
IV. OTHER PROGRAM COSTS									
A. Personnel									
1. Technical	6,582	12,475	19,057	8,120	7,767	15,887	14,702	20,242	34,944
2. Administrative	314	2,835	3,149	15,702	0	15,702	16,016	2,835	18,851
3. Support	1,280	4,445	5,725	4,831	15,700	20,531	6,111	20,145	26,256
B. Travel/Per Diem									
1. in country	1,207	3,154	4,361	17,491	19,656	37,147	18,698	22,810	41,508
2. International			0	1,330	0	1,330	1,330	0	1,330
C. Other Direct Costs (utilities, printing, rent, maintenance, etc.)	2,581	64,672	67,253	7,335	(53,008)	(45,673)	9,916	11,664	21,580
SUB-TOTAL IV	11,964	87,581	99,545	54,809	(9,885)	44,924	66,773	77,696	144,469
TOTAL HEADQUARTERS	16,020	97,338	113,358	72,722	5,920	78,642	88,742	103,258	192,000

22.

1991 COUNTRY PROJECT PIPELINE ANALYSIS: REPORT FORM A
PVO/COUNTRY PROJECT: PATH / INDONESIA CHILD SURVIVAL-PLUS TWO

FIELD	Actual Expenditures to Date (9/30/90 to 9/30/91)			Projected Expenditures Against Remaining Obligated Funds (10/1/91 to 9/29/93)			Total Agreement Budget (Columns 1 & 2) (9/30/90 to 9/29/93)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
COST ELEMENTS									
I. PROCUREMENT									
A. Supplies	8,005	0	8,005	23,163	0	23,163	31,168	0	31,168
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants									
1. Local			0	26,112	19,650	45,762	26,112	19,650	45,762
2. Expatriate	29,232	116,776	146,008	127,809	147,600	275,409	157,041	264,376	421,417
SUB-TOTAL I	37,237	116,776	154,013	177,084	167,250	344,334	214,321	284,026	498,347
II. EVALUATION/SUB-TOTAL II									
A. Consultant/Contract	7		7	9,750	0	9,750	9,757	0	9,757
B. Staff Support			0	10,000	0	10,000	10,000	0	10,000
C. Other			0	0	0	0	0	0	0
SUBTOTAL II	7	0	7	19,750	0	19,750	19,757	0	19,757
III. INDIRECT COSTS									
Overhead/field offices (%)			0	0	0	0			0
SUB-TOTAL III	32,020	59,770	91,790	140,207	(617)	139,590	172,227	59,153	231,380
	32,020	59,770	91,790	140,207	(617)	139,590	172,227	59,153	231,380
IV. OTHER PROGRAM COSTS									
A. Personnel									
1. Technical	6,593	44,070	50,663	129,173	(35,145)	94,028	135,766	8,925	144,691
2. Administrative	0	1,678	1,678	34,648	5,849	40,497	34,648	7,527	42,175
3. Support	1,444	7,845	9,289	11,255	(5,002)	6,253	12,699	2,843	15,542
B. Travel (Short Term)									
1. In country	8,896	14,492	23,388	63,647	(14,492)	49,155	72,543	0	72,543
2. International			0	0	0	0			0
C. Other Direct Costs (utilities, printing, rent, maintenance, etc.)	54,738	114,978	169,716	(5,441)	(109,772)	(115,213)	49,297	5,206	54,503
SUB-TOTAL IV	71,671	183,063	254,734	233,282	(158,562)	74,720	304,953	24,501	329,454
TOTAL FIELD	140,935	359,609	500,544	570,323	8,071	578,394	711,258	367,680	1,078,938

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1991 COUNTRY PROJECT PIPELINE ANALYSIS: REPORT FORM A
 PVO/COUNTRY PROJECT: PATH / INDONESIA CHILD SURVIVAL-PLUS TWO

Actual Expenditures to Date
 (9/30/90 to 9/30/91)

Projected Expenditures Against
 Remaining Obligated Funds
 (10/1/91 to 9/29/93)

Total Agreement Budget
 (Columns 1 & 2)
 (9/30/90 to 9/29/93)

TOTAL - FIELD & HEADQUARTER

AID	PVO	TOTAL
16,020	97,338	113,358
140,935	359,609	500,544
156,955	456,947	613,902

AID	PVO	TOTAL
72,722	5,920	78,642
570,323	8,071	578,394
643,045	13,991	657,036

AID	PVO	TOTAL
88,742	103,258	192,000
711,258	367,680	1,078,938
800,000	470,938	1,270,938

TOTAL HEADQUARTERS

TOTAL FIELD

TOTAL

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PERSON MONTH ATTACHMENT TO PIPELINE ANALYSIS

PVO/COUNTRY PROJECT OTR-0500-A-00-0100-00

POSITION -----	HEADQUARTERS		FIELD	
	AID ---	PVO ---	AID ---	PVO ---
Director	0.09	0.77	0.00	0.00
Senior Program Officer	0.06	0.04	0.00	0.00
Senior Representative in Indonesia	0.00	0.00	0.75	1.14
Program Officer	0.17	0.09	0.00	0.00
Associate Program Officer	1.07	0.60	0.00	9.28
Associate Procurement Officer	0.00	0.05	0.00	0.00
Associate Administrative Officer	0.07	0.78	0.00	1.56
Assistant Procurement Officer	0.00	0.07	0.00	0.00
Assistant Administrative Officer	0.02	0.00	0.00	0.00
Support	0.50	3.66	5.80	19.83
Total	<u>1.98</u> =====	<u>6.06</u> =====	<u>6.55</u> =====	<u>31.81</u> =====

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1991
USAID Health and Child Survival Project
Questionnaire

with AIDS/HIV Activities Reporting Schedule

PVO Grant

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Main Schedule.....	1 - 6
Schedule 1 - Demographic.....	7
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Schedule 3 - Immunization.....	10 - 11
Schedule 4 - Nutrition.....	12 - 13
Schedule 5 - High Risk Births.....	14 - 15
Schedule 6 - AIDS/HIV Activities.....	16 - 17
Schedule 7 - Other Health and Child Survival.....	18 - 19

Country Indonesia

Project Title FY 90 Child Survival Grant to PATH

Project Number 938PATH.01

Name(s) of Person(s) responding to the questionnaire Leona D'Agnes, Huan Linnan

Title(s) Project Manager, Technical Coordinator Date: October 1991

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USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

Where available, information for questions 1 through 7 has been supplied. Please carefully check the supplied information for accuracy and make any corrections necessary. Where questions are left blank, please supply the requested information. If the Project Number is incorrect, or if the project is new, please write the correct number here and in the spaces provided at the bottom of each page of the questionnaire.

PROJECT IDENTIFICATION

CIH/USE ONLY	
I.D.:	01.90
Number:	E90724
Region:	AS
Emphas:	nr

1. Project Number: 938PATH 2. Subproject Number: 01
 Country: Indonesia
3. Country: _____
4. a. Project Title: FY 90 Child Survival Grant to PATH
 b. Subproject Title: _____
90
5. a. Beginning FY: _____ b. Beginning FY of Subproject (if appropriate): N/A
 Fiscal Year Fiscal Year
6. a. Project Assistance Completion Date (PACD): 09/30/93 b. Termination Date of Subproject (if appropriate): N/A
 MM DD YY MM DD YY
7. Current Status: (CIRCLE ONE ANSWER) 0
- 1 - New, no activity yet 2 - Ongoing 3 - Discontinued 4 - Completed

PARTICIPATING AGENCIES

8. For each contract or grant, please provide the complete name of the contractor or grantee, the subcontractors working on the project, the host country counterpart(s) and the organization(s) responsible for implementation. Assign a type to each agency named as per the codes indicated below. Use additional sheets if necessary.

		Organization Type
a. Prime Contractor/Grantee or Partner in Cooperative Agreement	Program for Appropriate Technology in Health (PATH)	1
b. Subcontractors	YKSSI Yayasan Kelnarga Sehat Sejahtera Indonesia	2
c. Host Country Counterpart(s)	The Ministry of Health Republic of Indonesia	5
d. Organization(s) with Major Implementing Responsibility	Same as 8.C.	5

Codes for Organization Type (PLACE THE NUMBER CORRESPONDING TO THE CODE IN THE SPACES ABOVE.)

1 - Private Voluntary Organizations (U.S.)	5 - Government (Host Country)	8 - Multilateral Agencies
2 - Private Voluntary Organizations (Local)	6 - Other Non-profit Organization (U.S.)	9 - For-profit Firms (all countries)
3 - Universities (all countries)	7 - Other Non-profit Organization (host and other countries)	10 - Other _____ (Please Specify)
4 - Government (U.S.)		

- e. Provide the name and mailing address of the person or office that should receive relevant technical information from USAID. (PLEASE PRINT CLEARLY)
- Name: Leona D'Agnes
 Mailing Address: PATH
Tifa Building, 11th Floor, Suite 1102
Jl. Kuningan Barat No. 26
Jakarta 12710 INDONESIA

28'

USAID HEALTH AND CHILD SURVIVAL PROJECT QUESTIONNAIRE - FY 91

7. Percentage Attributions to Program Functions

This question should be answered in two steps. First complete Column A, and then complete Column B. This list of program functions is nearly compatible with the "Activity Codes" in the Agency's AC/SI system. If you are reporting attributions in this questionnaire which are different from those reported in the FY 1993 ABS, please note the reason for the discrepancy. The "AC" code corresponding to the USAID Health Information System category is displayed in parentheses for each program function.

This year, the questionnaire includes a new category for **Environmental Health** which does not correspond exactly to any of the activity codes available for attribution through the AC/SI system. In this questionnaire, environmental health refers to activity encompassing those diseases and health problems caused by or aggravated by environmental degradation. Activities in the following areas pursued for specific health objectives may be attributed to **Environmental Health**: wastewater management; solid waste management; air pollution control; toxic radiological and hazardous waste management; occupational health; injury prevention and control, and food hygiene. (Water and sanitation for health and vector-borne disease control should be attributed to the codes established specifically for those activities.)

Step 1 - In Column A write the percent of the Life-of-Project authorized budget (from all USAID dollar funding accounts) that is attributable to each of the functions listed below. The percentages in Column A should sum to 100%.

Step 2 - If the project has a child survival component complete Column B. The entry in Column B should be the percentage of the entry in Column A devoted to Child Survival; for example, if 40% of the project is to Immunization/Vaccination and all of that attribution is for child survival, enter 100% in Column B.

PLEASE REVIEW THE EXAMPLE BELOW BEFORE COMPLETING THE TABLE.

EXAMPLE

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration.....(HEDD)	40%	100%	↑ Schedule 2
.	.	.	.
.	.	.	.
m. Water and Sanitation for Health.....(HEWH)	60%	20%	↓ Schedule 7
.	.	.	.
.	.	.	.
TOTAL, All Functions	100%		

This means that 20% of the water and sanitation component of the project is attributed to child survival.

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USAID HEALTH AND CHILD SURVIVAL PROJECT QUESTIONNAIRE – FY 91

9. Life-of-Project Percentage Attributions to Program Functions – Continued (See instruction guide for definitions)

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and . .
a. Diarrheal Disease/Oral Rehydration..... <u>Handwashing w/soap</u>(HEDD)	5%	100%	◆ Schedule 2
b. Immunization/Vaccination..... <u>OPV0</u>(HEIM)	30%	100%	◆ Schedule 3
c. Breastfeeding..... <u>Education/promotion</u>(NUBF)	10%	100%	◆ Schedule 4
d. Growth Monitoring.....(NUGM)	N/A	N/A	◆ Schedule 4
e. Targeted Child Feeding and Weaning Foods.....(NUGM)	N/A	N/A	◆ Schedule 4
f. Vitamin A.....(NUVA)	N/A	N/A	◆ Schedule 4
g. Women's Health..... <u>ANC</u>(HEMH)	20%	100%	◆ Schedule 7
h. Women's Nutrition (including iron)..... <u>Iron supplements</u>(NUWO)	5%	100%	◆ Schedule 4
i. Nutrition Mangement, Planning and Policy.....(NUMP)	N/A	N/A	◆ Schedule 4
j. Other Nutrition (e.g., iodine fort. food tech.) _____ (Please Specify)	N/A	N/A	◆ Schedule 4
k. Child Spacing/High Risk Births.....(HECS)	5%	100%	◆ Schedule 5
l. HIV/AIDS.....(HEHA)	N/A	N/A	◆ Schedule 6
m. Water and Sanitation for Health.....(HEWH)	N/A	N/A	◆ Schedule 7
n. Environmental Health (See guidance on previous page) _____ (Please Specify)	N/A	N/A	◆ Schedule 7
o. Acute Respiratory Infections.....(HERI)	25%	100%	◆ Schedule 7
p. Malaria.....(HEMA)	N/A	N/A	◆ Schedule 7
q. Other Vector-borne Disease Control... ..(HEVC)	N/A	N/A	◆ Schedule 7
r. Health Care Finance.....(HESD)	N/A	N/A	◆ Schedule 7
s. Health Systems Development.....(HESD)	N/A	N/A	◆ Schedule 7
t. Other Health and Child Survival _____ (including: aging, prosthetics, essential drugs,orphans) (Please Specify)	N/A	N/A	◆ Schedule 7
u. All Non-Health.....	N/A	N/A	◆ None
TOTAL, All Functions	100%		

Project Number: 938 PATH

Subproject Number: _____

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

FUNDING INFORMATION

10. What is the total USAID authorized LIFE-OF-PROJECT funding for this project or subproject (authorized dollar funds from ALL USAID funding accounts)? \$ 1,078,938

11. Does this project receive PL 480 funding (for example, for commodities or ocean freight). 1 - Yes → ANSWER ITEM 12 AND 13
(2) - No } SKIP NOW TO ITEM 14
9 - Don't Know }

12. In the spaces provided, indicate the total PL 480 funding received by the project or subproject during FY 91 (Oct. 1, 1990 to Sept. 30, 1991). AMOUNT

a. PL-480, Title I.....	\$ _____
b. PL-480, Title II (including the value of food and monetization).....	\$ _____
c. PL-480, Title III.....	\$ _____

13. Please describe briefly how the PL 480 funding was used in the project during FY 91. (Use separate sheet if necessary).

14. Activities Involving the Private Sector of the Host Country

a. What type(s) of initiatives to stimulate or support the local private sector are a part of this project?
 (CIRCLE ALL THAT APPLY)

- 1 - Private production of health care goods or commodities.
- 2 - Assistance to privatize public health programs or services.
- 3 - Assistance to regulate private sector health services or commodity production and distribution.
- ④ - Training of private sector health care providers.
- ⑤ - Involvement of for-profit businesses in project activities.
- ⑥ - Other Development of Local PVOs Intrnl
 (Please specify) Capability

b. Of the total USAID Life-of-Project funding, estimate the percentage for the activities circled in question 16-a. _____ %

*Codes for "Source": DC: Data Collection System; BG: Best Guess; DK: Don't Know

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USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

15. Research Activity

a. Estimate the percent of Life-of-Project funds available to this project for research activities related to health and child survival.....% IF 0%, SKIP TO ITEM 18

b. Which program functions does this research address? (CIRCLE ALL THAT APPLY)

- 1 - ORT/Diarrheal Disease
- ② - Immunization/Vaccination
- 3 - Breastfeeding
- 4 - Growth Monitoring
- 5 - Targeted Feeding and Weaning Foods
- ⑥ - Vitamin A
- ⑦ - Maternal Health
- ⑧ - Women's Nutrition
- 9 - Nutrition Mgmt/Planning
- 10 - Other Nutrition
- 11 - Child Spacing/High Risk Births
- 12 - HIV/AIDS
- 13 - Water and Sanitation
- 14 - Water Quality Improv.
- ⑬ - Acute Resp. Infection
- 16 - Malaria
- 17 - Other Disease Control
- 18 - Health Care Financing
- ⑲ - Health Systems Devel.
- 20 - Other Health

c. What type(s) of research are addressed? (CIRCLE ALL THAT APPLY)

- 1 - Biomedical
- 2 - Vaccine Development
- ③ - Behavioral/Social Science/Communication
- 4 - Policy, Economic and Development
- ⑤ - Epidemiologic
- ⑥ - Operational Research
- 7 - Other _____ (Please Specify)

d. Please list descriptive titles of research being done under this project. For each title, also provide the years of the research and the name, affiliation and address of the primary researcher. (Use a separate sheet if necessary.)

Title: Attached

Year: BEG.: _____ END: _____

Name: _____

Affiliation: _____

Address: _____

TRAINING

16. During FY 91 how many persons involved in health services received training through this project?

	SHORT-TERM (< 1 Mo.)	LONG-TERM (> 1 Mo.)	Source of Information
Physicians	17		① DC BG DK
Nurses	54		① DC BG DK
Community Health Workers	526		① DC BG DK
Vaccinators	16		① DC BG DK
Traditional Healers	0		① DC BG DK
Community Leaders and Family Members	200		① DC BG DK

TECHNICAL ASSISTANCE

17. How many long-term expatriate advisors, classified by the description of their training, were supported by the project in FY 91? Include individuals supported by this project (A long-term advisor is one assigned to the project for 12 months or longer who was in-country for a part of FY 91.) (WRITE THE NUMBER OF ADVISORS IN THE SPACE PROVIDED)

<p>1 _____ Physician</p> <p>_____ Nurse</p> <p>_____ Midwife</p> <p>_____ Nutritionist</p> <p>_____ Demographer</p> <p>_____ Epidemiologist</p> <p>_____ Malariologist</p> <p>_____ Economist</p> <p>_____ Social Scientist</p>	<p>1 _____ Information Management Specialist</p> <p>1 _____ Communications/Education Engineer _____</p> <p>(e.g. Sanitary) (Please specify)</p> <p>Other _____</p> <p>_____ (Please specify)</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

18. Local vs. Expatriate Technical Assistance

During FY 91, how many person-months of technical assistance (both short-term and long-term) were provided by local (host country) advisors and by expatriate advisors?

Local Person-Months	Expatriate Person-Months
_____	_____

Attachment
Q.15.b

1. Title: Ethnographic study in a East Lombok Sasak Village with high rate of infant mortality
Year: BEG: May 1991 End: On-going
Name: Raharjo Suwandi, Ph.D. Dra. Ramaniya
Affiliation: YKSSI
Address: Jl. Pendidikan No. 56
Mataram - Lombok
2. Title: Small scale field trial for using BIRTHweigh scale in West Lombok
Year: BEG: April 1991 End: August 1991
Name: Nicolet Hutter, M.D.
Affiliation: PATH/Lombok
Address: Jl. Pendidikan No. 56
Mataram - Lombok
3. Title: Small scale PATHstrip user study at YKB Clinic
Year: BEG: September 1990 End: June 1991
Name: Huan Wan Linnan, M.D.
Affiliation: PATH/Jakarta
Address: Tifa Building, 11th Floor
Jl. Kuningan Barat No. 26.
Jakarta 12710
4. Title: Baseline KAP and immunization coverage survey in 18 CS-P2 Core Villages
Year: BEG: February 1991 End: Field work, March 1991
Name: Nicolet Hutter, M.D.; Huan Wan Linnan, M.D.; Dra. Latifa Bhay; and Brad Otto
Affiliation: PATH
Address: Jl. Pendidikan No. 56
Mataram - Lombok

5. Title: Survey of immunization coverage and vital registration system in Hepatitis B Model Immunization Program and CS-P2 core villages
- Year: BEG: March 1991 End: April 1991
- Name: Laura McDougall, M.D.
- Affiliation: PATH Indonesia Intern
- Address: 1923 Trafalgar Street
Vancouver, B.C.
Canada V6K 354
6. Title: Baseline and on-going mortality survey
- Year: BEG: April 1991 End: On-going
- Name: Nicolet Hutter, M.D. and Reny Bunyamin, M.D., MPH
- Affiliation: PATH, MOH/NTB Province
- Address: Jl. Pendidikan No. 56
Mataram - Lombok

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

HIGHLIGHTS

19. The primary uses of project highlights are for Congressional and other reporting. Please take a few minutes to make your project come alive for that reporting. Lively descriptions of specific project activities from FY 91 enhance the likelihood that your project will be described in reports such as the annual Report To Congress on Child Survival. Use the examples below as starting points for your description. (Attach additional sheets if necessary.)
- a. **Significant Success Stories:** (Example: Involving a locally based firm with expertise in social marketing strengthened the demand for ORS packets, resulting in an increase in the ORT USE RATE from 10% in 1990 to 25% in 1991...)
 - b. **Lessons Learned:** (Example: An operations research study showed that one incentive to continuing participation in the formal health sector was a "successful" first encounter; therefore, health workers were trained to spend extra time with new clients...)
 - c. **Anecdotes:** (Example: During a visit to a remote village, the young daughter of the village chief interrupted her mother to explain the proper technique for preparing ORS. This reflects the effect of training students in the use of ORS...)
 - d. **Policy Change:** (Example: Data from a major survey showed a shift in dietary practice to less nutritious foods leading the government to modify its pricing policy...)
 - e. **Relation to Country Programs/Strategy:** (Example: The project's major accomplishment is strengthening of the MOH's Family Health Division. In addition to the development of a strong financial control and accounting system, the project supported supervisory training which has facilitated the integration of services in health centers...)

See Attachment.

20. Because photographs can often communicate important concepts to busy decision makers much more quickly than words, can you include photographs to supplement the above text? (If yes, please include credit/caption information, including the location and year of the photo on a separate sheet and place picture, slide, or negative in an envelope.) Do not write on photos.

Photographs included? 1 - Yes 2 - No

ms

Schedule 1 DEMOGRAPHIC CHARACTERISTICS/PVO SCHEDULE

- 1 - 1 What is the geographical area in which this project is delivering and/or promoting health or child survival services? (CIRCLE ONE ANSWER)
- 1 - The entire country
 - ② - A geographical area smaller than the entire country
 - 3 - None. The project does not deliver or promote services
 - 9 - Don't Know
- } COMPLETE ITEMS
1 - 2 THROUGH 1 - 7
- } SKIP NOW TO NEXT SCHEDULE

- 1 - 2 What is (are) the particular name(s) of the major or political subdivisions (for example, St. John's Province or Isatoyl Department) in which project activities are being carried out? (If entire country, write "ALL".)
- 1 - Lombok Island, West
 - 2 - Nusa Tenggara Province
 - 3 - Republic of Indonesia
 - 4 - _____
 - 5 - _____

- 1 - 3 To which of the following subgroups are services targeted? (CIRCLE ALL THAT APPLY)
- ① - Children < 12 mos.
 - ② - Children 12 - 23 mos.
 - 3 - Children 24 - 59 mos.
 - 4 - Other children
 - ⑤ - Lactating or pregnant women
 - 6 - Other women of reproductive age
 - 7 - All other women
 - 8 - Men
 - 9 - The elderly (age 60 & older)
 - 10 - Other _____ (Specify)

- 1 - 4 Does this project attempt to serve all members of the targeted subgroups that live within the project area? (CIRCLE ONE)
- ① - Yes, attempts to serve all members of targeted subgroups in project area.
 - 2 - No, attempts to serve only a portion of the targeted subgroups that live within the project area. (COMPLETE COLUMN B IN ITEM 1 - 5 BELOW)
 - 3 - Other (Please explain) _____

1 - 5 Population

In Column A, enter the number of people in the following subgroups who live in the entire project area. In Column B, enter the number of people in each subgroup that the project is actually targeting. If it is the same as Column A, write "same" in Column B.

- a. Total Population.....
- b. Number of children aged < 12 months.....
- c. Number of children aged 12 - 23 months.....
- d. Number of children aged 24 - 59 months.....
- e. Number of children 0 - 6 years (0 - 72 months).....
- f. Women aged 15 - 19 years. 15-44 years.....
- g. Women aged 35 - 49 years.....
- h. Women aged 15 - 49 years.....
- j. Approximate number of births during FY 1990.....

Column A Entire Project Area	Source of Information*	Column B Target Population	Source of Information*
730,000	DC BG DK		DC BG DK
46,250	DC BG DK	SAME	DC BG DK
	DC BG DK		DC BG DK
	DC BG DK		DC BG DK
56,940	DC BG DK		DC BG DK
109,500	DC BG DK		DC BG DK
	DC BG DK		DC BG DK
	DC BG DK		DC BG DK
4,500	DC BG DK	SAME	DC BG DK

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

2/6

Attachment
Q.19.e

The goal and objectives of CS-P2 are consistent with the priorities and objectives delineated by the GOI in the Fifth Five-Year Development Plan (Repelita V). Repelita V aims to reduce maternal and infant mortality and increase participation in family planning, nutrition, immunization, diarrheal diseases control, and ARI control programs.

One of the highest health manpower priorities of the MOH during Repelita V is the development of the health sub-center at the village level as the backbone of primary health care in Indonesia. The CS-P2 project conforms with this long-term development policy and strategy and assists the Government of Indonesia to decentralize the provision of health services from the sub-district health centers to the village health sub-centers and integrated health posts in the hamlets.

The health sub-centers are staffed by a village nurse or a village midwife who is a graduate nurse receives one year of further midwifery training. Currently, four midwives are posted in the 18 CS-P2 core villages whereas the rest of health sub-centers are staffed by village nurses. These village nurse/midwives will be permanently stationed in the village to perform the following functions:

1. Provide risk approach antenatal care and child survival services to the community;
2. Provide technical support and supervision to integrated health service post and TBAs;
3. Deliver CS-P2 interventions at the health sub-center, integrated health service post and in the homes of newborns;
4. Participant data collection of the vital registration and mortality survey.

CS-P2 project has enhanced the capacity of the health sub-center in the project area. Prior to the project start, a needs assessment of basic equipment in the health sub-center was initiated in the 18 core villages. This assessment was followed up by the replacement of missing and broken equipment. Further, the village nurse/midwives were trained intensively in knowledge and skills in delivering CS-P2 interventions. Therefore, they are empowered to provide quality care to the community even after the termination of the project.

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE

20. Photographs (attached)

Envelope 1:

1. Indonesian health worker holding vaccinator's bag supplied to vaccinators and staff of the puskesmas pembantu in the Child Survival - Plus Two project area in April/May 1991.
2. Vaccinator's bag - close up.

Envelope 2:

1. 3 photographs of local tailor in Lombok, Indonesia making cloth slings for BIRTHweigh scale for use in PATH's Child Survival - Plus Two project. March 1991

Envelope 3:

1. Training of village and hamlet level leaders and community motivators in Semayan, Lombok, Indonesia. May 1991 (2 photos)
2. Trainer in Semayan, Lombok explaining one of the Child Survival - Plus Two record-keeping forms to village and hamlet level leaders and health cadres. May 1991
2. Training of health workers at the village and hamlet level, Dusun Tereng, Lombok, Indonesia. May 1991. (2 photos)
3. Training of trainers, Mataram, Lombok, Indonesia. May 1991. (2 photos)

All photographs were taken by the Child Survival - Plus Two project staff in Lombok, Indonesia during the first half of 1991.

Schedule 1 DEMOGRAPHIC CHARACTERISTICS/PVO SCHEDULE

(Continued)

1 - 6 Is the population served living primarily in an urban or rural environment? (CIRCLE ONE)

1 - Primarily urban
(If project serves primarily urban population or peri urban, please describe strategies employed).....▶

② - Primarily rural

3 - Mixed

4 - Don't know

1 - 7 If you use a demographic data collection system, please describe how data are collected and analyzed.

See Attachment.

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Schedule 2 DIARRHEAL DISEASE CONTROL

Important: Complete this schedule only if this project provides funding or otherwise supports activities in Diarrheal Disease Control.

COMMODITIES

- 2-1 During FY 91, were project funds committed for the purchase of ORS packets with the intention of distributing them to consumers? (CIRCLE ONE)
- 1 - Yes → COMPLETE ITEM 2-2
 ② - No } SKIP NOW TO ITEM 2-3
 9 - Don't Know }
-
- 2-2 If yes, write the number of packets purchased with USAID funds.
- No. of Packets

 *DC BG DK PACKET SIZE
 Source of information (in CCs or Liters)
-
- 2-3 Did the project support or promote the distribution of ORS packets (USAID, gov't or other donor purchased) through the national CDD program or through some other diarrheal disease control project or program?
- 1 - Yes, the national CDD } COMPLETE ITEM 2-4
 2 - Yes, an independent program }
 3 - No } SKIP NOW TO ITEM 2-5
 9 - Don't Know }
-
- 2-4 As part of that program, have packets been sold or are there plans to sell them?
- 1 - Have been sold } PLEASE DESCRIBE IN ITEM 2-12
 2 - Plans exist for sales }
 3 - Sales not envisioned }
 9 - Don't Know }
-
- 2-5 Did the project sponsor or promote the production of ORS packets within the participating country?
- 1 - Funds have been committed } COMPLETE ITEM 2-6
 2 - Promoted, but funds not committed }
 3 - No involvement with production } SKIP NOW TO ITEM 2-7
 9 - Don't Know }
-
- 2-6 Did the project sponsor or promote production of ORS packets by any of the following organizations or businesses? (CIRCLE ALL THAT APPLY)
- 1 - Governmental organizations
 2 - Private, commercial businesses
 3 - Joint governmental/commercial ventures
 4 - Other organizations

TRAINING

- 2-7 During FY 91, were project funds committed to support training in the control of diarrheal disease?
- ① - Yes → COMPLETE ITEM 2-8
 2 - No } SKIP NOW TO ITEM 2-9
 9 - Don't Know }

Training in hand washing before breastfeeding and infant feeding

2-8 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians.....	1	2	3	9
b. Nurses.....	1	2	3	9
c. Community Health Workers.....	1	2	3	9
d. Traditional Healers.....	1	2	3	9
e. Community Leaders and Family Members.....	1	2	3	9
f. Others (specify) <u>Vaccinators</u>	1	②	3	9

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Attachment
Schedule 1
Q.1-7

The CS-P2 project design relies heavily on existing community structures and resources. The reporting/recording of vital events that is essential for the identification of the priority target population is initiated at the hamlet and village levels. In CS-P2 program areas, village volunteers, hamlet chiefs, village leaders and other village administrative staff were oriented towards project goals, interventions and trained in accurate notification of vital events. They also motivate pregnant women and mothers with children under five years of age to visit the integrated health post (posyandu) and/or health sub-centers for vaccinations, ANC, and other health services.

The success of the CS-P2 program depends upon a timely reporting of pregnancies and births. The Hepatitis B Model Immunization Program developed a special birth notification system at the community level in areas that overlap with CS-P2 project. This system has been upgraded and strengthened in CS-P2 program areas. The system is initiated at the hamlet level by village volunteers, who are members of the Family Welfare Movement (PKK). In Indonesia the PKK is playing a key role in social mobilization for outreach clinic activities, including the delivery of EPI vaccines as well as for other community/hamlet level activities. In the CS-P2 program areas the PKK and TBAs provide oral notification of pregnancies, births, and deaths to the hamlet chief, who in turn will record the vital events and report to the village leader. Births are required to be reported to the village leader within 48 hours, while deaths and pregnancies are reported on a weekly basis. The village nurses/midwives (health sub-center staff) collect this information from the village chief every week. TBAs, village volunteers, hamlet chiefs and families are also encouraged to report births directly to the health sub-center staff.

Data from each newborn, post-partum woman (if not yet recorded during pregnancy), and pregnant woman is recorded in the hamlet record book (buku dusun) which is kept in the health center or health sub-center. Service provided are recorded on the child's and maternal Road to Health (KMS) card and on the daily records (form B4.1 and B4.2) and later copied into the hamlet record book. These routine records were slightly changed in the CS-P2 project areas in order to be able to record all services delivered to the target population. The new reporting/recording system ensure the pregnant women can be identified and motivated to attend ANC services at the health sub-center and/or outreach clinics. This system also identifies defaulters for vaccinations and allows village volunteers and hamlet chiefs to motivate mothers/families to bring their children to the integrated village health post (posyandu) for vaccination and other health services. Low birth weight (LBW) infants will also be identified for referral and follow-up services.

Schedule 2 DJARRHEAL DISEASE CONTROL

(Continued)

STRATEGIES

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
2 - 9 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities designed to prevent or treat diarrheal diseases or dehydration? (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW.)				
a. Free distribution of ORS packets through the public sector.....▶	1	2	3	9
b. The selling of ORS packets through the public sector.....▶	1	2	3	9
c. Marketing of ORS packets through commercial outlets or private health care providers.....▶	1	2	3	9
d. Promotion of sugar/salt solution prepared in the home.....▶	1	2	3	9
e. Promotion of other home-based solutions.....▶	1	2	3	9
f. Promotion of continued breastfeeding during diarrhea.....▶	1	②	3	9
g. Promotion of other appropriate feeding during and after diarrhea.....▶	1	2	3	9
h. Hygiene education.....▶	1	②	3	9
i. Improved water or sanitation.....▶	1	2	3	9
j. Modification of curriculum in medical or nursing schools.....▶	1	2	3	9

TECHNICAL ASSISTANCE

2 - 10 During FY 91, did the project provide technical assistance for improving diarrheal disease control programs? (CIRCLE ONE)	1 - Yes, Substantial Activity	3 - No
	2 - Yes, Minor Activity	9 - Don't Know

CHILD SURVIVAL INDICATORS

2 - 11 What is the ORT Use Rate (see the Instructions for Information on definitions) in the project area?	
a. ORT Use Rate.....▶	<input type="text"/>
b. Date (mo/yr) data was collected.....▶	<input type="text"/>
c. Source of the data used to make the estimate.....▶	<input type="text"/> *DC BG DK
d. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, WHO, UNICEF), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of collection (sample survey, clinic-based statistics, village-based statistics), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.). (Attach additional sheets if necessary.)	

ADDITIONAL BACKGROUND INFORMATION

2 - 12 Please provide any other background information which would enable us to understand better the unique nature of the diarrheal disease control component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary.)

The project mobilized contribution of soap from UNILEVER Company; the soap was distributed to mothers of newborns together with immunization interventions. Mothers were advised to wash their hands after toilet and before breastfeeding their infants and before preparing food for toddlers.

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 3 IMMUNIZATION

Important: Complete this schedule only if this project provides funding or otherwise supports activities in Immunization.

COMMODITIES

3-1 During FY 91, were project funds committed for the purchase of vaccines? (CIRCLE ONE ANSWER)

1 - Yes → COMPLETE ITEM 3-2
 ② - No } SKIP NOW TO ITEM 3-3
 9 - Don't Know

3-2 How many doses of each vaccine were purchased with USAID funds?

	BCG	DPT	Polio	Measles	Tetanus
Source of information (CIRCLE ONE)	*DC BG DK				

3-3 Did the project support or promote the distribution of vaccines (USAID, gov't or other donor purchased) through the national EPI program or some other vaccine distribution program or project? (CIRCLE ONE)

① - Yes, the national EPI } COMPLETE ITEMS 3-4 THROUGH 3-6
 2 - Yes, another program or project }
 3 - No } SKIP NOW TO ITEM 3-7
 9 - Don't Know

3-4 During FY 91, how many children were vaccinated as part of that program?

	BCG	DPT1	DPT3	Polio1	Polio3	Measles
a. Children of all ages.....▶						
b. Infants under one year.....▶						
c. Source of information.....▶	*DC BG DK	*DC BG D'				

3-5 During FY 91, how many women were vaccinated with tetanus toxoid as part of that program?

53%

Source of information (CIRCLE ONE) ① DC BG DK

3-6 At any time during FY 91, were fees charged for vaccinations during that program?

1 - Yes → PLEASE DESCRIBE IN ITEM 3-12
 ② - No
 9 - Don't Know

TRAINING

3-7 During FY 91, were project funds committed to support training in immunization? (CIRCLE ONE)

① - Yes → COMPLETE ITEM 3-8
 2 - No } SKIP NOW TO ITEM 3-9
 9 - Don't Know

3-8 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians.....▶	1	2	③	9
b. Nurses.....▶	①	2	3	9
c. Community Health Workers.....▶	①	2	3	9
d. Traditional Healers.....▶	1	2	③	9
e. Community Leaders and Family Members.....▶	①	2	3	9
f. Others <u>Vaccinators</u>▶	①	2	3	9

(Please Specify)

***Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know**

Schedule 3 IMMUNIZATION

(Continued)

STRATEGIES

3 - 9 During FY 91, did the project sponsor, promote or participate in any of the following vaccination strategies or activities?

(CIRCLE THE CHOICE THAT MOST NEARLY APPLIES FOR EACH STRATEGY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Mass Immunization Campaigns.....	1	②	3	9
b. Fixed Immunization Center(s).....	①	2	3	9
c. Mobile Vaccination Team(s).....	①	2	3	9
d. Social Marketing to Stimulate Demand.....	1	②	3	9
e. Local Production of Vaccines.....	1	2	③	9

TECHNICAL ASSISTANCE

3 - 10 During FY 91, did the project provide technical assistance for improving immunization programs? (CIRCLE ONE)

- ① - Yes, Substantial Activity
- 2 - Yes, Minor Activity
- 3 - No
- 4 - Don't Know

CHILD SURVIVAL INDICATORS

3 - 11 a. What is the vaccination coverage rate (see instruction guide for information on definitions) in the project area?

	BCG	DPT3	Polio3	Measles	Tetanus
Percent of fully vaccinated children, 12 - 23 mos. of age...	84%	82%	82%	81%	24%
Date (mo/yr) data was collected.....	3/91	3/91	3/91	3/91	3/91
Source of information (CIRCLE ONE).....	① DC BG DK				

b. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, WHO, UNICEF), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of collection (sample survey, clinic-based statistics, village-based statistics), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc). (Attach additional sheets if necessary.)

Please Attachment 7b.Q1-7.

ADDITIONAL BACKGROUND INFORMATION

3 - 12 Please provide any other background information which would enable us to understand better the unique nature of the immunization component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. Due to the newly announced measles initiative, we are particularly interested to hear about any measles activity undertaken through this project. (Attach additional sheets if necessary.)

Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 4 NUTRITION

Important: Complete this schedule only if this project provides funding or otherwise supports activities in Nutrition.

COMMODITIES

4 - 1 During FY 91, were project funds committed for the purchase of any of the following:

(CIRCLE THE CHOICE THAT MOST NEARLY APPLIES)

	YES	NO	DONT KNOW
a. Food.....	1	2	9
b. Vitamin A.....	1	2	9
c. Iron.....	1	2	9
d. Weighing Scales.....	①	2	9
e. Growth Monitoring Charts.....	①	2	9
f. Other (specify) <u>PATHstrips</u>	①	2	9

STRATEGIES for Proteinuria detection

4 - 2 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities designed to improve nutrition?

(PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Infant and Child Feeding Practices				
1. Increased duration of breastfeeding.....	①	2	3	9
2. Exclusive breastfeeding.....	①	2	3	9
3. Proper weaning and child feeding.....	1	②	3	9
4. Hospital practices supporting breastfeeding.....	1	2	③	9
5. Other approaches promoting initiation of breastfeeding.....	1	2	③	9
6. Modification of curriculum in Medical or Nursing Schools.....	1	2	③	9
b. Breastfeeding in the context of other interventions				
1. Breastfeeding during diarrhea.....	1	②	3	9
2. Contraceptive practices that preserve breastfeeding.....	1	2	③	9
c. Growth Monitoring				
1. Community-based.....	1	②	3	9
2. Clinic-based.....	1	2	3	9
3. Promoting the concept.....	1	2	3	9
d. Nutrition Surveillance				
1. Identification of nutrition problems.....	1	2	③	9
2. Monitoring the impact of economic policy.....	1	2	③	9
e. Vitamin A				
1. Assessment of levels of deficiency.....	1	2	③	9
2. Supplementation (capsules or liquid).....	1	②	3	9
3. Food fortification.....	1	2	③	9
4. Home and community gardens.....	1	2	③	9
f. Private Sector				
1. Commercial production/marketing of weaning foods.....	1	2	③	9
2. Commercial production/marketing of Vitamin A.....	1	2	③	9
3. Other (specify).....	1	2		
g. Supplementary Feeding Programs				
1. Food for work.....	1	2	③	9
2. Food in support of Maternal Child Health Programs.....	1	2	③	9
3. Emergency Food Relief.....	1	2	③	9
4. Other (specify).....	1	2		

4 - 3 If the project sponsored supplemental feeding during FY 91, which groups were targeted? (CIRCLE ALL THAT APPLY)

N/A

- | | |
|-------------------|---------------------|
| Children: | 5 - Lactating women |
| 1 - Under 12 mos. | 6 - Pregnant women |
| 2 - 12 - 23 mos. | 7 - Other _____ |
| 3 - 24 - 35 mos. | 8 - None |
| 4 - 36 - 60 mos. | 9 - Don't know |

Schedule 4 NUTRITION (Continued)

TRAINING

- 4-4 During FY 91, were project funds committed to support training in infant and child feeding practices and/or growth monitoring? (CIRCLE ONE)
- ① - Yes → } COMPLETE ITEM 4 - 5
 2 - No } SKIP NOW TO ITEM 4 - 6
 9 - Don't Know

4-5 Which of the following types of people received training as a consequence of project support? (CIRCLE ALL THAT APPLY)	Infant and Child Feeding Practices				Growth Monitoring			
	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians	1	2	③	9	1	2	③	9
b. Nurses	①	2	3	9	1	2	③	9
c. Community Health Workers.....	①	2	3	9	1	2	③	9
d. Traditional Healers.....	1	2	3	9	1	2	③	9
e. Community Leaders and Family Members.....	1	②	3	9	1	2	③	9
f. Other	1	2	3	9	1	2	③	9

TECHNICAL ASSISTANCE

- 4-6 During FY 91, were project funds committed to the provision of technical assistance in support of nutrition activities? (CIRCLE ONE ANSWER)
- 1 - Yes, Substantial Activity 3 - No
 ② - Yes, Minor Activity 9 - Don't Know

CHILD SURVIVAL INDICATORS

- 4-7 a. What is the rate of malnutrition (see instruction guide for clarification of definitions) in the target group served by the project?

N/A

	Group 1	Group 2	Group 3	Group 4
Target Group.....	Children 0-11 mos.	Children 12-23 mos.	Other Preg. Women (Specify)	Other Iodine Defic. (Specify)
Estimated Rate of Malnutrition..1st..&..2nd..Degree		20%	70% Anemic	30% of Pop. have visible Goitre
Date (mo/yr) of estimate.....				
Source of Information (CIRCLE ONE)	*DC BG DK	*DC ② DK	*DC ② DK	*DC ② DK

- b. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, UNICEF, WHO), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of the collection (sample survey, clinic-based statistics or village-based statistics) and the computation procedures (weighting in a sample, weighting of data from clinics or villages, etc.) (Attach additional sheets if necessary)

ADDITIONAL BACKGROUND INFORMATION

- 4-8 Please describe any other background information which would enable us to understand better the unique nature of the nutrition component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary.)

Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 5 HIGH RISK BIRTHS

Important: Complete this schedule only if this project provides funding or otherwise supports activities to prevent High Risk Births.

COMMODITIES

- 5 - 1 During FY 91, were project funds committed for the purchase of contraceptives with the specific intention of distributing them to prevent high risk births? Please refer to page 3 of the instruction guide for the definition of high risk births. (CIRCLE ONE)
- 1 - Yes
② - No
9 - Don't Know
-
- 5 - 2 Did the project support or promote the distribution of contraceptives to prevent High Risk Births (USAID, Government or other donor purchased) through a national program or some other program or project? (CIRCLE ONE)
- 1 - Yes, a national program
2 - Yes, another program or project
③ - No
9 - Don't Know
- } COMPLETE ITEM 5 - 3
} SKIP NOW TO ITEM 5 - 4
-
- 5 - 3 At any time during FY 91, were fees charged for contraceptives during that program? (CIRCLE ONE ANSWER)
- 1 - Yes → PLEASE DESCRIBE IN ITEM 5 - 11
2 - No
9 - Don't Know

TRAINING

- 5 - 4 During FY 91, were project funds committed to support training focused on the high risks of closely spaced births, births to very young or old women, or to high parity women in the project area?
- 1 - Yes → COMPLETE ITEM 5 - 5
② - No
9 - Don't Know
- } SKIP NOW TO ITEM 5 - 6
-
- 5 - 5 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)
- | | YES
Substantial
Activity | YES
Minor
Activity | NO | DONT
KNOW |
|----------------------------------------------|--------------------------------|--------------------------|----|--------------|
| a. Physicians..... | 1 | 2 | ③ | 9 |
| b. Nurses..... | 1 | ② | 3 | 9 |
| c. Community Health Workers..... | 1 | 2 | ③ | 9 |
| d. Traditional Healers..... | 1 | 2 | ③ | 9 |
| e. Community Leaders and Family Members..... | 1 | 2 | ③ | 9 |
| f. Others.....
(Please Specify) | 1 | 2 | ③ | 9 |

STRATEGIES

- 5 - 6 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities for the purpose of delaying conception or spacing births? (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW)
- | | YES
Substantial
Activity | YES
Minor
Activity | NO | DONT
KNOW |
|---------------------------------------|--------------------------------|--------------------------|----|--------------|
| a. Breastfeeding..... | 1 | ② | 3 | 9 |
| b. Other Natural Family Planning..... | 1 | 2 | ③ | 9 |
| c. Sterilization..... | 1 | 2 | ③ | 9 |

***Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know**

Schedule 5 HIGH RISK BIRTHS (Continued)

5 - 7 Did the project sponsor or participate in activities to promote child spacing or family planning specifically directed at one or more of the following high risk groups? (CIRCLE A RESPONSE FOR EACH CATEGORY)	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Women under age 18.....	1	2	③	9
b. Women age 35 or older.....	1	2	③	9
c. Women who have given birth within the previous 15 months.....	1	②	3	9
d. Women with 3 or more children.....	1	2	③	9

TECHNICAL ASSISTANCE

5 - 8 During FY 91, did the project provide technical assistance for improving high risk birth programs? (CIRCLE ONE ANSWER)	1 - Yes, Substantial Activity ② - Yes, Minor Activity 3 - No 9 - Don't Know
------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------

CHILD SURVIVAL INDICATORS

5 - 9 What is the Contraceptive Prevalence Rate (see instruction guide for information on definitions) in the project area.	
a. Contraceptive Prevalence Rate in area.....	44%
b. Date (mo/yr) data was collected.....	May-June 1991
c. Source of the data used to make the estimate.....	*DC BG DK
d. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, WHO, UNICEF), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of collection (sample survey, clinic-based statistics, village-based statistics), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc). (Attach additional sheets if necessary.)	
C. Source of the data used to make the estimate: Indonesia Demographic and Health Survey 1991: Preliminary Report, October 1991	

5 - 10 a. Estimate the percentage of total births in your project area during the reporting period that were high risk (see definition on page 3 of instruction guide.)	10 %
b. Please indicate the source of the data. (CIRCLE ONE)	*DC BG DK

Based on pilot LBW screening

ADDITIONAL BACKGROUND INFORMATION

5 - 11 Please provide any other background information which would enable us to understand better the unique nature of the high risk births component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. Please give special attention to activities designed specifically to the identification of candidates for high risk pregnancies and any particular steps taken to avert those pregnancies. (Attach additional sheets if necessary.)

Pilot project to screen for low birth weight infants in West Lombok

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 6 HIV/AIDS ACTIVITIES

Important: Complete this schedule only if this project provides funding or otherwise supports activities in HIV/AIDS prevention.

6 - 1 During FY 91, if the project sponsored, promoted or participated in HIV/AIDS activities, please provided a brief description of the objectives and methodology of those activities. (Attach additional sheets if necessary.)

N/A

6 - 2 Please summarize the lessons learned from the AIDS activities funded under this project. (Attach additional sheets if necessary.)

N/A

6 - 3 From the organizations listed on page 1 of the Main Schedule, please indicate which organizations were involved in HIV/AIDS prevention activities supported under this project, and list a contact person for each. (Note: this information will be used to identify which PVOs and NGOs are involved in USAID HIV/AIDS prevention activities and to compile a listing of US Government-sponsored international AIDS activities which will be disseminated to facilitate inter-agency coordination.)

	ORGANIZATION	CONTACT PERSON
1 -	_____	_____
2 -	_____	_____
3 -	_____	_____
4 -	_____	_____
5 -	_____	_____
6 -	_____	_____
7 -	_____	_____
8 -	_____	_____
9 -	_____	_____

Attachment
Schedule 5
Q.5-11

During the initial postpartum home visit, referral information on birth spacing and family planning will be given to postpartum women. The postpartum woman will be advised to go to the nearest family planning service point. Regular family planning services are provided in the health centers, in some sub-health centers, and during posyandu sessions. In most health centers, all modern birth control methods are available. New service points will be established for ANC services at the sub-health centers in CS-P2 project areas. The same service points can be used for birth spacing.

Schedule 6 HIV/AIDS ACTIVITIES

6 - 4 The table below is to be used to summarize the scope of the HIV/AIDS activities supported under this project.

The following are guidelines to be applied for completing information in the columns in the table starting with Column A.

- Column - A. Use Activity codes listed below to describe the nature of the HIV/AIDS activities.
- Column - B. Show the percent of total AIDS activity, as reported in question 9, of the Main Schedule, attributed to each activity reported in Column A. Column B should add to 100%.
- Column - C. Estimate the percent of resources supporting research for each activity reported in Column A.
- Column - D. List the organization(s) by number from question 6 -3 on page 16 which support each activity listed in Column A.
- Column - E. Cite target population for each activity listed in Column A. Use Population Code(s) listed below as appropriate for each activity.
- Column - F. Indicate by Y or N (Yes or No) whether activities listed in Column A are community-based with target community involvement in the design, implementation, and/or evaluation of the activities.
- Column - G. Please cite the number of individuals reached by prevention efforts in each activity area and indicate in Column H the source of the data by circling one of the the following: DC (Data Collection), BG (Best Guess), or DK (Don't Know).

A Activity	B % of AIDS Attribution	C % Research	D Organizations Supported	E Population Targets	F Comm. Based	G Nos. Reached FY91	H Data Sources
BTS							DC BG DK
CSP							DC BG DK
CPD							DC BG DK
HSV							DC BG DK
PNR							DC BG DK
STD							DC BG DK
PDM							DC BG DK
OAI							DC BG DK
	100%						

ACTIVITY CODES:

Blood Transfusion Screening..... BTS
 Condom Supply..... CSP
 Condom Promotion and Distribution..... CPD
 HIV Surveillance..... HSV
 Partner Number Reduction..... PNR
 STD Diagnosis Treatment Services..... STD
 Policy Dialogue/Modelling..... PDM
 Other..... OAI
 (Please specify)

TARGET POPULATION CODES:

General Public..... GPU
 Children (0-8 years)..... CHI
 Youth (9-14 years)..... YOU
 Female Sex Workers..... FSW
 Male Sex Workers..... MSW
 Other Women at Risk..... OWR
 Other Men at Risk..... OMR
 IV Drug Users..... IDU
 Clinic/Hospital-based
 Health Service Providers..... HSP
 Traditional Healers..... TRH
 Other Service Providers..... OSP
 Community Leaders..... CML
 Other..... OTH
 (Please specify)

5 - 5 What percentage of the condoms being supplied by USAID are used for AIDS prevention (rather than family planning)? _____ %

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Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

This schedule is designed to record information about health and child survival interventions other than those identified in schedules 2 through 6.

IDENTIFICATION OF OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

7-1 What type(s) of "other" health and child survival interventions received funding or other support through this project? (CIRCLE ALL THAT APPLY)

1 - Acute Respiratory Infections
 2 - Health Care Financing (answer 7-6)
 3 - Water and Sanitation
 4 - Malaria (answer 7-7)

5 - Maternal Health
 6 - Elderly/Adult Health
 7 - Other _____ (Please Specify)

7-2 Please describe each of these "other" health and child survival interventions; for example, "The malaria program is supporting the development of surveillance based on passive case detection in health clinics and using data from the surveillance to target spraying in areas of high endemicity." (Attach additional sheets of necessary.)

The ARI component is supporting early case detection and proper treatment of infants with ARI. The maternal health component is supporting detection and referral of pregnant women with urinary track infections and preeclampsia and distribution of TT vaccine and iron supplements to pregnant women.

COMMODITIES

7-3 During FY 91, were project funds for any of the interventions circled in item 7-1 above committed to the purchase of any of the following? (PLEASE CIRCLE THE LETTER PRECEDING EACH TYPE OF COMMODITY FOR WHICH FUNDS WERE COMMITTED.)

a. Essential drugs
 b. Laboratory equipment
 c. Medical equipment
 d. Clinic/office furnishings
 e. Construction materials for water/sanitation and other activities.
 f. Vehicles or other transport equipment
 g. Educational materials

h. Audio-visual equipment
 i. Computers—hardware or software
 j. Prosthetics
 l. Other _____ (Please Specify)
 m. Other _____ (Please Specify)

TRAINING

7-4 During FY 91, were project funds committed to support training in any of the types of interventions circled in item 7-1?

1 - Yes → COMPLETE ITEM 7-5
 2 - No
 9 - Don't Know

} SKIP NOW TO ITEM 7-6

7-5 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)

	YES Substantial Activity	YES Minor Activity	NO	DON'T KNOW
a. Physicians.....	1	2	<input checked="" type="radio"/> 3	9
b. Nurses.....	1	2	<input checked="" type="radio"/> 3	9
c. Community Health Workers.....	1	2	<input checked="" type="radio"/> 3	9
d. Traditional Healer.....	1	2	<input checked="" type="radio"/> 3	9
e. Community Leaders and Family Members.....	1	2	<input checked="" type="radio"/> 3	9
f. Others (specify).....	1	2	<input checked="" type="radio"/> 3	9

STRATEGIES

PLEASE ANSWER 7-6 ONLY IF YOU CIRCLED "2 - Health Care Financing" IN RESPONSE TO ITEM 7-1.

7-6 Health Care Financing Strategies N/A

During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities in the area of Health Care Financing? (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW)

	YES Substantial Activity	YES Minor Activity	NO	DON'T KNOW
a. Cost containment.....	1	2	3	9
b. Public sector cost-recovery or cost-sharing.....	1	2	3	9
c. Demand analysis for health activities.....	1	2	3	9
d. Private insurance companies or other pre-paid health providers (e.g. HMOs).....	1	2	3	9
e. Social insurance funds provided through the public sector or parastatal organizations.....	1	2	3	9
f. Other _____ (Please Specify)	1	2	3	9

Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

(Continued)

PLEASE ANSWER 7-7 ONLY IF YOU CIRCLED "4 - Malaria" IN RESPONSE TO ITEM 7-1.

7-7 Malaria Strategies.

During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities for the purpose of malaria control?

(PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW.)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Malaria surveillance and/or treatment.....	1	2	3	9
b. Surveys for chloroquine sensitivity/resistance.....	1	2	3	9
c. Mosquito control:				
1. Against adult mosquitos.....	1	2	3	9
2. Against larvae.....	1	2	3	9
3. Environmental modification..... (including source reductions)	1	2	3	9
d. Public education to promote:				
1. Anti-malarial treatment.....	1	2	3	9
2. Anti-mosquito measures.....	1	2	3	9
3. Impregnated bednets.....	1	2	3	9
4. Other _____..... (Please Specify)	1	2	3	9

TECHNICAL ASSISTANCE

7-8 During FY 91, did the project provide technical assistance in any of the types of interventions circled in item 7-1?

①- Yes → COMPLETE ITEM 7-9
 2- No
 9- Don't Know } SKIP NOW TO ITEM 7-10

7-9 For each type of intervention circled in item 7-1 above, indicate the level of technical assistance provided. (CIRCLE ONE RESPONSE FOR EACH INTERVENTION)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Acute Respiratory Infection.....	1	②	3	9
b. Health Care Financing.....	1	2	3	9
c. Water and Sanitation.....	1	2	3	9
d. Malaria.....	1	2	3	9
e. Maternal Health.....	1	②	3	9
f. Elderly/Adult Health.....	1	2	3	9
g. Other _____..... e.g. orphans, etc. (Please Specify)	1	2	3	9

ADDITIONAL BACKGROUND INFORMATION

7-10 Please provide any other background information which would enable us to understand better the unique nature of any or all of the other health and child survival components of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary.)

The project is helping the MOH Indonesia to establish standardized guidelines for referral and management of infants with ARI at rural health sub-centers and sub-district health centers.

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Attachment
Schedule 7
Q.7-10

ARI is a major cause of childhood morbidity and mortality. Inadequate health services and inadequate KAP of mothers contribute to this high morbidity and mortality in Indonesia. Studies in Kediri, Lombok (1986), revealed that more than 40 percent of deaths of children under the age of five years were related to ARI, and the main source of treatment prior to their death was traditional healers (76 percent). Similarly, verbal autopsy data collected by the Hepatitis B Model Program (1988), showed that 47 percent of infant deaths in the program area were related to ARI. Often infants and children die without being treated at all prior to their death (Operational trial on ARI, Kediri, West Lombok, 1989).

In the CS-P2 program areas, at least 60 percent of the mothers of newborns will receive information on signs of mild, moderate, and severe ARI, and the need for early treatment and home care. The focus will be on adequate home care for the mild ARI cases and on-time referral to the sub-health center for the moderate to severe ARI patients. Moreover, timely immunization with measles vaccine and a full series of DPT will be promoted.

Village nurses/midwives and posyandu/PKK Cadre will be trained in early case detection and case management. Additional training will also be given to health center doctors. They will be responsible for supervising other personnel involved in CS-P2 ARI intervention activities. Table 7 shows the approximate number of participants who will receive training in ARI case management. ARI intervention activities will be integrated into the ongoing home visits and the existing MOH service delivery system in CS-P2 project areas.

Within the CS-P2 project, TBAs and village nurses/midwives will be trained in early identification of high risk pregnancies. The village midwives and midwives in the health centers will be responsible for the supervision of the TBAs and will, themselves, be supervised by health center doctors. Midwives and/or female nurses will provide MOH standard ANC services in the sub-health centers in CS-P2 project areas. All sub-health centers and health centers in the CS-P2 program areas will be provided with PATHstrips and extra reusable specimen containers. Midwives, village nurses, and doctors will be trained in the use of PATHstrips. Table 6 shows the approximate number of participants who will receive training in interventions concerning management of high-risk pregnancies and births.

During antenatal visits, the MOH standardized ANC services will be provided to the pregnant women including: (1) monitoring pregnant weight gain; (2) measuring height of the pregnant women; (3) measuring fundal height; (4) monitoring blood pressure; (5) distributing iron/folic acid; and (6) health education on family planning, breastfeeding, and cord care. Simple, low-cost test strips (PATHstrips) will be introduced in CS-P2 areas to assist in screening for pre-eclampsia. Eclampsia is the third most common cause of maternal death in Indonesia after infections and hemorrhage. Pregnant women will receive health education concerning lactation management, cord care, and high risk pregnancy, i.e., bleeding, severe anemia, fever, swelling, and excessive vomiting. High risk pregnancies will be monitored and appropriate advice and treatment will be given. Pregnant women will be referred to health centers or hospital when necessary.

Appendix 1

QUESTIONNAIRE ON MOTHER & CHILD HEALTH (CS-P2) - LOMBOK

INTRODUCTION: Good morning/afternoon. My name is _____. I am from the Program for Appropriate Technology in Health (PATH), an organization who promotes community health. I would like to meet with housewives. INTRODUCTION TO HOUSEWIFE: I am collecting information about the health of mothers and children. This will take about 15 minutes. Please do not feel insulted if I am asking personal matters.

FAMILY NAME: _____

RESPONDENT'S NAME: _____

INTV'S NAME: _____

SUB-VILLAGE: _____ VILLAGE: _____

DATE: _____

KECAMATAN: _____ CLUSTER #: _____ LOCATION: _____

SCREENING

S1. First, I would like to know if you ...

- have children between 12-23 months living with you?
- have children under 12 months living with you?
- have no child and is expecting the first one?
- have ever had children and is now pregnant?

 HAVE CHILDREN 0-23 MONTHS --> CONTINUE, CHOOSE QUOTA
 FIRST PREGNANCY --> GO TO FIRST PREGNANCY QUESTIONNAIRE
 MORE THAN ONE CHILD UNDER 23 MONTHS, CHOOSE THE YOUNGEST

S2. How old are you?
 How old were you when you got married?

A. PREGNANCY/BIRTH HISTORY:

A1. How many children do you have including those who have died? (S) 1 2 3 4 5 6 7 8 9 10
 (CIRCLE NUMBERS)

A2. Who are still alive? (M) 1 2 3 4 5 6 7 8 9 10
 (CIRCLE NUMBERS) No one died 99

A3a. How old are those alive? From the oldest.
 (under 24 months note birth date)

A3b. Boy or girl?

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	YEAR	MONTH	DAY	MALE	FEMALE
1	___	___	___	1	2
2	___	___	___	1	2
3	___	___	___	1	2

4	___	___	___	1	2
5	___	___	___	1	2
6	___	___	___	1	2

7	___	___	___	1	2
8	___	___	___	1	2
9	___	___	___	1	2

10	___	___	___	1	2

A4a. Have you ever experienced miscarriage? Never 99
 How many times? Yes 1 2 3 4 5 (S)

A4b. How old are you when your child number ... died? number ...?

A4c. Boy or girl?

NUMBER	YEAR	MONTH	DAY	STILL BORN	MALE	FEMALE
___	___	___	___	1	1	2
___	___	___	___	1	1	2
___	___	___	___	1	1	2
___	___	___	___	1	1	2

IF NO ONE DIED → A6a.

A5. What caused his death, and what were the symptoms before he died?

CAUSE OF DEATH	
Diarrhea	(1)
Unable to suck	(2)
Breathing difficulties	(3)
Measles	(4)
Fever	(5)
Accident	(6)
Born prematurely	(7)
Sunken eyes	(8)
Hollow abdomen	(9)
Stiff neck	(10)
Malaria	(11)
Spasmodic	(12)
Still birth	(13)
Small-pox	(14)
Others: NOTE ----->	
Don't know	

DEATH CHILD:			
1 (M)	1 (M)	1 (M)	1 (M)
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9
10	10	10	10
11	11	11	11
12	12	12	12
13	13	13	13
14	14	14	14
99	99	99	99

A6a. Now I'd like to know about your youngest child. What's his name? Name: _____

5

- A6b. How old is he? Age _____ day/mo./yr.
 Birth date?
 Day Mo. Yr.
- A6c. Male or female? Male 1
 Female 2
- A6d. Do you have KMS card/other? Yes 1 --> WRITE BIRTH DATE
 No 2 --> PART B.

BIRTH DATE ON KMS CARD/OTHER

Day Mo. Yr.

Have card, but no record
 of birth date

99

B. MATERNITY CARE

Now I'd like to know about your pregnancy with _____ (YOUNGEST CHILD).

- B1. During your pregnancy with _____ (YOUNGEST CHILD) have you ever check your pregnancy with health staff/doctor/midwife/TBA? Yes 1 --> B2
 Never 2 --> B4a
- B2. Do you remember how many times you check your pregnancy with _____ (YOUNGEST CHILD)? once 1 (S)
 twice 2
 three times 3
- B3. Where did you check your pregnancy TBAs 1 (M)
 Posyandu 2
 Pustu 3

 Puskesmas 4
 Hospital 5
 Private midwife 6 --> B4b

 Private doctor 7
 Others: _____ 88
 Dont' remember 99
- B4a. Why don't you ever check your pregnancy?
 Not necessary if I'm healthy 1 (M)
 It's far from my house 2
 No money for transportation 3
 Busy with households 4
 Work/farmer 5
 Nobody takes care of the children 6
 Don't want injection 7
 Others: _____ 88

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B4b.	Do you think it is necessary for women to check their pregnancies?	Yes	1 (S)			
		Only if unhealthy	2			
		No	3			
		Don't know	99			
B5a.	Have you received Tetanus or other injection at <u>top arm</u> (tetanus injection) during your pregnancy with _____ (YOUNGEST CHILD)?	Yes	1			
		No	2 -> 88			
B5b.	Where did you get tetanus injection?	Home	1 (M)			
		Posyandu/Puskesmas	2			
		Hospital	3			
		Private practice	4			
B6.	How many times did you receive TT injection during your pregnancy with _____ (YOUNGEST CHILD)?	once	1 (S)			
		twice	2			
		three times	3			
		four times	4			
		five/more	5			
		don't know	99			
B7a.	Could you show me your checking card or injection record?	No card/book	1			
		The record is not at home	2			
		KMS for pregnant women	3			
		TT injection card	4			
		Puskesmas card	5			
		Other record: _____	88			
		KMS/record missing	99			
B7b.	When did you receive TT?		Day	Mo.	Yr.	No record
		I injection	____	____	____	99
		II	____	____	____	99
		III	____	____	____	99
		IV	____	____	____	99
		V	____	____	____	99
B8.	Did you receive Tetanus or other injection at your <u>top arm</u> (tetanus injection) before your pregnancy with _____ (YOUNGEST CHILD)?	Yes	1			
		No	2			
		Don't know	99			
B9.	Do you receive any drug/vitamin/iron tablet to add blood pressure during your pregnancy with _____ (YOUNGEST CHILD)?	Yes	1 -> B10a			
		No	2]			
		Don't know	99] -> PART C.			
B10a.	How often do you drink that drug/vitamin?	more than once/day	1 (S)			
		once every day	2			
		almost every day	3			
		once a week	4			
		others: _____	88			
		don't know	99			

M
5

B10b. How long do you drink that drug?	less than one week	1 (S)
	1 - 2 weeks	2
	3 - 4 weeks	3
	1 - 2 months	4
	3 months/more	6
	don't know	99

GO TO C. BIRTH, CORD AND BIRTH WEIGHT

C. BIRTH, CORD AND BIRTH WEIGHT

Now I'd like to ask you about _____ birth (YOUNGEST CHILD).

C1a. Where did you give birth to _____ (YOUNGEST CHILD)?	Home	1
	House of TBA	2
	House of Midwife	3
	Puskesmas	4
	Hospital	5

C1b. Who helped you giving birth to _____ (YOUNGEST CHILD)? (COULD BE MORE THAN 1 ANSWER)	TBA	1 (M)
	Health worker	2
	Nurse	3

	Midwife	4
	Doctor	5
	Relative	6

	Alone/nobody's assistance	7
	Others: _____	88

C2. What was used to cut the baby's cord?	bamboo	1	
	knife	2	} --> C3
	scissors	3	
	cutter	4	
	others:	88	
	record: _____		
	don't know	99	--> C4

C3. Was it (CUTTING) previously cooked or cleaned using alcohol?	wet w/ boiling water	1
	cooked	2
	use alcohol	3
	baked	4
	not cleaned	5
	don't know	99

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C4. How do you treat the baby's cord until it fell off?

- Do nothing 1 (M)
- Cleaned up using alcohol 2
- Cleaned up using medicine from ... 3
-
- Rubbed with traditional medicine (jamu) 4
- Rubbed with curcuma 5
- No water contact 6
-
- Regular bathing 7
- Bandaged 8
- Use warm rice, salt and wrapped by cotton 9
- Other: _____ 88
- Do not know 99

C5. Was he _____ (YOUNGEST CHILD) weighed at birth or one day after birth?

- yes 1 --> C6
- no 2 --> PART D
- don't know 99 --> PART D

C6. How much was _____ (YOUNGEST CHILD) birth weight?

- _____ grams
- don't know 99

INTERVIEWER:

- have KMS card 1
- mother's memory/no KMS card 2
- others: _____ 88

D. FAMILY PLANNING

Now about Family Planning.

D1a. Do you or your husband join family planning now? Do you use any contraceptive method?

- yes 1 --> D1b
- no 2 --> D2a

D1b. Do you have KB1 (red) card?

- Yes 1 |
- No 2 | --> D3

D2a. Are you or your husband planning to join family planning in the near future (next two months)?

- yes 1 --> D3
- no 2 --> D2b

D2b. Why don't you or your husband join FP? Why not planning it for the near future?

- Just giving birth/not 40 days yet 1 (M)
- Hoping to have more children 2
- Disagree with any contraceptive 3
-
- Know nothing about FP 4
- Breastfeeding, impossible to get pregnant 5
- Husband doesn't agree 6
-
- Forbidden by religion 7
- Pregnant 8
- Ashame/Afraid to ask about FP 9
- Afraid to use FP 10
- Not getting menstruation yet 11
- Widow 12
- Others: _____ 88
- Don't know/no specific reason 99 --> E

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- D3. (IF USING FP): What contraceptive do pills (will) you or your husband use?
- | | |
|---------------------|----|
| FP injection | 1 |
| spiral/IUD | 2 |
| implant | 3 |
| condom | 4 |
| breastfeeding | 5 |
| abstinence | 6 |
| sterilized (female) | 7 |
| sterilized (male) | 8 |
| others: _____ | 9 |
| don't know yet | 88 |
| | 99 |

E. BREASTFEEDING AND INFANT FOOD

Do you breastfeed your baby and what food do you give your youngest child?

- E1. Are you/have you ever breastfeeding?
- | | |
|-----------------------------------|---------|
| ever, not anymore | 1 (S) |
| breastfeeding now | 2 |
| never breastfeeding | 3-> E5a |
| not starting yet, <u>but will</u> | 4 |

 BREASTFEEDING --> E2
 NEVER BREASTFEEDING --> E5a FIRST FOOD/DRINK

- E2. When did you start breastfeeding your youngest child?
- | | | | | | | | |
|-------------------|---|---|---|---|---|---|----|
| 1 (birth day) | 2 | 3 | 4 | 5 | 6 | 7 | >7 |
| Don't know/forget | | | | | | | 99 |

- E3. Did you give your first breast milk (colostrum) to your youngest child?
- | | |
|------------|------------|
| Yes | 1 --> E5a |
| No | 2 --> E4 |
| Don't know | 99 --> E5a |

- E4. Why didn't you give colostrum to your youngest child?

- | | |
|---------------------------------------------------------|-------|
| No breast milk yet | 1 (M) |
| Not good for the baby/don't know why not | 2 |
| Midwife suggested not to give first breastmilk | 3 |
| ----- | |
| TBA suggested not to give first breastmilk | 4 |
| Qur'an suggested not to give first breastmilk | 5 |
| I thought it was not real milk | 6 |
| ----- | |
| I thought it was not good that it should be thrown away | 7 |
| Baby cannot suck | 8 |
| Elders suggested to throw it away | 9 |
| ----- | |
| Others: _____ | 88 |
| Don't know/no specific reason | 99 |

- E5a. Beside breastmilk, what food/drink do you give _____ (YOUNGEST CHILD) before he reaches 12 months? What else? CAN BE MORE THAN ONE ANSWER.

- E5b. At what age did you start giving these food/drinks? (ASK FOR EACH FOOD/DRINK)

- E5c. What food/drink are you giving your youngest child now?

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E5a. FOOD/DRINKS GIVEN TO CHILDREN BEFORE 12 MONTHS	E5b. STARTING AGE		E5c. NOW
	MONTH	DAY	
honey	1		1
bottled milk	2		2
coconut water	3		3
banana	4		4
fruits other than banana	5		5
poridge	6		6
cassava	7		7
vegetables	8		8
chewed rice	9		9
same as adult food	10		10
flour poridge	11		11
Others: NOTE	88		88

exclusive breast milk	99		99

 EVER/BREASTFEEDING --> E6
 NEVER BREASTFEEDING --> PART F. IMMUNIZATION

E6. When you breastfeed _____ (YOUNGEST CHILD), do you give it from both sides of breasts?

- | | | |
|--------------------------------------------|----|-------------------------------------------------------------|
| Always changing sides | 1 |] --> PART
F. IMMUNIZATION |
| Almost always changing sides | 2 | |
| Sometimes changing | 3 | |
| ----- | | |
| Hardly changing | 4 |] IF ONLY
SOMETIMES/
HARDLY/NOT
CHANGING --> E7, 8 |
| Previously changing sides, but not anymore | 5 | |
| Once from left side, then from right side | 6 | |
| Usually from one side only | 7 | |
| Don't remember | 99 | |

E7. Which side do you prefer to breastfeed your baby?

left	1
right	2
the same	3
don't know	99

E8. Why do you sometimes/hardly/not changing sides when breastfeeding? Why do you prefer left/right side?

- | | |
|-----------------------------------------------|----|
| lazy to change | 1 |
| while working: right (left) hand is free | 2 |
| baby likes left side/baby likes heart beat | 3 |
| I lay down on left/right side | 4 |
| ----- | |
| left (right) nipple is hurt | 5 |
| baby likes left (right), cry if it is changed | 6 |
| no reason | 7 |
| others: _____ | 88 |
| don't remember | 99 |

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F. **IMMUNIZATION** IF UNDER 12 MONTHS --> PART G.

I'd like to know about immunization of _____ (CHILD UNDER 12-23 MONTHS). I'd like to copy immunization record of _____.

CODER:	SEX:	Male	0	Birth date: <input type="text"/> <input type="text"/> <input type="text"/>	Day	Mo.	Yr.
		Female	1				
KMS:		No	0				
		Yes	1				

INTERVIEWER: COPY IMMUNIZATION RECORD FROM KMS/BUKU DUSUN.

FROM KMS/BUKU DUSUN		
VACCINATION	VACC. DATE	PLACE
HB 1		1 2 3 4
HB 2		1 2 3 4
HB 3		1 2 3 4
DPT 1		1 2 3 4
DPT 2		1 2 3 4
DPT 3		1 2 3 4
BCG		1 2 3 4
Polio 1		1 2 3 4
Polio 2		1 2 3 4
Polio 3		1 2 3 4
Measles		1 2 3 4

Place of vaccination:
 1 - Baby's house
 2 - Posyandu/Puskesmas
 3 - Hospital
 4 - Private Practice

SCAR: 0	1
No	= 0
Yes	= 1

CODER: MOVE TT VACCINATION DATE FROM LAST PREGNANCY: (B7b.)

FROM KMS/BUKU DUSUN		
VACCINATION	VACC. DATE	PLACE
TT 1		1 2 3 4
TT 2		1 2 3 4

Filled in by interviewer No. issue:	Filled in by coder No. Q'naire:
Youngest child -----> 12-23 months	Complete Questionnaire 1
Children 12-23 months -----> not the youngest	Immunization page only 2

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G. HEALTH STATUS OF THE YOUNGEST CHILD

Now about the health of _____ (YOUNGEST CHILD).

G1. Have _____ (YOUNGEST CHILD) ever been ill/showed the symptoms below in the last 2 weeks?

	YES	NO	DON'T KNOW
Cold	1	2	99
Coughing	1	2	99
Difficult breathing	1	2	99
Fast breathing	1	2	99
Snored breathing	1	2	99

IF "YES" FOR ANY SYMPTOM --> G2-3
 IF "NO", OR DON'T KNOW FOR ALL --> G4

G2. Where did you go for help to overcome those symptoms? (COULD BE MORE THAN 1 ANSWER)

- Nowhere/home treatment 1 (M) --> G3
- To relative: brother/sister/mother 2
- Traditional doctor 3

- TBA 4
- Posyandu/Dasa Wisma cadre 5
- Puskesmas pembantu 6

- Puskesmas 7
- Hospital 8
- Private midwife 9

- Private doctor 10
- Others: _____ 88
- Don't know/don't remember 99

G3. What medicine did you give at home?

- honey 1 (M)
- orange/citroen 2
- traditional herbs 3
- drug from Puskesmas
- medicine from last illness 4
- traditional medicine 5
- analgesic/general drugs 6
- others: _____ 88
- nothing 99

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G4. In case _____ (YOUNGEST CHILD) has difficulties/fast breathing, what would you do?

Nowhere/home treatment	1
To relative: brother/sister/mother	2
Traditional doctor	3

TBA	4
Posyandu/Dasa Wisma cadre	5
Puskesmas pembantu	6

Puskesmas	7
Hospital	8
Private midwife	9

Private doctor	10
Nothing	11
Others: _____	88

G5. Have _____ (YOUNGEST CHILD) ever had diarrhea (fluid stool more than 3 times a day) in the last 2 weeks?

Yes	1 --> G6
No	2 }
Don't know	99 } --> G1

G6. How long did he suffer?

1 day	1
2 - 3 days	2
4 - 5 days	3
6 - 7 days	4
more than 1 week	5
don't know	99

G7. What drink/food did you give _____ (YOUNGEST CHILD) during diarrhea?

Breastfeeding	1 (M)
Cease breastfeeding	2
Honey	3

Baby formula milk	4
Fruit juice	5
Oralit	6

Home made sugar-salt solution	7
Traditional herbs	8
Cintioen/orange juice	9

Tea	10
Plain water	11
Others: _____	88
Fasting/no drink/food	99

--> PART H. DEMOGRAPHY

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IF G5 "NO"/"DON'T KNOW"/"FORGET":

G8. What do you usually do when your child suffer from diarrhea?

Breastfeeding	1 (M)
Cease breastfeeding	2
Honey	3

Baby formula milk	4
Fruit juice	5
Oralit	6

Home made sugar-salt solution	7
Traditional herbs	8
Citroen/orange juice	9

Tea	10
Plain water	11
Others: _____	88
Nothing	99

H. DEMOGRAPHY

Now is about yourself and your family.

H1. Education

Did you go to school?	not at all	0	
	ES grade 1	1	
	ES grade 2	2	

	ES grade 3	3	
	ES grade 4 - 6	4	
	JHS grade 1	5	

	JHS grade 2	6	
	JHS grade 3	7	
	ES = elementary school	JHS grade 1 - 2	8
	JHS = junior high school	-----	
	HS = high school	HS grade 3	9
		College/University	10
	Don't know/forget	99	

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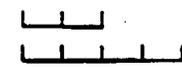
H2. Profession

	Housewife	Family Head
Farmer	1	1
Farmer/farm owner	2	2
Fisherman	3	3
Labourer	4	4
<hr/>		
Skilled labor	5	5
Store keeper/merchant	6	6
Company/factory worker	7	7
Government official	8	8
<hr/>		
Jobless/housekeeper	9	9
Cidomo driver (owned by other)	10	10
Cidomo owner/driver	11	11
Driver	12	12
<hr/>		
Don't know/don't want to answer	99	99
Others	88	88
NOTE :		
No husband/widow	--	98

H3. Monthly expenses

Now about household expenses; please tell me how much do you spend each month for household expenses, e.g. for food, tuition fee, etc.?	Less than Rp 10,000	1
	Rp 10,000 - 20,000	2
	Rp 20,001 - 30,000	3
	<hr/>	
	Rp 30,001 - 50,000	4
	Rp 50,001 - 75,000	5
	Rp 75,001 - 100,000	6
	<hr/>	
	Rp 100,001 - 125,000	7
Rp 125,001 - 150,000	8	
More than Rp 150,000	9	
Don't know/don't want to answer	99	

H4. How far is the nearest Puskesmas/Puskesmas Pembantu


 km or
 meter
 Don't know 99

H5. Can you read (Latin)?

Yes 1
 No 2

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H6. Does the family have:

Radio/radio cassette	1 (M)
Television	2
Sewing machine	3
<hr/>	
Lantern	4
Bicycle	5
Motor cycle	6
<hr/>	
Car	7
Cidomo	8
Bed	9
Baby's bed	10

H7. Do you sometimes:

read newspaper	1 (M)
read magazines	2
listen to radio	3
watching TV	4
listen to religious talks	5

H8. Do you sometimes/often go to women's meeting?

Yes	1 -> H9
No	2 -> PART O.

H9. What meetings?

PKK/DASA WISMA	1 (M)
KPKIA	2
KPA	3
Arisan	4
Pengajian	5
Others:	88
WRITE: _____	

THIS IS THE END OF THE INTERVIEW. SAY "Thanks" AND CONTINUE WITH VILLAGE DATA COLLECTION (OBSERVATION)

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O. **OBSERVATION - VILLAGE DATA**

() _____

O1. Are there:

	<u>Yes</u>	<u>No</u>
Electricity	1	2
School (ES)	1	2
Community wells	1	2
Private wells	1	2
Community water tap	1	2
WC	1	2

O2. Houses:

O2a.	Walls:	stone/brick/cement	1
		½ stone/brick/cement	
		½ bamboo	2
		bamboo	3
O2b.	Floor:	earth	1
		cement	2
		tile	3
O2c.	Windows:	wood/bamboo	1
		glass	2
		no window	3
O2d.	WC:	yes	1
		no WC	2
O2e.	Electricity:	yes	1
		no electricity	2
O2f.	Water source:	river	1 (M)
		irrigation	2
		private wells	3
		community wells	4
		fountain	5
		community water tap	6
		others: _____	88

2/0

Appendix 2

path

Program for Appropriate Technology in Health

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LOMBOK HEPATITIS B MODEL

IMMUNIZATION PROJECT

SURVEY OF IMMUNIZATION COVERAGE AND

VITAL REGISTRATION SYSTEMS

Prepared by

Program for Appropriate Technology in Health (PATH)

and

Ministry of Health, Republic of Indonesia

May 1991

WHO Collaborating Center on AIDS



WHO Collaborating Center for Hepatitis B Vaccination

WHO Collaborating Center for Research in Human Reproduction

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HEPATITIS B MODEL IMMUNIZATION PROGRAM - FINAL EVALUATION: SURVEY OF IMMUNIZATION COVERAGE AND VITAL REGISTRATION SYSTEMS

INTRODUCTION

Vital registration systems are a crucial link in the chain of health care delivery in Lombok. As in all jurisdictions, accurate reporting allows health care planners to follow natural trends and thereby match needs with services. The collection of such data also affords epidemiologists the opportunity to analyze the determinants of morbidity and mortality by making comparisons across time and between geographic regions. Perhaps the most urgent requirement of the local reporting network, however, is to facilitate the delivery of available health-related services to target populations.

The success of the Hepatitis B Model Immunization Program depends on neonates being identified and immunized within the first seven days of life. Similarly, the Child Survival Plus Two (CS-P2) project, which is soon to be implemented, is targeted at newborns and postpartum mothers. Health information and a Vitamin A supplement will be provided to the postpartum women, and efforts will be made to improve the detection and management of low birth weight infants and infants with acute respiratory infections. Interventions such as these will have the largest impact if they are initiated soon after parturition. Whereas postpartum mothers are a captive audience in regions where hospital delivery rates are high, this is not the case in Lombok where the home delivery rate is roughly 90%. Prompt reporting of births is therefore crucial if services are to reach newborns and their mothers in their homes.

A second aim of the CS-P2 project is to provide improved preventive care to expectant mothers in an effort to reduce infant and maternal mortality. The project will strive to increase the rate of antenatal care visits and will promote maternal immunization with tetanus toxoid, activities which rely on the timely reporting of pregnancies.

Accurate registries of pregnancies, births, and infant deaths will be required to determine how successfully these programs are reaching their target populations and to assess their impact. The general goal of the current research project is to evaluate the ability of the current system to provide such records. As well, given that the Hepatitis B Model Immunization Program is nearing the end of its fourth year of implementation, resources will be saved by combining this field work with the final coverage survey of hepatitis B and EPI vaccines.

Current Vital Registration Systems:

Indonesian law requires that all births be officially registered within 48 hours. It is the father who bears the responsibility for notifying the village chief (Lurah) of the event. Likewise, deaths are to be reported within one week. This system is thought to result in only 40 to 50% compliance, which may be partly attributable to the small fee that the Lurah is permitted to levy.

When the Hepatitis B Model Immunization Program was developed in 1987, the need for a more rapid and complete system of vital registration was apparent. Members of the PKK (Family Welfare Movement) were motivated to maintain a census of vital events occurring in 10 to 20 families, and to relay this information to the hamlet chief. Ideally, births are now reported within 24 hours and pregnancies and deaths within one week. The hamlet chief or his/her literate assistant can then transfer the information for each pregnancy to an FB-1 form (Buku Census Ibu Hamil), and complete a B3 form for each pregnancy, birth, and death. These forms are forwarded to the village office (kantor desa) within 24 hours. Vaccinators from the clinic (puskesmas) gather birth

information from the desa weekly, and they strive to immunize all infants against hepatitis B within seven days of birth.

Since then, traditional birth attendants have also been trained to report all births and deaths to either the hamlet chief, the kantor desa, or the puskesmas directly.

The 18 core villages of the CS-P2 project are in areas into which the Hepatitis B Model Immunization Program has expanded in the last 2 years. They are therefore less experienced with this reporting system. However, in these core villages of the CS-P2 project, plans are underway to modify the system further. The hamlet chief will continue to forward the B3 forms directly to the kantor desa, but now the staff at the sub-health centre (puskesmas pembantu) will take responsibility for completing the B5 form using the information they collect from the kantor desa, the TBAs, and other sources.

All childhood vaccinations should be recorded in a Road to Health (KMS) card which is kept by the mother, and in the hamlet's vaccination log (Buku Dusun) which is kept in the puskesmas. Mothers receive a personalized record of all their tetanus toxoid injections (kartu TT, KMS ibu hamil, or kartu imunisasi calon penganten), and this information should also be recorded in the hamlet log (Buku Dusun Ibu Hamil).

Research Questions:

A) For both the 18 core villages of the Hepatitis B Model Immunization Program and the CS-P2 project:

1) Of all the women who are currently pregnant, what percentage have had their pregnancies officially recorded in the:

- a) FB-1: Buku Sensus Ibu Hamil
- b) B3
- c) Buku Dusun

In which gestational month were the pregnancies generally reported?

2) Of all the live births occurring over the past year, what percentage were recorded in the:

- a) B3
- b) FB-1
- c) Buku dusun
- d) Surat Kelahiran
- e) Other record in the kantor desa

What proportion of these were recorded within 48 hours of birth?

3) Of all the still births and infants who died in the past year, what percentage were recorded in the:

- a) B3
- b) FB-1
- c) Surat Kematian
- d) Other record in the kantor desa

- B) In the 18 Hepatitis B Immunization core villages, what is the agreement between immunization records in KMS cards and in the Buku Dusun for 12 to 23 month old children? Based on the completion of either of these records, what are the coverage rates of hepatitis B and EPI vaccines for these children?
- C) For mothers of infants (0-12 months) in the 18 Hepatitis B Immunization core villages, what are the coverage rates of maternal tetanus toxoid administration according to both the cards given to the mothers and the Buku Dusun Ibu Hamil.

METHODS

Rates of vital event reporting will be established for the core villages of both the CS-P2 and the Hepatitis B Model Immunization projects. Data will be collected in a door-to-door survey of both groups of 18 villages using a standard WHO cluster sampling approach. Trained interviewers will ask an adult from each household whether any members are pregnant or have been pregnant during the past year, and whether any infants have died during the past year. The outcome of each pregnancy will be ascertained from the mother if she is alive, or the father if she is dead. Interviewers will ascertain the gestational duration if the woman is still pregnant; or the date of delivery, vital status of newborn at birth, status of child now, and date of infant's death if applicable. (See Appendix I for a copy of the questionnaires.)

Hepatitis B and EPI vaccine coverage rates will be determined for the Model project's core villages. Dates of immunization will be recorded from both KMS cards and the Buku Dusun for 12-23 month old children.

Maternal tetanus toxoid coverage will be calculated for these same 18 core villages. Immunization information will be gathered for mothers whose pregnancies have terminated within the past year. Both the various personal records given to women after injections and the Buku Dusun Ibu Hamil will be used.

Establishing overall rates of reporting requires that information be collected on 210 births and 390 pregnancies in each group of core villages. This translates into 30 clusters of 7 pregnancies and 13 births in each group. (See Appendix II for sample size calculations.) Tetanus toxoid information will be collected from the 390 mothers who gave birth in the Hepatitis B Model Immunization Program core villages. Vaccination records will also be collected for 210 children aged 12 to 23 months in these villages. (Seven respondents in each of the 30 clusters.)

A sample size has not been calculated for the rate of infant death reporting. All infant deaths identified in this survey will be cross-referenced and a rate will be calculated. The power of this calculation will be determined in a post hoc manner.

A recent survey in four villages found that a pregnant woman lived in roughly 5% of households. Consequently, approximately 7700 households will be visited in each group of core villages.

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Time Schedule:

It is hoped that the field work will begin during the last week of March. Approximately 3 days will be needed for pre-testing and revising the questionnaire and for training the interviewers.

It is assumed that it will take an interviewer three days to complete one cluster, which would involve visiting roughly 90 households per day. Twelve interviewers could complete the entire survey in 15 working days.

One week will be required for data preparation and entry. A further two weeks will be needed for analysis and report writing.

RESULTS

The number of dwellings visited per cluster ranged from 42 to 262, with 7039 domiciles being visited in total.

Reporting of Pregnancies:

There were 427 pregnant women surveyed in the hepatitis B and CS-P2 core villages combined. Self-reported gestational ages ranged from two to nine months with a mean of six months.

An FB-1 form had been initiated for 119 (27.9%) of the pregnancies, and 92 (77.3% of the total) included the registration date. The B3 forms, which are maintained at the village level, documented 35 of the pregnancies (8.2%), and all of these B3 forms included the date reported. The highest rate of pregnancy reporting was in the Buku Dusun where 156 (36.5%) of the pregnancies had been registered. (See Table 1.)

Of the 119 pregnancies listed on an FB-1 form, 82 (68.9%) were also noted in the Buku Dusun. Of the 35 pregnancies registered on a B3 form, 21 (60.0%) were found in the Buku Dusun.

A correctly registered pregnancy has a dated entry in the FB-1 and B3 forms and is also recorded in the Buku Dusun. Using these criteria, only 11 of the 427 pregnancies (2.6%) were correctly registered. However, 195 of the pregnancies (45.7%) were reported on at least one of these forms.

The average gestational ages at the time of recording were 4.4 and 4.6 months for the FB-1 and B3 forms respectively. Of the 209 pregnancies that were in the third trimester, 78 (37.3%) had been reported in the FB-1, 21 (10.0%) were in the B3, and 97 (46.4%) were recorded in the Buku Dusun (precision +/- 5%).

In a post hoc analysis, no significant differences were found in the pregnancy reporting rates on the FB-1 and B3 forms between the three geographic districts of Lombok. The differences in the rates of pregnancy reporting in the Buku Dusun, however, were statistically significant: West Lombok 45.3%, Central Lombok 29.1%, and East Lombok 36.1% ($X^2 = 6.89$, $p < .04$).

Reporting of Births:

Data was collected on a total of 781 live births and five stillbirths that occurred during the previous year in the hepatitis B and CS-P2 core villages. If the interview was conducted within one week of the birth, the records were re-examined after the infant was at least 7 days old.

Males accounted for 353 of the births (44.9%) and females accounted for 433 (55.1%). At the time of the interview, 747 (95%) of the infants remained alive while 39 (5%), including the stillbirths, had died.

The date of birth was recorded on an FB-1 form for 293 (37.3%) of the births, but the date of recording was included on only 208 of them (71.0%). Ideally, births should be registered in the FB-1 within 24 hours. This target was achieved in 103 cases (13.1%), and was significantly more likely to occur in the hepatitis B core villages (16.6%) than in the CS-P2 core villages (9.6%) ($X^2 = 13.9$, $p < .001$). See Table 2.

There were no significant differences in the recording of male and female deliveries. In the hepatitis B core villages, infants who were dead at the time of the interview were less likely to have had their births recorded in the FB-1 than infants who remained alive ($X^2 = 4.85$, $p < .03$).

In the hepatitis B and CS-P2 core villages combined, 229 of the 786 births (29.1%) were recorded on a B3 form. The date of recording was included in 189 of the records (82.5%), and 91 of these were recorded within two days of the birth (48.1%). The average time between birth and recording was 7.9 days, with a median of 2.7 days. Infants in the Hepatitis B core village clusters were significantly more likely to be reported on the B3 form within 48 hours of birth (14.8%) than were their peers born in the CS-P2 core village clusters (8.3%) ($X^2=8.06, p<.005$). See Table 3.

Of the 293 births reported in the FB-1, 269 (91.8%) were also noted in the Buku Dusun. Of the 229 births listed on a B3 form, 207 (90.4%) had also been reported in the Buku Dusun.

The Buku Dusun provided the most complete record of births. The date of birth was registered for 310 of 391 births in the hepatitis B core village clusters (79.3%) and 291 of 395 births in the CS-P2 core village clusters (73.7%). Overall, 76.5% of the births were recorded in the Buku Dusun for the two areas combined, while 81.3% were recorded in either the FB-1, the B3, or the Buku Dusun.

There were no gender difference in the reporting rates, but infants who were dead at the time of the interview were significantly less likely to have had their births reported in the Buku Dusun ($X^2=15.49, p<.0001$).

Birth reporting rates in the Buku Dusun were not significantly different between the three districts in Lombok. There were differences in the completeness of birth recording on the FB-1 forms: West Lombok 49.8%, Central Lombok 34.7%, East Lombok 31.3% ($X^2=19.95, p<.0001$). Similar differences were found for birth reporting on the B3 forms: West Lombok 46.4%, Central Lombok 24.2%, East Lombok 21.8% ($X^2=42.23, p<.0001$).

A Surat Kelahiran was completed for 30 (3.8%) of the births in this survey.

Reporting of Deaths:

All 7039 households that were visited in the survey were asked whether any members aged 0 to 12 months had died during the previous year. A total of 57 stillbirths and infant deaths were identified which had occurred at least one week prior to the interview. Males accounted for 65% of the deaths and females for 35%.

The date of death was recorded on either the FB-1, the B3, the Surat Kematian, or the Keratas Catatan in 21 cases (37%). The precision in the estimates of infant death reporting for the hepatitis B and CS-P2 core villages combined is therefore:

$$57 = \frac{2 (1.96^2 \times .37 \times .63)}{y^2} \quad y = +/- 18\%$$

Sixteen of the deaths were recorded in the FB-1 (28%) and nine were noted in the B3 (16%). A Surat Kematian was completed for two deaths (4%) and a Keratas Catatan was completed for one death (2%).

Maternal Tetanus Toxoid Coverage: *

* (Precision in the estimates of TT coverage and tetanus protection = 5%)

Tetanus toxoid (TT) immunization status was ascertained for the 391 women who had given birth within one year of the interview in the hepatitis B core villages. TT1 had been received by 150 of these women prior to delivery (38.4%). Records were available in the Buku Dusun Ibu Hamil for 140 women (35.8%), and 27 women (6.9%) maintained private records: twelve women kept a Kartu TT (3.1%), 13 kept a KMS Ibu Hamil (3.3%), and 2 kept a Kartu Imunisasi Calon Pengantin (0.5%). Of the 141 women who had received TT1 during their last completed pregnancy, the average time of administration was 121 days before delivery.

TT2 had been given to 113 of the mothers prior to the completion of their pregnancies (28.9%). The Buku Dusun Ibu Hamil had records for 105 of the doses (26.8%), and 20 mothers maintained personal records (5.1%). Nine women (8.0%) received TT2 less than 28 days after TT1. Of the 108 women who received TT2 during their last completed pregnancy, the average time of administration was 94 days before delivery.

A neonate is considered to be protected from tetanus if his or her mother has received TT1 and TT2 within three years of delivery. The interval between TT1 and TT2 must be at least 28 days, and the last injection must be at least two weeks prior to delivery. In this survey, 96 women (24.5%) met these criteria for tetanus protection.

Hepatitis B and EPI Vaccine Coverage:

In 30 clusters in the Hepatitis B core villages, 211 children were surveyed who were between the ages of 12 and 23 months and who were born in a Hepatitis B core village. The mother was asked to produce the child's KMS card, the child was examined for the presence of a BCG scar, and the immunization record was transcribed from the Buku Dusun.

Of the 211 children sampled, 191 (90.5%) had been registered in the Buku Dusun and 123 (58.3%) had a KMS card. Nine children (4.3%) were neither in possession of a KMS card nor listed in the Buku Dusun.

The crude and on-schedule coverage rates are summarized in Table 4. The mean age at which HB 1 was administered was 11.8 days (SD = 22.8 days). As evidenced by the median of only 4.9 days, the mean is highly influenced by a small number of infants who received HB 1 well after 7 days.

A BCG scar was identified in 81% of the children examined.

DISCUSSION.

This study provided the opportunity to examine the recording of vital information from three successive cohorts:

- 1) pregnant women
- 2) births and stillbirths from the past 12 months
- 3) children aged 12 to 23 months

Pregnancy Reporting:

Pregnant women will only benefit from the antenatal components of the CS-P2 project once their pregnancies are officially registered. The delivery of hepatitis B vaccine to neonates is also facilitated by pregnancy reporting in as much as it allows births to be anticipated. A cohort of pregnant women was therefore surveyed to determine the ability of the current system to identify pregnancies, and to determine the stage at which pregnancies are generally reported.

Of the 427 pregnancies which were identified, 27.9% had been recorded on an FB-1 form, while 36.5% appeared in the Buku Dusun. This discrepancy suggests that the puskesmas staff learn of pregnancies through channels other than the FB-1 forms. It is also possible that FB-1 forms are misplaced sometime after the information is relayed to the puskesmas. It became clear during the survey that many of the Kepala Dusun do not maintain their FB-1 forms in an orderly system. Instead of remaining in a book, the sheets are often loose, unorganized, and therefore prone to misplacement.

Ideally, a pregnancy will be reported within one week of the woman becoming aware of her condition so that her period of contact with the CS-P2 project can be maximized. The survey revealed that on average, pregnancies are recorded on the FB-1 at 4.4 months gestation which is early enough for CS-P2 services to be effective. But with only one-third of pregnancies being registered in the Buku Dusun, the deficiencies in the reporting system are more in the completeness than in the timeliness of pregnancy reporting. Not only are the Kepala Dusun and Kantor Desa failing to initiate FB-1 and B3 forms for the majority of pregnant women; but once recorded, the information is often failing to reach the puskesmas. Only 69% of pregnancies noted on an FB-1 form, and 60% noted on a B3 form, are also documented in the Buku Dusun.

The survey examined the incidence of pregnancy reporting in a cross-section of pregnant women. This ensured that the pregnancy records had not been added retrospectively at the time of birth reporting. A limitation of this approach, however, is that the proportion of pregnancies which are ultimately reported cannot be calculated since some of the pregnancies detected here may still be reported prior to parturition.

Birth Reporting:

One source of information on birth reporting comes from a cohort of 786 births that occurred during the past year. Ideally, births are recorded on the FB-1 form within 24 hours. In the context of the whole cohort, 13.1% of the births were recorded within this time frame. Of the dated FB-1 forms which were located, 49.8% were reported on time.

The relaying of birth notifications from the dusun and desa to the puskesmas is reasonably efficient: over 90% of births recorded on the FB-1 or the B3 are also entered into the Buku Dusun.

It is worth noting that infants in the Hepatitis B core villages who were dead at the time of the interview were less likely to have had their births recorded on the FB-1. The chain of causation is impossible to determine. Either these babies received less services as a result of not being reported and

were therefore more prone to fatal illness, or stillbirths and unhealthy babies were less likely to have had their births registered.

The B3 form should be completed within 48 hours of birth. Unfortunately, the success of the program in reaching this objective is difficult to evaluate since the date of recording was missing from 17% of the B3 forms. For only 11.6% of the 786 births was a B3 form located on which the birth was recorded within the target of 48 hours. In all likelihood, some of the B3 forms have been misplaced. Of all the dated forms available, 48.1% had the birth recorded within 48 hours of birth.

The highest rate of birth recording was in the Buku Dusun (76.5%). These records are not dated, however, so the reporting interval cannot be calculated. At least seven days were allowed to elapse between the birth of the child and the examination of the Buku Dusun by the interviewers. Nevertheless, some of the younger infants whose births were not recorded within the first week of life may yet be recorded. The cohort of children aged 12 to 23 months provides a clue as to how many infants would eventually be recorded if they were all followed for at least one year: 90% of the 12 to 23 month old children had records in the Buku Dusun. This is somewhat of an overestimate, however. One must bear in mind that the 12 to 23 month old children were all alive, whereas the sample of births over the past year included still births and infants who had already died. Infants who do not survive to the age of 12 months are the ones who are least likely to have been registered in the Buku Dusun.

For only 3.8% of the births was a Surat Kelahiran available. These certificates are either rarely issued or they are often lost.

Death Reporting:

This study was not designed to allow the direct calculation of an infant mortality rate. What it did demonstrate, however, was the current reporting system's capacity to provide information about stillbirths and infant deaths.

Of the 57 stillbirths and infant deaths that were identified in the field, 36 (63%) had not been recorded in any official document. Because of the small sample size, the precision in this estimate of the true reporting rate is +/- 18%. Hence, mortality rates calculated from the official documents would underestimate true mortality rates by anywhere from 45 to 81%.

Maternal Tetanus Toxoid Coverage:

Of the 391 women surveyed who had given birth within the past year in the Hepatitis B core villages, the records show that 24.5% were protected from tetanus prior to delivery. The true rate of protection may be somewhat higher. Records of TT received by these women at school or in other dusuns were inaccessible since so few mothers keep private records of their TT injections. Nevertheless, the true rate of protection is likely well short of the CS-P2 target of 80%, and will remain that way until the puskesmas are informed of substantially more than 36% of pregnancies.

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Hepatitis B and EPI Vaccine Coverage:

Crude coverage rates for hepatitis B and EPI vaccines in 12 to 23 month old children all exceeded 90%. However, the ability of the antigens to stimulate effective immune responses may be limited by sub-optimal scheduling. The commitment of the program to reducing off-schedule dosing needs to be re-assessed. Once priorities are set, efforts must be directed at determining the field conditions that contribute to early and late vaccine administration.

Survivorship bias is one of the limitations inherent in the standard coverage survey methodology used here. Coverage rates may be deceptively high because, by selecting only living children, the sample is biased in favor of children who have been vaccinated. Unvaccinated children are the ones most likely to have already succumbed to a vaccine-preventable disease, in which case they are rendered ineligible for the survey.

Appendix I:

Questionnaires and Daily Log

1. Are there any pregnant women living in this house? (FORM A)
2. Have any women given birth or had a stillbirth or had a miscarriage in the past 12 months? (FORM B)
3. In the past year, has a child died who was younger than 1 year old? (FORM C)
4. (IN HEPATITIS B IMMUNIZATION AREAS ONLY)
Are there any children living here who are 12-23 months old? (FORM D)

NUMBER OF HOUSES VISITED:

Form A: FOR PREGNANT WOMEN

Date of interview: ___/___/___
Name of interviewer: _____
Name of respondent: _____
Cluster Number: _____ Dusun: _____
Desa: _____ Questionnaire No.: _____

Number of months pregnant? _____

PREGNANCY RECORD:

	No/Yes	Date Recorded
FB1	N Y	___/___/___
B3	N Y	___/___/___
Buku Dusun	N Y	

Form B: FOR WOMEN WHO HAVE COMPLETED A PREGNANCY DURING THE PAST YEAR

Date of interview: ___/___/___
 Name of interviewer: _____
 Name of respondent: _____
 Cluster Number: _____ Dusun: _____
 Desa: _____ Questionnaire No.: _____

Date Pregnancy Ended: ___/___/___

Status at birth: alive _____
 stillbirth _____ (# months ___)
 miscarriage _____ (# months ___)

Name of child: _____

Boy _____ or Girl _____

Current status: alive _____
 dead _____

BIRTH RECORD:

	No/Yes	DOB	Date Recorded
FB1	N Y	___/___/___	___/___/___
B3	N Y	___/___/___	___/___/___
Buku dusun	N Y	___/___/___	___/___/___
Surat kelahiran	N Y	___/___/___	___/___/___
Other	N Y	___/___/___	___/___/___

MATERNAL TT RECORD: (IN HEPATITIS B IMMUNIZATION AREAS)

1. MOTHER'S RECORD

- (Circle One)
- a. No card at all
 - b. Kartu TT
 - c. KMS Ibu Hamil
 - d. Kartu Imunisasi calon penganten

TT.1 ___/___/___
 TT.2 ___/___/___

2. BUKU DUSUN

No _____ Yes _____
 # in Buku _____
 TT.1 ___/___/___
 TT.2 ___/___/___

Form C: FOR WOMEN WHOSE 0-12 MONTH OLD CHILD HAS DIED DURING THE PAST YEAR

Date of interview: ___/___/___
 Name of interviewer: _____
 Name of respondent: _____
 Cluster Number: _____ Dusun: _____
 Desa: _____ Questionnaire No.: _____

Name of child _____

Boy _____ or Girl _____

Number of months old _____

Date of death ___/___/___

Age at death (months) _____

INFANT DEATH RECORD:

	No/Yes		DOB	Date of Death
FB1	N	Y	___/___/___	___/___/___
B3	N	Y	___/___/___	___/___/___
Surat kematian	N	Y	___/___/___	___/___/___
Other	N	Y	___/___/___	___/___/___

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Form D: FOR CHILDREN AGED 12 TO 23 MONTHS
(HEPATITIS B IMMUNIZATION AREAS ONLY)

Date of interview: ___/___/___
 Name of interviewer: _____
 Name of respondent: _____
 Cluster Number: _____ Dusun: _____
 Desa: _____ Questionnaire No.: _____

Name of child _____

Boy _____ or Girl _____

KMS card? No _____ Yes _____

Date of birth ___/___/___ : from: KMS _____ Memory _____
 from Buku Dusun: ___/___/___

IMMUNIZATION RECORD:

A. KMS

	<u>DATE</u>		<u>DATE</u>
HB.1	___/___/___	POLIO.1	___/___/___
HB.2	___/___/___	POLIO.2	___/___/___
HB.3	___/___/___	POLIO.3	___/___/___
DPT.1	___/___/___		
DPT.2	___/___/___	MEASLES	___/___/___
DPT.3	___/___/___		
BCG	___/___/___		

SCAR: Yes / No

B. BUKU DUSUN: Child's # in BUKU _____

	<u>DATE</u>		<u>DATE</u>
HB.1	___/___/___	POLIO.1	___/___/___
HB.2	___/___/___	POLIO.2	___/___/___
HB.3	___/___/___	POLIO.3	___/___/___
DPT.1	___/___/___		
DPT.2	___/___/___	MEASLES	___/___/___
DPT.3	___/___/___		
BCG	___/___/___		

SCAR: Yes / No

Appendix II: Sample Size Calculation

Pregnancy and Birth Reporting:

The rate at which pregnancies and births are reported is unknown. They will be estimated at 50% in order to maximize the sample size. Setting alpha at .05 ($z=1.96$) and accepting a precision of 10%:

$$N = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.1)^2} = 97 \quad 97 \times 2 = 194$$

Therefore, if 194 respondents are sampled from each group of core villages, we can estimate the rates of reporting for each group within +/-10% of the true rates with 95% certainty.

However, if we want a rate of reporting for the 36 villages combined, and we want to be accurate within +/- 5%, then the overall sample size should be:

$$N = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2} = 384 \quad 384 \times 2 = 768$$

We can therefore use 384 as our sample size for each group, have adequate power to determine rates for each group with 10% precision, and then combine the data to reveal overall rates of reporting with 5% precision. (Two groups of 30 clusters with 13 respondents per cluster = 390 per group of core villages.)

Maternal Coverage Rate For Tetanus Toxoid:

This rate is unknown and will be estimated at 50%. While only 194 respondents would be required to calculate a rate with 10% precision, information will be collected from all 390 mothers with infants contacted in the Hepatitis B Immunization core villages.

Hepatitis B and EPI Coverage Rates:

A standard EPI cluster sample will be used for the 12-23 month old children in the Hepatitis B Immunization Model Program core villages: alpha = .05, estimated frequency = 50%, and precision = 10%:

$$N = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.1)^2} = 97 \quad 97 \times 2 = 194$$

To allow for an equal number of respondents per cluster, we will use 30 clusters of 7 respondents each (N=210).

-
- * The design effect of cluster sampling requires that sample size be doubled in order to achieve the same precision as a random sample.

**Table 1: PREGNANCY REPORTING
FB-1, B3, and Buku Dusun**

	Hep B (N=214)	CS-P2 (N=213)	Total (N=427)
	Precision +/- 10%		Precision +/- 7%
<u>FB-1</u>			
Pregnancy Recorded	63 (29.4%)	56 (26.3%)	119 (27.9%)
Dated	52 (24.3%)	40 (18.8%)	92 (21.5%)
Avg. Time to Recording	4.2 months	4.7 months	4.4 months

<u>B3</u>			
Pregnancy Recorded	25 (11.7%)	10 (4.7%)	35 (8.2%)
Dated	25 (11.7%)	10 (4.7%)	35 (8.2%)
Avg. Time to Recording	4.6 months	4.5 months	4.6 months

<u>Buku Dusun</u>			
Pregnancy Recorded	82 (38.3%)	74 (34.7%)	156 (36.5%)

<u>FB-1 or B3 or Buku Dusun</u>			
Pregnancy Recorded	105 (49.1%)	90 (42.2%)	195 (45.7%)

**Table 2: BIRTH REPORTING
FB-1**

	Hep B (N=391)	CS-P2 (N=395)	Total (N=786)
	Precision +/- 7%		Precision +/- 5%
<u>FB-1</u>			
Birth Recorded	136 (34.8%)	157 (39.7%)	293 (37.2%)
Dated	93 (23.8%)	114 (28.9%)	207 (26.3%)
Recording:			
- within 24 hours	65 (16.6%)	38 (9.6%)	103 (13.1%)
- 2-7 days	22 (5.6%)	38 (9.6%)	60 (7.6%)
- >7 days	6 (1.5%)	38 (9.6%)	44 (5.6%)

Table 3: BIRTH REPORTING
B3 and Buku Dusun

	Hep B (N=391)	CS-P2 (N=395)	Total (N=786)
	Precision +/- 7%		Precision +/- 5%
B3			
Birth Recorded	136 (34.8%)	93 (23.5%)	229 (29.1%)
Dated	119 (30.4%)	70 (17.7%)	189 (24.0%)
Recording:			
- within 48 hours	58 (14.8%)	33 (8.3%)	91 (11.6%)
- 3-7 days	38 (9.7%)	20 (5.1%)	58 (7.3%)
- >7 days	23 (5.9%)	17 (4.3%)	40 (5.1%)

<u>Buku Dusun</u>			
Birth Recorded	310 (79.3%)	291 (73.7%)	601 (76.5%)

<u>EB-1 or B3 or Buku Dusun</u>			
Birth Recorded	330 (84.4%)	309 (78.2%)	639 (81.3%)

Table 4: Crude and On-Schedule Coverage Rates for Hepatitis B and EPI Vaccines

Children Surveyed	211
HB 1	201 (95.3%)
- within 7 days of birth	143 (71.1%)
HB 2	201 (95.3%)
- within 9 weeks of HB 1	166 (82.6%)
HB 3	196 (92.9%)
- within 6 months of birth	167 (85.2%)
DPT 1 / Polio 1	202 (95.7%)
- minimum age 6 weeks	149 (70.6%)
DPT 2 / Polio 2	200 (94.8%)
- minimum interval 4 weeks	189 (89.6%)
DPT 3 / Polio 3	196 (92.9%)
- maximum age 12 months	195 (92.4%)
- minimum interval 4 weeks	187 (88.6%)
BCG	200 (94.8%)
Measles	191 (90.5%)
- minimum age 9 months	166 (78.7%)
- maximum age 12 months	188 (89.1%)
Children Completely Vaccinated (Within 12 Months)	191 (90.5%)
	188 (89.1%)
Children With Card	123 (58.3%)

Appendix 3

Q2'

Child Survival - Plus Two
Baseline Survey Preliminary Analysis

Survey dates: 13-28 Feb 1991
Universe: 18 Core villages in 3 districts of Lombok
Sample: 667 respondents, women with children under 24
months of age at the time of the survey
Methodology: Cluster survey, with 11-12 respondents in each of
56 clusters

Age of respondents: mean, 27 years; range, 15-47
Age at marriage: mean, 18 years; range, 10-34

Pregnancy/birth history:

Births per respondent: mean, 3.3; range, 1-12
Children still living: 1686 or 2.5 per mother; range 1-12

Women having had miscarriage: 88 (14% of responders), mean: 1.2
miscarriages per mother reporting miscarriage, with breakdown:

Miscarriages

1	11%
2	2%
3	.2%
4	.2%

Deaths: 544, 0.82 per mother, or 2.3 deaths per mother
reporting deaths with a range of 1-8 deaths per mother.

Mothers reporting no children having died: 431 (mean age 25
years, mean age at marriage 18 years, mean number of children
born 2.4).

Mothers reporting deaths: 236 (mean age 30 years, mean age at
marriage 17 years, mean number of children born 5.1).

Percent of children dying by birth order:

Order	Births	Deaths	%
1st	667	127	19%
2nd	522	103	20%
3rd	357	97	27%
4th	243	79	33%
5th	174	66	38%
6th	106	31	29%
7th	69	18	26%
8th	44	11	25%
9th	26	7	27%
10th	16	5	31%
Overall	2224	544	24%

Of 415 deaths with further information:

Ranking of reported symptoms/cause of deaths

Fever/infection	181	43.6%
Convulsions	78	18.8%
Not able to breastfeed	63	15.2%
Rigid neck	48	11.6%
Measles	48	11.6%
Breathing difficult	43	10.1%
Stillborn	27	6.5%
Diarrhea	24	5.8%
Sunken abdomen	11	2.7%
Unknown	10	2.4%
Handicapped	8	1.9%
Sunken eyes	7	1.7%
Malaria	6	1.4%
Accident	4	1.0%
Premature	2	0.5%

Deaths by age group and sex

	0-30 days	1-12 months	1-5 years	5-1 years
#	158	144	101	12
	38%	35%	24%	3%
M	60%	52%	47%	50%
F	40%	48%	53%	50%

Overall:
M - 53.3%
F - 46.5%

Percent of deaths by age group and reported symptoms

SYMPTOMS	AGE GROUP				
	ALL	0-30 days	1-12 months	1-5 years	5-15 years
Diarrhea	6%	0%	8%	13%	0%
Unable to breastfeed	15%	20%	17%	8%	0%
Difficult breathing	10%	9%	12%	11%	0%
Measles	12%	7%	13%	19%	8%
Fever/infection	44%	28%	54%	53%	33%
Accident	1%	0%	1%	3%	0%
Premature	0%	1%	0%	1%	0%
Sunken eyes	2%	1%	2%	3%	0%
Sunken abdomen	3%	1%	2%	6%	0%
Rigid neck	12%	15%	13%	6%	8%
Malaria	1%	1%	2%	2%	0%
Convulsions	19%	23%	22%	9%	8%
Stillborn	7%	15%	1%	1%	0%
Handicapped	2%	1%	1%	4%	17%
Unknown	2%	3%	2%	2%	0%

95

Concerning mother's youngest child:

n=667

Sex: M-354 (53%)
F-313 (47%)

Have KMS: 496 (74%)
with DOB: 474 (71%)

ANC

Mothers reporting antenatal exam: 550 (83%)

Number of antenatal exams:

Visits	
1	7%
2	17%
3	20%
4	10%
5+	46%
Unknown	1%

Site of antenatal exams:

	# women reporting*	
Posyandu	262	48%
Pusk. pembantu	221	40%
Puskemas	125	23%
TBA	101	18%
Private midwife	29	5%
Hospital	19	3%
Private doctor	14	3%
Other	7	1%
Unknown	1	0%

* more than one answer possible

Number of women reporting ANC by TBA only: 4

For those not having antenatal exams (n=117)

<u>REASON</u>	<u># women reporting*</u>	
Not needed if not sick	50	43%
Too busy, housework	13	11%
Too expensive	12	10%
Shy/lazy	9	8%
Too busy, work	9	8%
Too far	7	6%
Don't want injections	7	6%
No information	6	5%
No one doing exams	4	3%
No reason	4	3%
Not Accustomed	3	3%
No one to care for child	1	1%

* more than one answer possible

For all respondents:

Antenatal care necessary

Yes	569	85%
Only if not well	63	9%
No	8	1%
Don't know	27	4%

Tetanus Toxoid:

Mothers reporting having received TT, 457 (69%)

Site:

Posyandu/Puskesmas/Pusk. pembantu	434	(95%)
Private practice	8	
Hospital	7	
Home	6	
No answer	2	

Number of doses reported received:

1	102
2	240
3	4
4	1
5	1
Unknown	26

This shows a high degree of confusion among mothers about TT.

91

They are receiving multiple injections during pregnancy many of which are not TT. Some may only be receiving multiple non-TT injections.

Recording of TT:

With vaccination card:	23 (5%)
Other record	114 (25%)
Card not kept at home	33 (7%)
Card lost	53 (12%)
No card	231 (51%)

TT info needs to be compared to results of coverage survey which show much lower TT coverage. Reasons: no records, lack of mothers' understanding of TT.

Missed opportunities, comparing # of ANC visits with # of TT reported received:

117 mothers (21%) reporting having receiving antenatal care, did not report receiving TT.

76 mothers (19%) reporting 2 or more ANC visits did not report getting a 2nd TT shot.

Mothers reporting having received TT before last pregnancy:

Yes	134 (20%)
No	521 (78%)
Don't know	12 (2%)

Mothers reporting having taken vitamins/Fe during last pregnancy:

Yes	403 (60%)
No	252 (38%)
Don't know	12 (2%)

Of those reporting having taken vitamins/Fe tablets (n=403):

Frequency	#	%
> 1x per day	244	61%
1x per day	106	26%
Almost daily	17	4%
1x per week	3	1%
Other	18	4%
Unknown	15	4%

Duration	#	%
< 1 week	201	50%
1-2 weeks	74	18%
3-4 weeks	42	10%
1-2 months	27	7%
3+ months	24	6%
Unknown	35	9%

** Needs interpretation: Poor understanding of iron/vitamin tablets.

Only 17 of 403 mothers (4%) report having taken tablets at least daily for 3 months or longer.

Birth, Cord Care, Birth Weight

Place of birth:

Home	596 (89%)
TBA's home	17 (3%)
Midwife's home	11 (2%)
Puskesmas	14 (2%)
Hospital	27 (4%)
Other	2 (.3%)

Birth assisted by:

TBA with or without help of family, friends, etc.	570 (85%)
TBA with health professional with or without family, friends, etc.	10 (1%)
Health professionals without TBA with or without family, friends	59 (9%)
Family, friends, neighbors, etc. only without TBA or health professional	20 (3%)
Alone, no assistance	6 (1%)
Unknown	2 (.3%)

99

Cutting tool used for cord:

Bamboo	171	(26%)
Knife	5	(1%)
Scissors	300	(45%)
Razor blade	60	(9%)
Unknown	131	(20%)

Cleaning of tool:

Hot water	173	(33%)
Boiled	12	(2%)*
Alcohol	77	(14%)*
Flamed, burned	2	(.3%)*
Not cleaned	74	(14%)
Unknown	196	(37%)

* correct

91 of 534 (17%) of tools were possibly correctly disinfected.

Cord care:

	#*	%
No special care/allowed to get wet when bathed		
Alcohol	48	7%
Iodine, mercurochrome	117	18%
Rice or rice mixture	102	15%
Ash	124	19%
Traditional herbs/ medicine	106	16%
Modern medicine, powder/oil (rivanol, tetra)	223	33%
Cow-dung	26	4%
Other practices	5	1%
Unknown	4	1%
	33	5%

* more than one answer possible

Mothers reporting cord care with alcohol, iodine and/or mercurochrome only: 124 (19%)

Birth weight:

Mothers reporting birth weight of child: 181
Of these, 22 mothers have record of birth weight

mean birth weight: 3131 gram, range 1500-4500, 6.6% < 2.500 gram.
(n=181)

180

Family Planning

Mothers reporting current use of FP, 257 (39%).
Of these, 206 (81%) have card.

Of those not using FP (n=410), 229 (56%) plan to start within the next 2 months.

For those not using and not planning to use FP (n=181):

<u>REASON</u>	<u>#</u>	<u>%</u>
Just delivered (< 40 days)	4	2%
Wants to get pregnant	36	18%
Currently pregnant	9	5%
Husband not present/dead	28	14%
Not yet menstruating	11	6%
Breastfeeding, can't get pregnant	7	4%
Not suitable	19	10%
FP services too far	1	1%
Too expensive	2	1%
Husband doesn't agree	32	16%
Against religion	3	2%
Afraid, shy to ask about	3	2%
Afraid to use FP	30	15%
Not yet decided	2	1%
Unknown	11	

101

Breastfeeding and feeding practices

With regards to the mothers' youngest child:

Did breastfeed, but no longer	43	(6%)
Still breastfeeding	623	(93%)
Never breastfed	1	(.1%)
Have not started but will	0	

When started breastfeeding:

Day		
1	341	(51%)
2	113	(17%)
3	169	(25%)
4	14	(2%)
5	8	(1%)
6	2	(.3%)
7	16	(2%)
>7	2	(.3%)
Forgot	2	(.3%)

Mean, 1.97 days

Only 51% of the children were given breast milk on the first day. Various other drinks/foods were given instead (see next page).

Mother reporting giving colostrum:

Yes	526	(79%)
No	138	(21%)
Unk	3	(.4%)

However, 124 of the 138 (90%) women reporting not giving colostrum started breastfeeding within the first 3 days, thus the children probably got colostrum.

Reasons for not giving colostrum (n=138):

	# women responding	
Milk not yet coming	4	3%
Not good for infant, reason unknown	5	4%
Not good for infant, causes vomiting/ill	12	9%
Not really milk, milk not ready, milk dirty	74	54%
Baby can't yet suck	10	7%
Baby doesn't want	9	7%
Baby sick	5	4%
Not allowed/recommended by TBA, neighbor, midwife, parent	48	35%
Too much milk	10	7%
Still breastfeeding older sibling	1	1%
So the breast will not become too big	1	1%
Unknown	7	5%

Additional foods given before age 1 year:

Food item	# Mothers reporting	%	# with age started giving			# with age started giving		
			in days	mean age days	range days	in months	mean age months	range months
Unkown	132	20%	122	1.2	1-10	0	0	
Milk (canned/bottled)	78	12%	46	3.1	1-20	22	3.0	1-10
Young coconut water	81	12%	72	1.4	1-14	0	0	
Tea	7	1%	1	1.0	1	4	7.0	1-12
Rice water	5	1%	2	1.0	1	0	0	
Water	5	1%	4	1.0	1	1	6.0	6
Bananas	347	52%	190	2.6	1-15	124	4.0	1-13
Fruit	88	13%	5	7.6	1-15	77	7.5	1-18
Rice (steamed/porridge)	152	23%	28	4.4	1-25	91	4.7	1-12
Pre-masticated rice	287	43%	183	2.3	0-46	95	4.2	1-12
Flour porridge	199	30%	70	4.3	1-27	101	3.2	1-10
Rice	33	5%	3	3.0	1-7	17	5.0	1-12
Bread	29	4%	2	1.0	1	18	4.5	1-12
Vegetables	99	15%	1	7.0	7	82	7.8	1-18
Eggs	13	2%	0			9	6.2	2-12
Cassava/tapioca	60	9%	0			24	9.5	1-23
Same as adult's food	190	28%	0			81	8.5	1-22
Breastfeed only (child < 4 months of age)	17	12%						

Breastfeeding Practices:

Using both breasts		
Always	536	80%
Usually	54	8%
Sometimes	14	2%
Rarely	0	0%
Before, but not now	1	0%
Usually 1 feeding-1 breast, next feeding the other side	2	0%
Usually only one side	60	9%

103

Of those not usually using both breasts (n=77),

Preferred side:

Left	68	88%
Right	8	10%
No preference	1	1%

Reasons for using only one breast by side preferred

	Left	Right	No pref.
Easier for mother	12		
Baby prefers/doesn't want other	37	2	
Other breast sore	5	5	
Child vomits	4		
No milk	6	1	
not allowed/recommended by TBA	1		
No reason	1		
Baby cries if switched			1
Other	1		

Health status of mother's youngest child in the last two weeks

ARI:

	#	%
Running nose	483	72%
Coughing	429	64%
Difficult breathing	219	33%
Fast breathing	140	21%
Wheezing	137	21%

Mothers reporting no ARI symptoms: 153 (23%)

Mothers reporting simple cough and cold, without difficult/fast breathing: 280

Mothers reporting difficult or fast breathing, with or without running nose and/or cough: 234

Where did the mother go for treatment* :

	simple cough/cold (n=280)		diff./fast breathing (n=234)	
	#	%	#	%
home treatment	127	45%	56	24%
family	2	1%	2	1%
traditional healer/birth attendant	54	19%	75	32%
kader	13	5%	13	6%
puskesmas pembantu	60	21%	63	27%
puskesmas	45	16%	42	18%
hospital	4	1%	3	1%
private practice midwife	2	1%	5	2%
private practice doctor	17	6%	22	9%
other/unknown health professional	3	1%	7	3%
unknown	4	1%	5	2%
overall health profes.	131	47%	142	61%

* more than one answer possible

For mothers reporting no ARI symptoms (n=153):

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Diarrhea:

Mothers reporting child suffered from diarrhea in the past two weeks: 196

Duration of diarrhea episode

	#	%
1 day	17	9%
2-3 days	94	48%
4-5 days	32	16%
6-7 days	31	16%
> 7 days	21	11%
unknown	1	1%

Food/drinks/treatment given to the child with diarrhea (n=196)*

	#	%
breast milk	140	71%
stop giving BF	2	1%
milk (canned/bottled)	2	1%
oralit	83	42%
salt-sugar solution	21	11%
trad. herbs/medicine	15	8%
western medicine (tetra injection, syrup)	32	16%
honey	2	1%
tea	23	12%
water	25	13%
coffee and salt	1	1%
no food/drinks given	2	1%
porridge (flour, rice, banana)	10	5%
rice	3	2%
other	4	2%

* more than one answer possible

For mothers reporting no diarrhea (n=471):

What treatment/food/drinks will the mother give if her child is having diarrhea*:

	#	%
breast milk	213	45%
stop giving BF	5	1%
milk (canned/bottled)	1	.2%
oralit	192	41%
sugar-salt solution	74	16%
trad. herbs/medicine	39	8%
western medicine (tetra injection, syrup)	41	9%
honey	6	1%
tea	31	7%
water	51	11%
rice water	2	.4%
porridge	4	1%
jambu	6	1%
no food/drinks given	38	8%
go to trad. healer/TBA	22	5%
go to puskesmas/ puskesmas pembantu	75	16%
go to hospital	3	1%
other	6	1%
unknown	8	2%

* more than one answer possible

Demographic data

Mother's education

	#	%	Cum. %
No formal schooling	279	41.8%	41.8%
Elementary school, 1 year	23	3.4%	45.3%
Elementary school, 2 years	44	6.6%	51.9%
Elementary school, 3 years	49	7.3%	59.2%
Elementary school, 4-6 years	169	25.3%	84.6%
Junior High school, 1 year	11	1.6%	86.2%
Junior High school, 2 years	17	2.5%	88.8%
Junior High school, 3 years	33	4.9%	93.7%
Senior High school, 1-2 years	11	1.6%	95.4%
Senior High school, 3 years	27	4.0%	99.4%
University / Academy	4	0.6%	100.0%
Total	667	100.0%	

Mother able to read

	#	Percent
yes	295	44.2%
no	372	55.8%
	667	100.0%

Mother's profession

	#	%
Farmer	93	13.9%
Farmer/land owner	40	6.0%
Unskilled laborer	5	0.7%
Skilled laborer	17	2.6%
Merchant/shop owner	44	6.6%
Government employee	15	2.3%
Housewife/no other work	442	66.3%
Animal husbandry	1	0.2%
Unknown	10	1.5%
	667	100.00%

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Head of household's profession

	#	%
Farmer	254	38.0%
Farmer/land owner	68	10.3%
Unskilled laborer	72	10.9%
Skilled laborer	55	8.2%
Merchant/shop owner	61	9.1%
Government employee	55	8.2%
Driver on hired horse car	22	3.3%
Driver on own horse car	10	1.5%
Driver/chauffeur	14	2.1%
Factory worker	10	1.5%
Animal husbandry	4	0.5%
Religious leader	1	0.1%
University student	1	0.1%
Unemployed	6	0.9%
Unknown/refused to answer	13	1.9%
No husband/head of household	22	3.4%
	667	100.0%

Monthly expenditures

	#	%	cum.%
< 10.000 rupiah	1	0.1%	0.1%
Rp 10.000 - 20.000	8	1.2%	1.3%
Rp 20.001 - 30.000	150	22.5%	23.8%
Rp 30.001 - 50.000	212	31.8%	55.6%
Rp 50.001 - 75.000	191	28.6%	84.2%
Rp 75.001 - 100.000	66	9.9%	94.1%
Rp 100.001 - 125.000	13	2.0%	96.1%
Rp 125.001 - 150.000	9	1.4%	97.5%
> 150.000 rupiah	4	0.6%	98.1%
Unknown/refused to answer	13	1.9%	100.0%
	667	100.0%	

Mother's/family's property

	#	%
Radio/cassette recorder	259	38.8%
Television	63	9.5%
Sewing-machine	63	9.5%
Kerosine-lamp	22	3.3%
Bicycle	80	12.0%
Motorcycle	42	6.3%
Car	8	1.2%
Horse car	31	4.7%
Bed	542	81.3%
Bed for infant	107	16.0%

Use of media

	#	%
sometimes look into newspaper	203	30.4%
sometimes look into magazine	238	35.7%
sometimes listen to radio	545	81.7%
sometimes watch TV	416	62.4%
sometimes listen to Khotbah (sermon)	473	70.9%

Mother's meetings

Mothers reporting attending meetings: 505 (75.7%)

	#	%
Women welfare organization (PKK)	70	13.9%
Mother child health care meeting (KPKIA)	3	0.6%
Water users group (KPA)	2	0.4%
Arisan	120	23.8%
Religious meeting (Pengajian)	461	91.3%
Social gatherings	10	2.0%
Other/unknown	7	1.4%

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Observations

Data concerning facilities in dusun (n=55)

	#	%
Electricity	49	89.1%
Elementary school	48	87.3%
Public well	39	70.9%
Private wells	39	70.9%
Public tap (kran warga)	25	45.5%

Data concerning house of respondents (n=667)

		#	%
Housing walls	stone/cement	316	47.4%
	$\frac{1}{2}$ stones/cement- $\frac{1}{2}$ bambu	120	18.0%
	bambu	231	34.6%
floor	earth	282	42.3%
	cement	377	56.5%
	tiles	6	0.9%
	unknown	2	0.3%
windows	wood/bambu	210	31.5%
	glass	265	39.7%
	none	191	28.6%
	unknown	1	0.2%
toilet present		86	21.9%
electricity		386	57.9%

Water source of family

	#	%
river	64	9.6%
irrigation	17	2.6%
private well	119	17.8%
public well	224	33.6%
well neighbor	75	11.2%
spring	139	20.8%
public tap	175	26.2%
private tap	8	1.2%
caught rain water	2	0.3%
unknown	2	0.3%

Appendix 4

CS-P2 WORK PLAN-SECOND PROJECT YEAR
(October 1991 - September 1992)

ACTIVITIES	1991 OCT	1991 NOV	1991 DEC	1992 JAN	1992 FEB	1992 MAR	1992 APR	1992 MAY	1992 JUN	1992 JUL	1992 AUG	1992 SEP
Phase I Activities:												
• Year 1 villages												
- Implementation	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X
• Expansion to Year 2 and Year 3 villages												
- Training	X	X X										
- Implementation		X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X
LBW Screening and Case Management:												
• Year 1 villages												
- Training	X	X X										
- Implementation		X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X
• Year 2 & 3 villages												
- Training								X X				
- Implementation								X X	X X X X	X X X X	X X X X	X X X X
ARI Case Detection and Management:												
• Year 1 villages												
- Training				X X								
- Implementation				X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X
• Year 2 villages												
- Training								X X				
- Implementation								X X	X X X X	X X X X	X X X X	X X X X
ANC Screening/Referral of High Risk Pregnancy:												
• Year 1 villages												
- Training								X X				
- Implementation								X X	X X X X	X X X X	X X X X	X X X X
Safe Birth Kit:												
• Assembling												
• Marketing								X X				
Mid-term Evaluation						X X X X						
Mortality Data Collection	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X

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