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CARE - INDONESIA

CHILD SURVIVAL IV

VILLAGE PRIMARY HEALTH CARE (VPHC)

1991 ANNUAL REPORT

NOVEMBER 4, 1991

CARE INDONESIA
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I. Changes in Project Design

A. Statement of Country Project Objectives

The objectives included in CARE Indonesia's Detailed Implementation Plan (DIP) have been modified since the 1989 Annual Report. Some of these changes were included in the Mid-Term Evaluation submitted in November 1990 (part of the 1990 Annual Report). Recommendation 1 of the Mid-Term Evaluation outlined the need to revise the DIP and incorporate these modifications. Recommendation 2 stated the revised DIP should only include one impact goal of increased health post (posyandu) attendance and relevant indicators, reflecting the fact that the modifications made earlier had unreasonably increased the number of objectives. The recommendations were acted upon, the objectives were again modified and the revised DIP was submitted to USAID in April 1991. (Appendix A - Please note. **This revised DIP is being used as the reference point. Therefore, all changes outlined in this report will have been made since April 1991 when the revised DIP was submitted to USAID**). The project objectives are as follows:

Final Goal: To reduce the rate of child morbidity and mortality in subdistricts by working in collaboration with the local government and village leaders to increase the effectiveness and quality of services offered in the integrated health post (posyandu).

Intermediate Goal #1: Village Supervision Team operates independently to improve and maintain village health system.

Intermediate Goal #2: Comprehensive and convenient posyandu services are regularly functioning in all villages.

Intermediate Goal #3: Subdistrict Team (SDT) and Puskesmas health center staff adopt a community participatory approach to village primary health care services.

Intermediate Goal #4: Information, materials and media to support the PHC program developed and utilized.

The indicators utilized to measure these intermediate goals are listed in Appendix A, pages 5-6.

B. Location and Size of the Priority Population Living in the Child Survival Impact Area

There have been no changes made in the size or location of the priority population since the revised DIP.

C. Health Problems Which the Project Addresses

No changes have been made in the project focus since both the 1989 Annual Report and revised DIP. VPHC is still addressing the health problems outlined in the original DIP: low immunization coverage, diarrheal diseases, poor nutritional status, ARI and maternal mortality.

D. Child Survival Interventions

During this past year the project has placed increased emphasis on the provision of prenatal services to pregnant women. This is in support of the recent Government of Indonesia strategy of placing midwives in all villages in order to accelerate the reduction of maternal and infant mortality rate. Although this Government of Indonesia (GOI) strategy has just begun to be implemented, VPHC has taken steps to improve the quality and variety of services being offered to prenatal women. Adult weighing scales have been supplied to almost all posyandu making the monitoring of pregnant women's weight gain possible. Where midwives are still not available and the local health center midwife supportive, Traditional Birth Attendants (TBAs) are being trained in prenatal examination procedures by Puskesmas staff and encouraged to attend posyandu to examine pregnant women. TBAs are also having regular meetings with the Puskesmas midwife in order to coordinate and monitor their work. These services are in addition to the TT immunizations, iron tablet and vitamin A distributions which are already a part of many posyandu.

The implementation of other child survival interventions proceed as before. Immunization was the project's first priority. Other inventions included in the project after the initial focus on immunization include diarrheal disease control, growth monitoring, nutrition education, and acute respiratory infections. This last intervention, ARI, has received the least focus to date.

E. Strategies for Identifying and Providing Service to Individuals at Higher Risk

During this recent year the project has placed emphasis on developing or activating written referral systems from posyandu to Puskesmas. The GOI's somewhat complicated system has been reviewed and the essential forms from it have been extracted. In selected posyandu, project staff are working on training the posyandu volunteers (kader) to use these forms. This referral system is focused on high risk children, pregnant women and sick children.

II. Human Resources and Collaboration

A. Job Descriptions and Resumes of New Staff

The job descriptions of all project field staff have been reviewed and modified (Appendix B). The project coordinator, an expatriate position, was replaced just as the mid-term evaluation began last year. The former coordinator was transferred to another assignment after five years in Indonesia. The resume of the new coordinator, Anne Lynam Goddard transferred from CARE Bangladesh, can be found in Appendix C. One of the three project managers, who is responsible for all activities within one subdistrict, was replaced due to a staff promotion. His replacement, Pudji Aswati, had recently successfully completed a year as a CARE management trainee. Her resume can be found in Appendix D. On the recommendation of the midterm evaluation, six additional field staff were hired in February/March 1991, four as additional field officers and two as replacements for two staff who were promoted to supervisory positions within the project.

B. Technical Assistance

14 project staff from VPHC participated in a total of four workshops organized by the International Private Voluntary Organizations - Child Survival (IPVO-CS) Programs Forum. Workshop topics included:

- Kader (volunteer) Motivation
- Survey Techniques
- Management Information Systems
- Income Generating Activities.

CARE was one of the founding members of the Forum which consists of 14 international NGOs working in child survival/primary health care projects. CARE is also one of the four NGO members which form the planning team for each workshop.

This forum has proved to be a valuable avenue for improving staff skills and exchanging information on the latest developments in child survival. The USAID Child Survival Coordinator has been a participant and valuable contributor to the workshops.

C. Community Activities Supporting the Project

The majority of project activities have focused on developing community health committees (in the project called village supervision teams or VSTs) to manage child survival activities themselves. CARE project staff are not implementing child survival activities directly. In Indonesia, all child survival services are offered through the posyandu or integrated health post. The strategy of this nation-wide program is for the posyandu to be community managed and supported with only technical services (e.g. immunization) being supplied by the concerned government workers. VPHC's goal is to operationalize the concept of community management and improve the support being given by the government.

The first year and a half of the project focused on establishing the teams. During the last year and a half project energies have turned to developing the teams to work independently and effectively. In total, 51 teams have been established and are operational - one in every project village. During this past year, 8 of these teams are new as the project expanded to include another subdistrict. At the same time 6 teams have been evaluated as being able to work independently and the villages have begun to phase out from the project.

Team responsibilities, as outlined in the revised DIP, are as follows:

- Promoting and maintaining a sufficient number of kader
- Developing and promoting a support system for kader
- Supervising the operational management of posyandu
- Supervising the posyandu's reporting and recording system
- Summarizing and reporting posyandu data to subdistrict

- Collaborating with other sectors/institutions
- Developing a system for posyandu financial support
- Participating in posyandu feedback sessions
- Meeting regularly to plan their work
- Encouraging community participation at posyandu.

Team membership is comprised of both formal and informal leaders. The team also encourages other informal leaders to promote the posyandu and deliver specific health messages to communities. Therefore, during this past year much effort has gone into training religious leaders, teachers and traditional birth attendants.

D. Linkages to Other Health and Development Activities

Approximately a year and a half ago the GOI, under instruction from the Ministry of Home Affairs, created an institution (entitled Pokjanal) to improve the quality of supervision and support to posyandu activities. With this move, the GOI established integrated teams at the central, provincial, district and subdistrict levels to improve the village management of the posyandu - clearly stressing that the posyandu is not the sole domain of the Ministry of Health. In effect this decree established as official government strategy CARE's approach to improving posyandu - the establishment of integrated subdistrict and village teams. CARE field staff have been quick to point out to their counterparts the direct link between the subdistrict and village teams, already established, and their new requirement to establish a Pokjanal subdistrict team and support effective village management of the posyandu. The VPHC teams, therefore, have became the teams required under the Pokjanal initiative.

CARE has discussed our strategy for the establishment and effective functioning of these teams with the central level Pokjanal team members and further discussion will continue in the upcoming year.

III. Progress in Health Information Data Collection

A. Baseline Survey

As the results of our baseline survey were discussed previously, this will not be discussed at length here. However, the original baseline survey report, issued in January 1990, included only the data obtained from mothers in the project areas. Data was also collected in control villages as well as from kader but it had not been analyzed. In Appendix E can be found the revised baseline report which

includes the following:

- mother baseline data in project villages
- mother baseline data in control villages
- kader baseline data in project villages
- kader baseline data in control villages.

In addition, during this last year a new subdistrict was brought into the project - Bandar subdistrict. A baseline survey was also conducted in Bandar and the results can be found in the attached revised report.

B. Routine Data Collection

Not applicable for a CS IV project.

IV. Improvements in Program Quality and Technical Effectiveness

A. Lessons Learned

The major lesson learned, or reinforced, this year was the length of time required to institutionalize strong, effective village supervision teams. One field site, East Java, has had particular success with the village teams which demonstrates that the strategy is appropriate and effective. This same field office was able to begin phase out from several villages during this year and extend project operations to another subdistrict. The delays experienced in the other two sites have shown that due to many factors the village supervision concept will require much more time to implement successfully than was originally envisioned. These other sites, therefore, will not include a second subdistrict as was planned in the original DIP but will concentrate on the one subdistrict. This change in strategy and project target population was outlined in the attached revised DIP.

A second lesson, again reinforced rather than learned, was the value in "seeing is believing". In the project's most difficult location, NTB, where government bodies and village structures are weak, much frustration has been encountered in the struggle to develop strong subdistrict and village teams. A few months ago a cross visit was conducted where subdistrict and village team members from NTB visited the subdistrict where primary health care was born in Indonesia - Banjanegara. During the visit team members were able to see first hand the pivotal role strong effective leadership plays in the delivery of primary health care services. The visit has produced many positive spin-offs for the project: supervision visits by subdistrict leaders to remote villages, the establishment of posyandu services in previously non-served areas, etc. The feeling in NTB is that after three years of work, the benefits

are finally able to be seen and this visit played a major role in these recent advancements.

The final lesson came as a result of the work of a doctoral student, Richard Columbia, who assisted with the baseline survey. In addition to the kader baseline data collected by the project, Columbia collected additional data from kader and focused his dissertation on these volunteer health workers.[1] The conclusion reached by Columbia was that the gap in knowledge between the formal health system and mothers lies not between kader and mothers but rather between the health system and kader. According to his analysis, kader have proved themselves effective in transferring their health knowledge to mothers but the system is ineffectual in upgrading the health knowledge of kader.

If Columbia's conclusion is correct, then the strategy of VPHC is appropriate. The project's main thrust is to close the gap between the formal health system, represented by the Puskesmas, and the kader by developing a village based structure to serve as a bridge. Thus the Puskesmas staff and other subdistrict officials do not have to attempt to supervise or train up to as many as 100 posyandu and perhaps up to 400 kader (the situation in the project's East Java office). Instead they can focus on the 17 village supervision teams that are now training kader and supervising posyandu in their villages.

B. Strengthening the Technical Quality of Health Programming

The first step taken during this year to strengthen the technical quality of the project was the procurement of needed equipment and materials for the posyandu. The project's goal had been to obtain as many of these supplies as possible through the government. The project did not want to usurp the government's position by providing equipment which they should provide. During VPHC's first two years, much effort was expended in getting the needed supplies from government - and indeed many materials were obtained. The remaining equipment required was then purchased by the project this year. This included such things as a Puskesmas refrigerator, adult weighing scales for posyandu for monitoring weight gain in pregnant women, the prenatal monitoring/reporting cards, cooking equipment for starting feeding programs for malnourished children, etc.

The next step undertaken was the establishment of 2-3 "model" posyandu in each subdistrict. The development of model posyandu was a recommendation put forth in last year's mid-term evaluation. The rationale behind the recommendation was as follows. The VPHC II project does not intervene directly

at the posyandu level but rather is working with and through the subdistrict and village teams to improve their skills in implementing posyandu. The evaluation team believed to compliment this strategy there was the need to establish some model posyandu so that subdistrict and village teams would have a concrete example of what they are working towards. These models are based on GOI guidelines for "ideal" posyandu so they are firmly within the GOI current thinking.
Ten model posyandu have been started during this past year. In addition to the usual five posyandu program areas (immunization, diarrhea, nutrition, maternal and child health, and family planning), these model posyandu emphasize simple curative services through the provision of basic medicines and first aid equipment as well as the establishment of feeding/nutrition programs for malnourished children. These additional services have been well received by the communities served.

The last major step taken to strengthen the technical quality of the project was the final production and printing of 21,000 copies of a set of kader reference cards. (Sample enclosed as Appendix F.) UNICEF/WHO/UNESCO's Facts for Life was the major source for the messages included in the cards, however, some modifications were made based on the GOI's latest policies.

These cards are being distributed to kader, members of the SDTs and the VSTs, and to members of the PKK (Women's Development Movement) who are active in supporting posyandu. At the request of local government counterparts, these cards are being distributed far beyond the four subdistricts of VPHC. Designed as a handy, inexpensive, pocket-size reference material, the cards are being extremely well received. At a recent local health fair where they were displayed, requests were even received to purchase copies!

V. Work Schedule

A. Problems and/or Constraints to Implementation

In general, no major problem arose during this past year. Several planned activities were not completely implemented. In many cases these activities were not conducted due to delays in, or unreadiness of, the village itself. Change in leadership in the village/subdistrict slows down the activities and sometimes new leaders mean new plans have to be developed. Joint visits between CARE and the GOI staff to villages were not easy to plan due to the busy schedule of the GOI staff.

The last noteworthy constraint is that about one third of the project staff, i.e. (4 additional field officers; 2 new field officers to replace positions vacated by promotions; and 2 replacements for resigned field officers) are new as of early 1991 and it has naturally taken them a while to get oriented. Two positions needed to be filled to replace positions vacated by staff promoted to the newly created mid-level supervisory positions. Thus although the project is hurt somewhat by having to hire new staff, the expertise of the staff vacating those positions has not been lost to the project. On the contrary, these experienced staff are now in a better position to use their skills to benefit overall improved project implementation.

To overcome this problem of new, inexperienced staff, a week of orientation training was held for all new staff in March 1991. As the year closed, planning had begun for a week of in-service training for both new and experienced staff which is scheduled to take place in October 1991.

B. Work Plan for Fiscal Year 1991-1992

The work plan for fiscal year 1991-1992, outlining all activities to be carried out, can be found in Appendix G.

VI. Changes in Project Expenditures and Justification for Budget Changes

A. Pipeline Analysis

The pipeline analysis is attached to this report as instructed (Appendix H).

B. Justification for Major Budget Changes

No major budget changes have been made to the original budget submitted to and approved by USAID.

VII. Sustainability

A. Recurrent Costs

There is no plan for projected costs and revenues that need to be maintained after USAID CS funding ends. As much as possible, VPHC has been designed so as to avoid any dependency or linkage between the future sustainability of the major project achievements and continued recurrent costs. In some cases, supporting activities have been undertaken, because of their potential contribution to the achievement of the project's intermediate goals, which could benefit from

continued future funding. These activities are outlined below. If these activities are not sustained because of lack of funding, however, this will not affect the sustainability of the project's main achievements.

During this past year the project has encouraged some communities to establish kader incentive support schemes (KISS) to encourage and motivate kader to be active in supporting posyandu. For some of these schemes, the project has provided an initial small investment to initiate or develop activities. A range of activities are being carried out from establishing credit groups to sponsoring cross visits to other villages. It is anticipated that some of these activities will generate enough funds to continue their own support while others might not be sustained due to the inability of the community to continue providing support and/or supporting funds.

As mentioned earlier, feeding groups are being established for malnourished children in several villages. In some sites, project funding is supporting up to 50% of the ongoing costs with the communities or participating families or Puskesmas providing the remaining funds. It is hoped that by the end of the project, 100% of costs will be borne by any one group or a combination of these mentioned groups. However, this is an extremely difficult activity to develop, no less sustain, and it is anticipated that some of these groups might cease functioning without continued project support. When first undertaking this activity the difficulties were already foreseen but due to the potential benefit for the concerned children the activity was pursued nonetheless.

The main component the local governments must maintain is continued supervision by the subdistrict team to the village teams. Without this supervision the village teams might eventually become non-functional. In order to provide this support, local governments must allocate per diem and transport costs to concerned staff for field visits. Since the beginning of the project, VPHC has never paid any of these costs out of project funds. In one field office, the local government allocated a special operating fund for this purpose. In the other offices costs are either borne out of the regular government budget or government officials "hitch" rides on CARE motorcycles or vehicles in order to accompany a project staff on a supervision visit. On some occasions, government officials are even paying gasoline expenses out of their own pockets. VPHC is already initiating discussion with the concerned government officials to explore the possibility of them starting to cover these costs now and/or continuing to provide these operational costs after the project is finished.

The remaining project component which the government might not be able to absorb before the project ends is the provision of transport for immunizers to attend posyandu in remote areas. At present, the project is providing that service in one project locale. Recently, however, a field visit was conducted with the staff of the large World Bank health project through which the procurement of motorcycles for GOI staff is being carried out. Hopefully, some of these motorcycles will be made available to immunizers in our project area.

B. Strategies for Reducing Sustainability Concerns

VPHC's goal is to reduce child mortality and morbidity through improvement in the quality and effectiveness of services offered at the posyandu. In the short term to ensure the achievement of this goal, the project could have been designed to intervene directly at the posyandu level. However, the sustainability of such improvements would be highly unlikely. Therefore the project's entire strategy was developed with the issue of long-term sustainability in mind. The project's main thrust has been the establishment and development of subdistrict and village teams whose main responsibility is to support and improve posyandu. In order to make these teams effective, the project has also taken a facilitation role rather than a leadership role with these groups. As would be expected, this approach is slower than the more direct approach but the payoff is a more sustainable output.

During this past year more regular monitoring of project monthly expenditures was conducted and shared with staff. Partly as a result of this it is estimated that sufficient funds are available to last a full four years (until September 1992) although a three and a half year budget was originally submitted to and approved by CS/Washington.

Since cost recovery and price setting is not an issue in this project, no training was conducted on this topic.

C. Cost Recovery Activities

As stated above, no cost recovery mechanism has been included in the project. However, as a possible follow-up to this project, CARE is exploring the possibility of a community health insurance project in which cost recovery would obviously play a major role.

As mentioned earlier, the project has initiated several kader incentive support schemes which includes income generating activities for kader. However as this began late in the year, it is too early to comment on their financial success or acceptability to communities.

CARE INDONESIA
CHILD SURVIVAL IV
VILLAGE PRIMARY HEALTH CARE (VPHC)
1991 ANNUAL REPORT

LIST OF APPENDICES

Appendix A	Revised Detailed Implementation Plan (DIP)
Appendix B	Revised job descripitons for project staff
Appendix C	Project Coordinator's Resume
Appendix D	Project Manager's Resume
Appendix E	Revised Baseline Report
Appendix F	Kader Reference Cards
Appendix G	Annual Implementation Plan (AIP 1.2) for 1991-1992
Appendix H	Pipeline Analysis
Appendix I	USAID Health & CS Project Questionnaire
Appendix J	CDD Curriculum

APPENDIX A

CARE

VILLAGE PRIMARY HEALTH CARE II

DETAILED IMPLEMENTATION PLAN

INDONESIA

WEST JAVA, EAST JAVA

NUSA TENGGARA BARAT

1989 - 1992

Revised

April 1991

14.

List of Acronyms and Common Terms

BKKBN	Badan Koordinasi Keluarga Berencana Nasional
CS I	Child Survival I
FO	Field Officer
GOI	Government of Indonesia
Kader	Community Voluntary Health Worker
KAP	Knowledge, Attitude and Practice
KKBS	Keluarga Kecil Bahagia Sejahtera
KMS	Kartu Menuju Sehat (Growth Card)
LGG	Home made sugar salt solution for rehydration therapy
NGO	Non-Government Organization
Nilai	Grade used to indicate child's weight on growth card
NTB	Nusa Tenggara Barat
Oralit	Oral electrolyte formula for Rehydration therapy
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PIE	Planning, Implementation and Evaluation
PKK	Pendidikan Kesejahteraan Keluarga (Family Welfare Education)
PRITECH	Technology for Primary Health Care
PVO	Private Voluntary Organization
Posyandu	Pos Pelayanan Terpadu (Integrated Health Service Post)
Puskesmas	Pusat Kesehatan Masyarakat (Community Health Center)
RTA	Regional Technical Advisor
RMU	Regional Management Unit
SDT	Subdistrict Team
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID/I	United States Agency for International Development/Indonesia
USAID/W	United States Agency for International Development/Washington
VPHC	Village Primary Health Care
VPHC/II	Village Primary Health Care/II
VST	Village Supervision Team

TABLE OF CONTENTS

		Page No.
A.	COUNTRY PROJECT SUMMARY TABLE	1
B.	BACKGROUND	2
	B.1	2
	B.2	2
C.	PROJECT DESIGN	4
	C.1	4
	C.2	10
	C.3	11
	C.4	12
D.	HUMAN RESOURCES	22
	D.1	22
	D.2	23
	D.3	23
E.	HEALTH INFORMATION SYSTEM	24
	E.1	24
	E.2	24
	E.3	26
	E.4	26
	E.5	27
F.	SCHEDULE OF ACTIVITIES	27
G.	FINANCIAL PLAN	30
H.	SUSTAINABILITY STRATEGY	31
	H.1	31
	H.2	31
	H.3	31
	H.4	31
	H.5	32
	H.6	32

Attachment #1	Grant Application for the Development of Material and Educational Aids
Attachment #2	Map of Project Location VPHC II
Attachment #3	Child Growth Card and Pregnant Women Card
Attachment #4	Project Implementation Report (PIR), Major Project Activities FY 91
Attachment #5	Schedule of Training Activities
Attachment #6	VPHC Monitoring System
Attachment #7	Baseline and Close-out Survey - VPHC 1989 Methodology

A. DIP COUNTRY PROJECT SUMMARY TABLE

FORM E: COUNTRY PROJECT SUMMARY TABLE

COUNTRY: **Indonesia** PVO: **CARE**

PROJECT TITLE: **Village Primary Health Care II**

I. INTERVENTIONS AND TARGET POPULATIONS:

Number:	< 1 year	< 2 years	< 5 years	Women 15-45 yrs	Total Population in Service Area
1. ORT *	8,097	18,915	38,673	43,561	82,234
2. IMMUNIZATION	8,097	18,915	38,673	43,561	82,234
3. NUTRITION *	8,097	18,915	38,673	43,561	82,234
4. CHILD SPACING					
5. OTHER (specify)					
a. ARI *	8,097	18,915	38,673		

b. Prenatal Care for pregnant women (6,730)

* Interventions conducted for all under fives; see section C.2 for target population.

II. ACTIVITIES: Circle all activity codes * that apply

1. ORT ..... 1 / **2** / 3 / **4** / **5** / 6 / 27
2. IMMUNIZATION ..... 7 / **8** / **9** / 10 / 27
3. NUTRITION ..... 11 / 12 / 13 / **14** / **15** / **16** / **17** / 27
4. CHILD SPACING ..... 23 / 24 / 25 / **26** / 27
5. OTHER (specify): **Acute Respiratory Infection & Prenatal Care**

* Activity Codes: 1=ORS packets distribution, 2=ORT training, 3=promotion of home-based fluids for ORT, 4=improved management of ORT/ORS program, 5=distribution of vaccines, 6=immunizing mothers/children, 7=training in immunization, 8=promotion of immunization, 9=improved management of immunization programs, 10=nutrition counselling to mothers/community (includes breast-feeding, adequate weaning, dietary management of diarrhea), 11=growth monitoring, 12=nutrition training (for growth monitoring and/or infant feeding practices), 13=food supplements, 14=nutrient supplements (Vitamin A, iodine, iron, etc.), 15=child spacing, 16=other (specify).

III. DURATION: Start Date: Sep. '88, Estimated Completion Date: Sep. '92.

IV. BUDGET:

A.

By Year	A.I.D.	PVO	TOTAL
YEAR 1	285,560	64,000	349,560
YEAR 2	207,600	174,195	381,795
YEAR 3	204,347	163,488	367,835
YEAR 4	129,710	94,673	224,383
Subtotal Field Costs	827,217	496,356	1,323,573
Subtotal HQ/HO Costs (overhead)	76,440	0	76,440
TOTAL =	903,657	496,356	1,400,013

-17

B. By Intervention: PERCENT OF TOTAL AID FUNDS REQUESTED

1. ORT	40 %
2. IMMUNIZATION	20 %
3. NUTRITION	20 %
4. CHILD SPACING	0 %
5. OTHER (specify)	20 %

B. BACKGROUND

B.1 Project Location

CARE Indonesia's Village Primary Health Care (VPHC II) project is a continuation of the Child Survival I/VPHC project that began in 1985. The FY 1989 VPHC II project will be initially implemented simultaneously in three subdistricts within the provinces of: Nusa Tenggara Barat, West Java and East Java. The specific locations are selected in cooperation with the respective Provincial Governments. It has been agreed that during the first year of the project period CARE will conduct the VPHC II project activities in the following areas:

Province	Number of Village	Subdistrict	Total Population	IMR
Nusa Tenggara Barat	10	Gunung Sari	66,750	126/1,000
West Java	17	Gunung Halu	90,297	74/1,000
East Java	16	Tulakan	69,436	70/1,000
TOTAL:			226,483	

The estimated total population in these three subdistricts is 226,483. (Refer to Attachment #2 for map of project locations).

Criteria for site selection was based on government reported infant mortality rates (IMR), isolation or economically disadvantaged communities and absence of appropriate health support services. CARE is implementing the VPHC II project in the areas of most need.

In FY 91, an additional subdistrict is being included in the project: Bandar subdistrict in East Java: Bandar is comprised of 8 villages with a total population of 37,959. Thus the estimated total population of the 4 subdistricts is 264,442.

In each province, the VPHC II project will be managed by the provincial CARE Field Office. [Refer to section D for Field Office staffing pattern.] CARE's project officers will work with clusters of three to four villages at one time to promote sharing of experiences. This strategy was developed and found to be effective in the VPHC I project. In addition, this approach also reduces the logistical costs and support services required.

-18.

B.2 Current Status and Substance of Agreements

CARE's basic country agreement was approved by Ministry of Foreign Affairs in 1967. CARE has had a cooperative umbrella agreement with the Ministry of Home Affairs since 1978. This agreement recognizes CARE as a international developmental organization, and allows CARE to cooperate with selected Provincial Governments in a variety of development activities. Every year, CARE signs an operational agreement with each of the respective Provincial Governments. This agreement (addendum) specifies site selection, stipulates CARE's and counterpart responsibilities, mutual funding arrangements, management procedures and methods of project operation.

To ensure that project activities are in line with the government policies and to enhance communication CARE has sought out and received formal approval from all appropriate government counterparts, in each province, to implement the VPHC II project.

Besides interacting directly with the Government of Indonesia, (GOI) CARE is also seeking assistance from the following organizations/groups:

The British Embassy/Indonesia is financially supporting a project designed to promote health education through a mass media approach at the village level. [Refer to Attachment #1 for a copy of approved proposal: "Grant Application for the Development of Material and Educational Aids"].

CARE is an active member of the Child Survival NGO Network which began in April 1990. The NGO Network, which meets four times a year, has the following objectives:

- to provide training/information about selected topics or themes
- to share information about project accomplishments/problems
- to visit other CS projects, if possible.

Topics selected for the first year of the network are as follows:

- Volunteer (Kader) Motivation
- Survey Techniques
- Management Information Systems
- Income Generation Activities.

Network members include: Save the Children, Adventist Development Relief Agency, Helen Keller International, Project Concern International, World Relief, Catholic Relief Services, Project HOPE, PATH, Church World Services and of course CARE Indonesia. This network was proved an effective forum for exchanging ideas on the strengthening of CS project in Indonesia.

19

CARE senior staff presently meet regularly and coordinate activities with Program for Appropriate Technology and Health (PATH). Both CARE and PATH are operational in NTB.

C. PROJECT DESIGN

C.1 Project Objectives and Strategy

VPHC's final goal is to reduce the rate of child morbidity and mortality in subdistricts by working in collaboration with the local government and village leaders to increase the effectiveness and quality of service offered in the integrated health post (Posyandu).

The principle strategy for achieving this goal is the formation and independent functioning of Village Supervision Teams (VSTs). The teams, made up of formal and informal village leaders and kader supervisors, are charged with the responsibility of effectively supervisioning all posyandu activity. The teams are in turn supported and supervised by Subdistrict Teams (SDTs). The Subdistrict team works in close collaboration with Puskesmas (Health Center) staff.

Concept of Village Supervision Team

A. General Definition

Village Supervision Team (VST) is a group of people led by Village Head (or his/her delegate) at the village level, consisting of formal and/or informal community leaders, who are responsible for the establishment, development and on-going supervision of Posyandus and whose activities are coordinated by the Village Resistance Committee (LKMD).

B. Membership

A VST should have sufficient members to enable them to conduct their responsibilities. The size of the VST will vary according to the size of the village but the maximum number of members should be 2-3 times the number of village hamlets. The members of the VST should consist of:

- Village Head (Kepala Desa
- Head of LKMD
- Section 7 of LKMD (Health Section)
- Section 10 of LKMD (Women' Section)
- Head of hamlet and kader supervisor
- Village officials
- Community leaders

20

C. **Role and Responsibilities**

In general, VST should play important role in and be responsible for the following:

a. Establishment of posyandu
b. Development of posyandu
c. Monitoring and Supervision of posyandu
d. Evaluation of and feed-back to posyandu
e. Coordination with other sectors/institutions

D. **Job Description**

Specifically, the VST should be able to conduct the following activities:

a. Promoting and maintaining a sufficient number of kaders
b. Developing and promoting a support system for kader
c. Monitoring and supervising operational management of Posyandu
d. Monitoring and supervising posyandu's recording and reporting system
e. Summarizing and reporting Posyandu data to Subdistrict
f. Collaborating with other sectors/institutions
g. Developing system for Posyandu financial support
h. Participating in Posyandu's feedback session
i. Meeting on regular basis to plan their work.
j. Encouraging community participation at posyandu.

<u>Intermediate Goal # 1</u>

Village Supervision Team (Tim Pembina Desa) operates independently to improve and maintain village health system.

<u>Indicators</u>

- 70% of VSTs established.
- 70% of VSTs meet regularly in accordance with agreed schedule.
- 70% of villages implement workplans for priority health problems.
- 70% of Posyandu sessions are supervised by VSTs.
- 70% of VSTs conduct training for kader.
- 70% of TBAs trained by the project are active in promoting the Posyandu, relaying health messages and referring high risk pregnancies.
- 70% of informal community leaders (religious leaders and/or teachers) trained by the project are actively involved in promoting the Posyandu and relaying health messages.
- 70% of villages have at least 2 oralit posts distributing and restocking their supplies.
- Support system for kader established in 50% of villages.

21

Intermediate Goal # 2

Comprehensive and convenient posyandu services are regularly functioning in all villages.

Indicators:

- 90% of posyandu hold monthly sessions in all villages.
- 70% of Posyandu operate with 'four table system'.
- 50% of children under 5 weighed at Posyandu.
- 50% of pregnant women are examine during their pregnancy.
- 70% of mothers report they would provide the appropriate treatment if their child had diarrhea.
- 70% of mothers demonstrate improved health knowledge and attitudes.
- 70% of Posyandu complete F1 form monthly
- 70% of Posyandu complete F1 form monthly.
- Kader at 70% of Posyandu are making home visits.
- 70% of Posyandu have referral system to Puskesmas operating.
- 70% of Posyandu have feedback sessions.
- Children 0 to 12 month receive immunizations as follows:

BCG	90%
DPT 1	90%
Polio	80%
Measles	80%

- 80% of pregnant women receive 2 TT immunizations.
- 40% of malnourished children are enrolled in a feeding/education group.

Intermediate Goal # 3

Subdistrict team (SDT) and Puskesmas staff adopt a community participatory approach to village primary health care services.

Indicators

- 100% of SDTs develop written plan to supervise and support Posyandu activity.
- SD/Puskesmas staff provide immunization services to 70% of Posyandu, as required.
- 100% SDTs conduct quarterly supervision visits with VSTs.
- 100% of subdistricts implement participatory training events which have as outputs action plans which are followed.

Intermediate Goal # 4

Information, materials and media to support the PHC program developed and utilized.

- Nilai System to assist mothers monitor their children's growth utilized in at least 1 subdistrict.
- At least two materials developed and promoted by project are utilized in a subdistrict.

-22

Outputs

1. 700 VST members representing 51 villages participate in a minimum of 30 hours of CARE coordinated training designed to upgrade Posyandu and kader services as well as specific monitoring procedures in the respective villages.

2. 51 VSTs are provided assistance in developing and implementing 190 workplans for managing village primary health care activities in 51 villages.

3. 500 kader supervisors from 51 villages participate in a minimum of 30 hours of CARE coordinated training designed to assist them in performing the following duties:
   - participate in the selection of kader
   - train kader
   - maintain accurate Posyandu records
   - monitor the quality of Posyandu services
   - ensure that a referral system to the Puskesmas operates.

4. 1000 kader from 51 villages are sufficiently trained to provide appropriate services at each posyandu and effective follow-up services.

5. 30 villages have developed and operate a kader support system.

6. 700 informal village leaders (religious leaders and/or teachers) representing 51 villages participate in a minimum of 25 hours of CARE coordinated training designed to activate them to promote the Posyandu and relay health messages.

7. 150 TBAs representing 50 villages participate in a minimum of 50 hours of CARE coordinated training designed to activate them to promote and/or participate in the Posyandu.

8. 550 Oralit posts/diarrhea treatment centres are established and actively functioning in 51 villages.

9. 40 nutrition education and feeding programs for malnourished children are established in 40 villages.

10. a. 291 Posyandus are operating in four subdistricts and in total are weighing at least 50% of the 23,000 children under 5.
    b. 160 Posyandus are operating which are individually weighing at least 50% of their children under 5.

11. a. 291 Posyandus are operating in four subdistricts and in total are weighing at least 30% of the 6,000 pregnant women.

23

b. 80 Posyandu are operating which are individually weighing at least 50% of their pregnant women.

12. 100 subdistrict team members participate in a minimum of 35 hours of CARE coordinated training for effectively supporting community-based posyandus.

13. Model for sustainable community-based Posyandu developed, tested in 22 villages and results documented.

14. Nilai, child growth grade monitoring system and educational approach, functioning in at least two subdistrict.

15. At least two materials developed by the project for promoting primary health care activities are being utilized in at least three subdistircts.

16. Documentation made of the plan of action required for replicating VPHC's approach to increasing the effectiveness and quality of services offered at the posyandu.

Village Phase-Out Criteria

In order to ascertain when villages have achieved a sustainable level of improved posyandu supervision and implementation, phase-out criteria which can be applied to individual villages have been developed. As intermediate goal indicators apply to one activity across all villages, the phase out criteria select the most important indicators and are applied to individual villages. As a result of the mid-term evaluation, these criteria were developed and applied to 6 villages in East Java. Based on the results, these villages are being phased out in the beginning of 1991 and VPHC is expanding to a new subdistrict. At the end of each semester until the end of the project, these criteria will be applied against any on-going villages to determine if more villages can be phased out before the end of the project period. If possible, this will maximize the project's resources by allowing field staff to concentrate their time on villages requiring more assistance.

These phase out criteria are as follows:

CORE INDICATORS
(100% must be achieved)

1. 70% of posyandu sessions are supervised by VST.

2. VST conducts training for kader.

3. 50% of children under 5 are weighed at posyandu.

4. 70% of posyandu have referral system to Puskesmas operating.

-28

IMPORTANT INDICATORS
(50% must be achieved)

1. VST meets regularly in accordance with agreed schedule.

2. VST implement workplans for priority health problems.

3. 70% of TBAS trained by the project are active in promoting the posyandu, relaying health messages and referring high risk pregnancies.

4. 70% of informal community leaders (religious leaders and/or teachers) trained by the project are actively involved in promoting the posyandu and relaying health messages.

5. Village has at least 2 Oralit posts distributing and restocking their supplies.

6. 80% of posyandus hold monthly sessions.

7. 70% of posyandus operate with 'four table system'.

8. 70% of mothers demonstrate improved health knowledge and attitudes.

9. Kader at 70% posyandu are making home visits.

10. 70% of posyandus have feedback sessions.

11. Children 0-12 months receive immunizations as follows:

BCG	90%
DPT 1	90%
Polio 3	80%
Measles	80%

12. 80% of pregnant women receive TT immunizations.

VPHC hopes that at least 70% of the project's villages will pass these phase-out criteria.

NOTE: It is already anticipated at this half-way mark of the project, the villages in NTB will have difficulty in achieving several of the project's indicators and, hence, several of the phase out criteria. The prime reason for this, the weak village structure in NTB, as well as several other reasons were explained at length in the mid-term evaluation report. Therefore, it is felt prudent at this time to revise downward one specific indicator: the percent of children under 5 attending posyandu. For West Java and East Java subdistricts it will remain at 50%; for NTB the indicator is reduced to 35%.

25

C.2 Priority Population in the Proposed Project Area

	Province	NTB[2]	West Java[3]	East Java[4]	Total
1.	Total number of districts	1	1	1	3
2.	Total number of subdistricts	1	1	2	4
3.	Total number of rural villages	10	17	24	51
4.	Total population	66,750	90,297	107,395	264,442
5.	Total population broken down by target group:				
	a. 0-11 months	2,525	3,346	2,226	8,097
	b. 12-23 months	2,525	3,832	4,461	10,818
	c. 24-59 months	7,577	5,063	7,118	19,758
	d. pregnant women	1,900	3,683	1,147	6,730
	e. women 15-45	12,724	15,280	15,557	43,561
	f Total target (priority) population (a+b+c+e)[5]	25,351	27,521	29,362	82,234

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1 Nilai or grade system transforms a child's monthly age and weight data recorded on a growth card into a whole number or grade (nilai) ranging from one to ten. Each grade is percentile range on the growth curve. Proponents of the system maintain that transformation of age/weight data into grades makes interpretation far easier for parents.

2 For NTB, number of children under five years (12,627) was estimated from provincial and kecamatan information; number of children 0-11 months and 12-23 months, was estimated as 1/5 respectively of number of children under five years old.

3 For West Java, number of total population was collected from kecamatan; number of children under five years age group was collected from kecamatan and Puskesmas.

4 For East Java, number of women 15-45 was estimated as 60% of number of total household in the subdistrict (13,279 household).

5 Number of pregnant women are already included in women 15-45 age group.

26

C.3 System for Enrolling the Priority Age Groups

High Risk Groups Enrolling and Motivation

The priority risk group are children under five years of age. The following criteria will be used to identify children most "at risk":

1. Child has not completed immunization series (Measles, Polio/3, DPT/3)
2. Child has diarrhea (more than three watery stools in one day)
3. Mother does not know how to prevent diarrhea or how to prepare ORS
4. Child begins to loose weight or no weight gain for three consecutive months
5. Child does not come to Posyandu (missed more than two months)

The second high risk target group is pregnant women. The criteria that will be used to identify women most "at risk" are:

1. Does not have two Tetanus Toxoid (TT) immunizations
2. Age: under 20 years or over 35
3. Women with more than four pregnancies
4. Youngest child less than two years old
5. Has vaginal bleeding or other unusual discharge
6. Does not have acceptable weight gain each month
7. Reports having had, in the past, difficult pregnancy, delivery more than 12 hours, abnormal position of child delivery, child die at birth or spontaneous abortion
8. Does not have at least 3 pre-natal check-up by midwife/doctor.

Both high risk groups will be identified by trained health kader through interviews conducted at monthly Posyandu sessions.

The Government of Indonesia (GOI) has set a goal of establishing, by March 1988, at least five Posyandus in each village. This would permit a coverage rate of one Posyandu for 125 children under the age of five years. Enrollment in the Posyandu will be promoted by kader and village leaders. Existing village census data will be used to ensure all target group members are contacted.

Kader at the Posyandu using a specifically designed criteria will identify children and pregnant women most "at risk" and provide the necessary counselling and referral. In addition, kader supervisors supported by community leaders will establish a kader home visiting follow-up procedure, for those identified "at risk" or not attending the Posyandu regularly. Elaborate but often cumbersome attendance records are already maintained at each Posyandu. Child growth cards and pregnancy charts used to monitor weight and immunizations are available and are beginning to be used regularly.

C.4 C.4a - DIP for Immunizations

4a.1 Puskesmas (Health Center) staff are responsible for providing all technical support and services to the Posyandu, including immunization. Therefore, CARE VPHC II relies on the Puskesmas to provide and administer immunizations. CARE's role is to promote, through subdistrict teams and village supervision teams, community participation in all routine immunization activities. The national immunization strategy is to provide BCG, DPT/3; Polio/3 and Measles to children under 12 months old. Pregnant women are provided with TT1 and TT2. In some designated areas women must have TT1 "certificate" before they are allowed to legally marry.

Immunization campaigns will not be sponsored by CARE. Rather CARE promotes routine immunizations along with other Posyandu services. The project may provide supplementary immunization equipment when such equipment is not in sufficient supply and the project effectiveness is severely limited by the lack of such equipment.

4a.2 According to the data compiled by the Central Bureau of Statistics and Ministry of Health the level of immunization coverage is estimated to be 76.7% for BCG, 63.5% for DPT3 and 27.2% for TT2 among women. The project's objective is to increase immunization coverage by facilitating increased participation in immunization sessions in all villages within the target subdistricts. The project's target for immunization coverage is the same as the GOI's targets, as follows:

BCG	90%
DPT 1	90%
Polio 3	80%
Measles	80%

4a.3 Immunizations are provided according to a fixed schedule by the Puskesmas staff at village Posyandu meetings. The amount of vaccines used are calculated based on the estimation of the number of children that require a specific vaccine, number of months between immunization sessions divided by number of doses in a vial. This is handled by the Puskesmas in collaboration in collaboration with the VSTs.

To monitor coverage, every vaccination is recorded on the child's growth card as well as in the immunization register and kader immunization booklet. If a child growth card is lost the immunization history can be checked easily. Tracing defaulters, can be done by systematically reviewing the immunizators or kader record books. This last activity, tracing defaulters, is the responsibility of the kader supervision. VPHC will have a positive influence in ensuring this follow-up occurs.

28

4a.4 To verify whether all required immunizations are given and if the intervals between visits is appropriate, CARE field staff with kader supervisors and village leaders will review and record, on a bi-monthly basis, all Posyandu immunization records. Any defaulters or children missed will be referred to the kader supervisors for appropriate follow-up. Noted discrepancies between appropriate age and required immunizations and length of intervals between immunizations will be reported to the Puskesmas physician.

CARE will follow and promote the following government immunization guidelines:

* BCG, DPT I, Polio	-->	0 > 2 months
* Polio, DTP II	-->	3 - 6 months
* Measles	-->	9 months
* Polio, DPT III	-->	9 - 11 months

For pregnant women, TT I and TT II are provided by the Puskesmas staff when the women come to the clinic or are available at the Posyandu.

4a.5 Cold chain monitoring and maintenance is the responsibility of Ministry of Health. The system is considered reliable and well developed in most areas. The potential problem areas that CARE can most reasonably deal with are the storage of vaccines at the Puskesmas and distribution system to the villages. Frequently, refrigerators are used for other purposes than storage of vaccines. CARE will review with the Puskesmas physician procedures used and encourage that appropriate practices are followed. In areas where cold boxes are not available, the project will provide a limited supply. CARE has a (UNICEF) EPI manual that will be shared with the Puskesmas staff as a basis for planning. [Manual not provided with attachments due to excessive number of pages].

4a.6 Over the past three years the VPHC project has had favorable experiences using surveys to measure mothers' knowledge, attitude and practices (KAP). CARE will continue the practice by conducting baseline and phase-out KAP surveys in the target communities. In addition, CARE's field staff will be specifically trained to monitor the trends of the project interventions.

CARE will coordinate the implementation of village leader and kader leader training opportunities at the village level throughout the year. These training programs are designed to upgrade Posyandu and kader including involvement in promotion of immunizations and related education. Village leaders will plan immunization coverage activities with the local Puskesmas staff responsible for vaccinations at the Posyandu. Kader will provide immunization education at each monthly Posyandu meeting. Home contacts will be conducted by assigned village kader to all parents with eligible children not enrolled in the immunization program.

4a.7 The VPHC II project is not designed to train health workers for immunization delivery. The available Puskesmas health staff will perform the required immunization services. CARE will assist with coordination of local immunizer training as required.

4a.8 Disease surveillance activities will be done by the communities themselves. The trained kaders who live in the communities will indirectly or directly keep the Puskesmas staff informed of disease occurrences. When a disease outbreak becomes apparent, kader and village leaders will be encouraged to follow-up with Puskesmas staff to ensure that the necessary action is taken.

C.4b - DIP for Management of Diarrheal Diseases

4b.1 Mothers with children under the age of five years will be trained by village health kader how to identify potential causes of diarrhea and how to appropriately avoid dehydration. The focus of training will be on helping mothers to know when to use and how to mix at least one type of ORS solution. The following messages will guide the kader educational presentations:
Basic Messages

How to Prevent Diarrhea

1. Wash your hands before feeding your child.
2. Breast-feed your child for at least two years. Feed your child well. When your child is fed properly they are more resistant to diarrhea.
3. Store drinking water in a clean pot. Use a clean container to take water from the pot. Do not put your hands in the drinking water.
4. Wash your hands well after going to the latrine.

How to Take Care of your Child with Diarrhea

1. Give your child plenty of any clean liquid he will drink. Your child is loosing water when he has diarrhea.
2. Give your child one cup of water for each loose stool.
3. Give your child food. Your child needs food to get better.
4. Continue to breast-feed your child.
5. Take your child to the health worker when:
   He has five or more stools in one day.
   He vomits and passes loose stools in the same day.
   He is very dry[6].

The VPHC II project will promote the use of pre-mixed ORS packets that are currently being distributed by Ministry of Health. [Two hundred (200) ml. ORS packets are available in most areas] If packets are not available then the home mix will be taught.

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[6] The Medex Primary Health Care Series, Introduction to Training, A Workbook for Community Health Workers, 1982.

4b.2 The method for determining knowledge, attitude and practices (KAP) of mothers regarding treatment of diarrhea in infants and children will be the same procedures already described in section; DIP for Immunization. Specifically, baseline and phase-out KAP surveys will be used.

4b.3 The best estimates provided by Ministry of Health indicate that the average number of diarrhea episodes are two to three times per year and the length of the episodes are normally less than two weeks. The objective of this component of the project is to reduce the severity of dehydration associated with diarrhea among children five years of age and younger in all villages within four subdistricts. The VPHC project will ensure that at least two kader supervisors from every village are sufficiently skilled to train and supervise other kaders in their community.

The kader supervisors will be responsible for ensuring that all mothers that attend the Posyandu are correctly taught how to mix ORS. In addition, all mothers that report their children as having diarrhea will be visited by a family kader who will provide supplementary education.

In addition, the VPHC II project will assist kader supervisors to establish and maintain a minimum of two ORS depots in each village. The use of ORS packets will be recorded and replacements provided by the Puskesmas.

4b.4 According to the latest survey (1986) conducted by Ministry of Health, 52% of all the families in the target areas use ORS. It is estimated that 70% of the population have been exposed to ORT education in some form. In each of the VPHC II project target areas a baseline survey will be conducted to determine, as accurately as possible, the actual level of ORT education and use of ORS. The VPHC II project objectives is to increase to 70% the number of mothers (with children under five years of age) who report that they would use ORS to treat their child if s/he was suffering from diarrhea.

It is expected that TBAs in the targeted districts will have satisfactorily completed ORT training. It is also planned by the end of the project period there will be, at least, a 30% increase in the numbers of mothers (with children five years of age or younger) who can correctly prepare at least one type of ORS mixture and state how much ORS should be provided to a child suffering from diarrhea. This information will be obtained by comparing the results of the KAP survey administered at the time of phase-out to the baseline survey results.

ORT education will be provided by kader at the monthly Posyandu sessions, in mother group meetings and during home visits. Emphasis will be on promoting and reinforcing positive health behaviors. As a part of the ORT education mothers will be taught preventive health practices, how to mix ORS and to identify signs of dehydration. The ORT education sessions will stress giving children liquids whenever diarrhea occurs. [Emphasis of the educational messages will be "diarrhea doesn't kill, but it does make babies dehydrated -- dehydration kills. Rehydration saves lives"]. In each of the four target areas, kader will be taught that the priority is to follow-up on mothers with children identified as most "at risk".

4b.5 ORS packets are usually available through the Puskesmas. Supply is sometimes irregular but is not a major concern. In NTB the supply of packets has been erratic but it is anticipated that in the future this situation will improve due to funds being provide by a World Bank PHC project. Access to ORS packets in the villages will be enhanced through the establishment of kader managed ORS depots. CARE will monitor the ORS depots and assist as required to keep them functioning. CARE is not planning to purchase or distribute ORS packets during the project period.

4b.6 Since VPHC's emphasis will be on establishing Oralit (pre-packaged ORS packets) posts in every project village, ORS home mix will only be taught in areas where supply of ORS packets is not available or supply is irregular. Home mix technique is well accepted in most households. When it is necessary, the project's standard home mix preparation is:

One (1) teaspoon sugar
One fourth (1/4) teaspoon salt
Mix in 200 ml. (tea glass) of clean boiled water

[This formula is endorsed by the Ministry of Health]. Home ORS mixture is not a cost to the project and the ingredients required are usually available in most homes or in the neighborhood.

4b.7 A major objective of the VPHC II project is to ensure that village health kader train mothers to treat episodes of diarrhea among infants and children. The VPHC staff in cooperation with the Puskesmas personnel and village leaders will help select and train two kader supervisors in all villages. The kader supervisors with Puskesmas and subdistrict government approval will in turn train and support between 10-20 kaders per village. Kader supervisors will be selected on ability to teach, their management ability and willingness to work. Practical tests will be used to ensure that the kader supervisors are sufficiently skilled to perform their jobs.

32

When problems are identified CARE staff with subdistrict government counterparts will conduct problem solving sessions directly with the village leaders and kader. [It is expected that this rapid feedback loop will help to ensure that the project is effective].

4b.8 Health worker's guides for the treatment of cases of diarrhea are provided by the local Puskesmas. CARE will not train or employ clinical staff. Village leaders and kader supervisors will be trained (through organized workshops and village to village cross visits) to correctly educate mothers, assess and refer cases that they encounter. The local subdistrict Puskesmas physician will provide all technical back-up support required.

C.4c - DIP for Nutritional Improvement

4c.1 The best estimate of nutritional deficiencies from the total population of children five years and younger are: 3% malnourished and 30% undernourished. The growth card (refer to Attachment #3) is used as the standard growth monitoring instrument throughout the country. Any child with a weight below the red line is considered malnourished. Data on increased or no growth is recorded monthly and tabulated on a subdistrict basis by the Puskesmas.

4c.2 Lack of knowledge concerning appropriate feeding practices, strong traditional beliefs and low economic status are the major constraints on attempts to improve children's nutritional status. The VPHC II project strategy is to focus on improving the quality of services provided at the monthly village Posyandu. Mothers with young children will be encouraged by local kader to attend the monthly weighing post. At that time, children that are identified as losing weight or at a critical period i.e. weaning age, will be provided special educational and feeding assistance. One form of assistance is the traditional beras jimpitan or family rice collection. Rice is collected monthly from each family and sold to purchase a variety of foods required for malnourished children. The food is then used in group education feeding demonstrations. This form of participation has proven to increase community awareness and ability to find alternative solutions to the child nutrition problems.

The VPHC II staff with village leaders and kader will closely monitor the growth status of children in each village by reviewing the records maintained at the Posyandu. These records note the growth status of all children in the community and helps to determine the ongoing needs as well as the impact of the interventions introduced.

4c.3 The nutritional improvement objectives of the project focus on providing services to the malnourished children in project villages and improving mothers' nutrition knowledge, particularly on the importance of colestrum. It is hoped that a minimum of 40% of the malnourished children will be enrolled in a feeding/education program by the end of the project period. It is also planned that by the end of the project, 70% of mothers will demonstrate at least a 30% improvement in their nutrition - related health knowledge. As with the improvements in ORS - related knowledge, this information will be obtained by comparing the results of the KAP survey administered at the time of phase-out to the baseline survey results.

4c.4 The VPHC II project staff will monitor all growth monitoring activities and ensure that village health kader adequately conduct nutrition counselling and home follow-up.

The type of scale that is available at the Posyandu is a hanging bar balance. Locally available, this type of scale is easy to use and affordable for most communities. Scales are either bought by the communities themselves, provided by the Puskesmas or will be provided as required by the project for a small fee. This fee will be given back to the respective Posyandu for their own use.

Growth monitoring is already considered an established activity in most Posyandu sessions. The objective of the VPHC II project is to upgrade the growth monitoring component and kader follow-up services. Improving growth monitoring activities will be accomplished by working through village leaders and kader supervisors. This will be done in a phased manner by conducting training and supervision with representatives from two to three villages at one time.

4c.5 Growth monitoring is conducted once a month. The Ministry of Health average number of growth monitoring visits per child per year is not known. The objective of the VPHC II project this year is to increase the number of children that attend the weighing sessions and number of home visits per child in each target village. [A baseline was recorded before the project interventions are introduced]. Monitoring the proportion of children by age group and frequency will be done by periodically checking the kader record books. The kader books list the children that attend the Posyandu, their weight gain and those that loose weight each month. These records will be used as the starting point for scheduling kader follow-up home visits. Defaulters can be traced using the kader Register Book. It will be the kaders' responsibility to follow-up on all children that have missed at least two consecutive Posyandu weighing sessions.

4c.6 Kader will be responsible for ensuring that mothers receive the appropriate information that will positively influence the growth of their infants and children. Kader will conduct education sessions at the monthly Posyandu and provide follow-up for children identified as "at risk". A special effort will be made to encourage kader to effectively use the mothers waiting time at the Posyandu for dynamic education presentations. In addition, emphasis will be placed on improving the kader nutrition counselling skills. This will be done, in part, by providing the kader with resource information cards that they can use easily to recall important messages when talking with mothers.

Finally kader will be taught how to organize small groups of mothers for education and discussion sessions. This practice limits kader work load. In the group meetings a participatory approach will be used. Visual aids - flip charts - will be promoted and function as discussion starters. Mothers will be encouraged to express their ideas, opinions on specific topics throughout the meetings. Kader supervisors trained by CARE will learn how to teach and promote mothers participation.

The following messages will be emphasized in all the nutrition educational sessions:

1. Start breast-feed immediately after birth and continue at least 24 months.
2. Start porridge at four months (rice maize, millet, wheat, mashed fruit, potatoes).
3. Add protein foods to porridge (legumes e.g. peas, beans).
4. Give child four good meals a day.
5. Give fruits; vegetables, yellow or orange fruit carrots to children over four months.
6. Sick children need feeding.

4c.7 Village health kader will be trained and supported by the village leaders and supervised by kader leaders. Training began in February 1989. Each training session will be approximately 4-5 days. At least one village leader and kader supervisor training session will be scheduled every month. (Refer to Attachment #4 for a list of the major project activities that will be conducted in each province during FY 1991).

All training will be conducted as much as possible in cooperation with the Puskesmas and subdistrict training teams. CARE staff will conduct routine visits to all villages in the targeted subdistricts to access the level of progress that the village leaders and kader supervisors have had in implementing improved Posyandu and follow-up

services. Quarterly, the existing Posyandu records will be summarized utilizing specifically designed monitoring forms. Following the recording of the data CARE's staff will review the findings with the village leaders and kader supervisors. The data collected will again be evaluated by CARE's offices. If trends indicate that progress is not satisfactory in a specific village CARE staff and their government counterparts will work out appropriate alternative strategies with the village leaders and kaders.

4c.8-9 - Prevention of night blindness is not a part of the VPHC II project. High doses of Vitamin A are provided by the Puskesmas to children and lactating mothers every six months.

C.4d - DIP for Birth Spacing Component

4d.1 Birth spacing practices have been incorporated into the KAP baseline.

4d.2 Birth spacing is not a major component of the project. Family planning services in Indonesia are extensive and financially well supported. The VPHC II project is designed to focus on other critical issues.

The VPHC II project, however, will include birth spacing if provincial government counterparts insist. For example, East Java counterparts have already requested that family planning be included in the project. CARE has agreed to promote birth spacing education and appropriate referral. Modern birth control methods are readily available throughout the country. Kader training on birth spacing will be incorporated into kader training sessions and instruction will follow guidelines provided by the government.

C.4e - DIP for Other Project Interventions

The VPHC II project will include identification of Acute Respiratory infection (ARI) and prenatal education. Respiratory infections are responsible for 14% of all infant deaths. Respiratory infections associated deaths were found in 27% of infant deaths. Influenza and pneumonia are significant killers, representing 25% of all causes of deaths among children under five years of age.

It is evident that respiratory infections are a serious problem among children in Indonesia and should be included as part of the kader work responsibility. Kader need to be able to provide accurate information about Acute Respiratory Infection (ARI) to members of the community and to help them to cope effectively with the problem. Mothers can easily be taught to distinguish between mild, moderate and severe ARI classifications using two main signs - rapid breathing and in drawing of the chest. Kader will be taught to teach

mothers to recognize the signs of ARI, how to care for the sick child at home and when cases must be referred to the Puskesmas for treatment. (Breathing rate in excess of 40-50 per minute is an another sign that a child may need antibiotic help). Kader will not dispense drugs. Most cases of ARI are mild and do not require antibiotic therapy. A specific training module will be developed with the local Puskesmas physician utilizing existing Ministry of Health, ARI training materials. The ARI module will be introduced to kader in a phased manner after kader have adequately mastered and implemented the ORT, nutrition and immunization components. The Posyandu session will serve as the focus point for providing ARI education.

The additional ARI component will not be a significant burden to the kaders workload. Conducting training at the Posyandu will be a relatively easy addition and an efficient means of reaching the majority of the mothers.

Prenatal education will be the second health component that will be phased into the project. Maternal mortality due to complications of pregnancy and child birth accounts for 2.5% of all deaths in the country.

Kader will be taught the following messages:

1. Tetanus vaccination is very important - should be given at the 6th, 7th or 8th month of the pregnancy if the first time or if vaccinated before one booster during the 7th month.
2. Eat right - eat foods rich in protein, vitamin, iron and calcium (chicken, fish, heart, liver, milk, maize, rice, eggs, beans, peas, ground nuts, vegetables with dark green leaves, cassava leaves and cassava roots).
3. Good hygiene - wash regularly and brush your teeth every day.
4. Importance of taking few or no medicines.
5. Stay away from children with measles.

The mothers will also be taught by kader the danger signs of pregnancy i.e. bleeding, multiple pregnancies, young or old maternal age, etc. (refer to section C.3 for a more complete list). It is anticipated that kader will be able to learn the additional lessons quickly and reach most of the expecting mothers at the Posyandu or through home visits. Prenatal care follow-up will be an extra work assignment for kader. The plan is to arrange, through kader supervisors, kader follow-up schedules that do not burden kader and keeps their home visits limited to three or four per week within their own neighborhood.

31

D. HUMAN RESOURCES

D.1 CARE Indonesia primary health care activities are the responsibility of the CARE National Health Project Coordinator, an expatriate based in the Headquarters in Jakarta. She is responsible for all aspects of CARE's health program; administrative and technical oversight, financial management and program administration. The Health Program Coordinator reports to the Deputy Country Director and Country Director who are ultimately responsible for all mission programs and operations. The Project Coordinator receives programming assistance from the Deputy Country Director and an Assistant Project Coordinator.

In addition, the mission has a full time expatriate evaluation officer based in the central office who will be responsible for monitoring and evaluation of all CARE Indonesia's projects. The evaluation officer oversees VPHC project management information systems and assist with subsequent follow-up evaluations. The evaluation officer has more than five years of development work experiences in Sri Lanka, Sudan, Uganda and Bangladesh.

The Training Officer (a national) will set up and coordinate all CARE staff required training seminars and assist with the continued development of village and kader leader training curriculums.

At each of the CARE field offices, there is a Chief Representative, Assistant Chief Representative and Project Manager assigned to the project. Each Chief Representative has a minimum of five years experience in management of development and health related programs. At present, all of the three Chief Representatives are Indonesians. The basic function of the Assistant Chief Representative is to assist the Chief Representative coordinate all field office related planning, administration, program implementation and evaluations. Each Assistant Chief Representative must have one to three years prior experience as a program officer in CARE.

The Project Manager is a senior staff member (Indonesian) who reports to the Chief Representative of the field office. The Project Manager is responsible for overseeing all implementation at the field level and collection of data. In addition to seeking guidance from the Chief Representative, Project Managers consult with the Assistant Chief Representative. Their jobs are to coordinate and integrate all program activities at the field level. Finally, under the Project Manager's supervision are a Project Officer or a Junior Project Officer and Field Officers based in subdistricts. Project Officers and

Junior Project Officers work directly with subdistrict government officials in facilitating their support for the Village Supervision Teams. Field Officers are charged with carrying out project activities in the villages. Data collection and monitoring of project activities in villages are also the responsibility of the Field Officers. Data are collected from existing GOI registrations and from surveys sponsored by CARE. Data analysis and reporting are the ultimate responsibilities of the Project Coordinator and mission Evaluation Officer.

Part-time national consultants will be hired as required to perform specific tasks. For example, one Consultant was hired in 1988 for streamlining the projects monitoring and evaluation systems.

The CARE mission is backstopped by a CARE Regional Technical Advisor for Primary Health Care based in Bangkok and by the Primary Health Care Unit in CARE USA's headquarters in New York. Principally, they provide technical assistance and support and ensure quality control of the project. The CARE Regional Technical Advisor already conducted, an in-country review of the project during 1990. The CARE USA Primary Health Care Unit Deputy Director also assessed the project during a visit made in 1990. The CARE USA Headquarters Regional Manager will also make at least one visit to the project during its lifetime.

D.2 CARE staff have and will regularly participate in training exercises throughout the project period. The training is usually conducted in the field offices or at a central location to all three field offices. The first training session was held for 14 days in November 1988. At this session new and current staff had the opportunity to learn new PHC technical skills taught by local professionals. In addition, the VPHC II staff drafted a village leader and kader supervisor training curriculum, practiced how to collect the required data and conduct interviews with mothers. The training held in June 1989 focused on enhancement of teaching skills. (A schedule of training activities already held as well as new ones planned until the end of the project is in Attachment #5).

D.3 It is anticipated that a over 600 kader supervisors will take part in the VPHC II project during the project period. Identifying feasible cost-effective incentives that will motivate kader to remain active and mothers to regularly attend the Posyandu sessions is an important strategy of the VPHC II project. To accomplish this, it is planned to introduce a variety of service recognition rewards for deserving kader, mothers and villagers. For example, communities will be encouraged to meet the costs of providing training certificates, official shirts, photographs, plaque or transportation money.

39

Posyandu improved and quicker services will hopefully encourage mothers to attend each month. Every effort will be made to upgrade the quality of interaction at each Posyandu to ensure that meaningful services are provided. Mothers who attend sessions regularly will be recognized by the community. Kader follow-up systems will be established for mothers that miss a Posyandu meeting. In addition, dramatic mass-media health messages will be used throughout the villages to educate as well as motivate mothers to attend all Posyandu sessions.

E. PROJECT HEALTH INFORMATION SYSTEM

E.1 The VPHC II project's monitoring system has been designed to track, on a regular basis, all project interventions. The Field Offices, trained as data collectors, will use a participatory approach involving village leaders and kader in the process of monitoring and assessing progress. During village visits existing record systems will be checked and the relevant data will be recorded on specific monitoring forms. This monitoring system is designed to regularly record quantitative as well as qualitative information. Phase-out surveys with mothers will be a key indicator of project impact. GOI subdistrict counterparts will also be involved as much as possible in this monitoring process.

All data collected will be summarized using specially designed computer programs. The VPHC II management information system will use a simple menu driven command that will enable the project management staff to review project progress and problems from any period in the project life.

E.2 As described, information will be collected monthly from the Posyandu, village team, kader supervisors and subdistrict team and Puskesmas. Community leaders and subdistrict teams' management and their impact on project progress will be monitored. Feedback will be provided based on progress and problems identified. The local Puskesmas will be another data resource that will provide information on the numbers of immunization actually conducted, and the number of nutrition and ARI referrals.

The VPHC II project's monitoring system will also use existing records and monitoring forms currently used by Ministry of Health at the Posyandu. Kaders update this information on a monthly basis. The following are the forms commonly used at the Posyandu.

1. **Growth Monitoring Card (KMS)** provides several important indicators such as the monthly weight and nutritional status of each child, a chronological listing of illnesses experienced by the child, and other personal data.

40

2. **Pregnant Mothers Card** monitors each woman's weight during pregnancy and provides information concerning nutrition and immunization.

3. **The Kader Activity Development Book** is used by kader to measure each child's nutritional status, the number of times the child has been immunized and the number of times a child has had diarrhea.

4. **The Teaching Activity Book** is used by kader to record the type of information conveyed to mother groups about immunization, diarrhea prevention and treatment, and nutrition.

5. **The Nutrition, Sickness and Death Form** is used by kader and village officials for measuring the number of children weighed during a specific month, their nutritional status, rate of illness and deaths.

6. **The Monthly Immunization Forms** are used by community health center staff and working groups to monitor the number of children and pregnant women who need to receive immunizations each month as well as the number who have already been immunized.

All information collected will be analyzed at each respective field office. On a monthly basis information will be reviewed and used to determine project needs and priorities.

The CARE evaluation process will use a standard monitoring document supplemented by an initial random sample to establish a baseline and to measure the project impact on various status and coverage indicators.

The CARE monitoring and evaluation system will be an on-going process, based on CARE's standard "Project Implementation Report (PIR)" document. This reporting procedure is accepted by USAID worldwide. CARE will monitor inputs, activity targets, intermediate goal achievements on a semesterly basis. The CARE PIR document submission schedule to CARE Headquarters and USAID is as follows:

31 January	First Semester
31 July	Second Semester

The evaluation strategy will blend formative, impact, and outcome evaluation elements. Formative evaluation will be conducted to determine population's initial beliefs and practices and the acceptability of the various educational messages. The effectiveness of the various training sessions for government official village leaders, kader and Traditional Birth Attendant will be determined through knowledge and practical pre and post tests.

41

CARE procedures also, where appropriate, require narrative field trip reports on project implementation and effectiveness from each of its field supervisors. These reports will supplement normal staffing and expense records basis which are submitted to CARE every month.

Measurable objectives, process indicators, and feedback methodologies have been developed to ensure effective service delivery. Timeliness for each intervention and refinements have been prepared and will be checked monthly to ensure that the processes are on track.

Annual progress reports will be submitted as required to USAID. These reports described plans, progress to date, constraints and highlights from the preceding year.

E.3 During the first year of the project, VPHC had 2 specially trained field staff (Data Collectors) in each field office responsible for collecting information at the village and Puskesmas and subdistrict level. This strategy has dropped, however, after approximately one year because it was found not to be an efficient use of staff. At present, all field officers are responsible for implementing project activities as well as for data collection. Specific data collection forms have been prepared and already revised. All information will be collected from each village. The CARE staff will interview village leaders, kader and mothers, observe kader work activities, and review all existing record books. The CARE staff will monitor these activities in participation with assigned village leaders and kader. As problems are identified the field staff will work with the community members to find possible solutions or report back to the project manager at the field office.

The project manager is responsible for reviewing all data collected. Each month the information from the villages will be entered into a specially designed computer program. This program will enable CARE's project officers to monitor and summarize all information collected. The Assistant Project Coordinator and Evaluation Officer will examine the accumulated records, every three months, to ensure that the monitoring systems are functioning properly. In addition, field visits to selected target villages will be conducted every month by the project managers and other senior staff to confirm the information previously collected, and assist to solve problems identified.

E.4 A baseline survey was conducted in February 1989 prior to implementing project activities in West Java, East Java and NTB. The baseline information was collected in two parts:

1. The data from the monitoring system serves as one part of the baseline source. The information collected the first month will serve as a baseline indicator of the health status in the target subdistrict before CARE interventions are introduced. [Refer to Attachment #6].

2. A Knowledge, Attitude and Practice (KAP) survey of the target population [mothers -- caretakers, with children 0-5 years] is the second source of information. A randomly selected sample population was interviewed. After CARE phases out from the village, a second interview will be conducted in order to assess the degree of change. The methodology for conducting this survey has already been developed. [Refer to Attachment # 7].

   After the analysis of the baseline survey results, it was determined that several of the questions produced either unreliable or unusable data. In addition, the coding system utilized was too cumbersome and required excessive amounts of time for data input. The survey has since been revised, several questions were discarded and the coding system was improved.

Control Sites

Selected villages in a neighboring subdistrict will serve as control sites. The villages in the target or intervention sites were matched as closely as possible using such criteria as a) GOI classification of villages into Swadaya (Selfhelp), Swasembada (Selfsustaining), Swakarya (Selfsupporting), b) Villages have established, working clean water systems and electricity, c) Similar status of Posyandu and kader activities, d) Similar Puskesmas status and Puskesmas [in minutes] from surveyed village, e) Religious and educational facilities in the village, f) Proximity to main roads, g) Level of estimated income, h) Equivalent population men, women and children 0-5 years. Using control sites, coupled with the awareness that the interpretation of the findings requires considerable caution, is regarded as worth the effort to determine the projects true effectiveness as compared to existing interventions now advocated by the government.

Interviews

350 to 375 interviews were conducted in each province as the baseline survey during February to March 1989. The survey was carried out by trained surveyors. The Baseline Survey Summary Report was produced in January 1990. Delays were experienced in producing the report, as mentioned earlier because of the cumbersome coding system. Baseline data was also collected in March 1991 for the new subdistrict of Bandar in East Java.

Mid-term Evaluation. Approximately 20 months after project implementation started, in October 1990, there was an assessment of the project's achievements to determine if its final goals are realistic and can eventually be achieved by the end of the project funding period. The mid-term evaluation was used to assess the projects overall progress and encourage recommendations on how the project could be modified. This document (DIP) is being revised since the projects implementation strategy has changed somewhat since the beginning of the project and the evaluation team recommended changes in the goals and indicators. It was felt that there was sufficient changes to warrant a revision of the DIP.

E.5 A census was conducted in NTB only. This census of 13,000 households started in February 89. After the initial census was conducted, a record system was established and there will be no need to repeat this process in the future.

F. DIP SCHEDULE OF ACTIVITIES

Refer to Format F.

F.1 Refer to Attachment #4 for a description of planned activities: Planning, Implementation Report (PIR).

F.2 Current Status of VPHC II Project

Oct.'88: External evaluation and survey of existing VPHC project activities

Nov.-Dec'88:
* All required project staff hired.
* Twenty day orientation training completed for all project staff.
* VPHC Provincial Detailed Implementation Plan (DIP) prepared.

Jan.'89:
* Training curriculum for village and kader leaders drafted.
* Input for Health Information System prepared.
* Programmer consultants begin to create VPHC reporting system.
* KAP surveys and methodology prepared [field testing completed].
* Negotiations and site selection completed in cooperation with provincial governments of West Java, East Java and NTB.

Feb.-March'89:
* Baseline survey conducted in all three provinces.
* Curriculum materials for training GOI subdistrict village leaders and kader supervisors finalized.
* Monitoring systems field tested and revised as required.

April-Sept.'89	*	Training of village leaders was conducted in each province (43 villages).
	*	Evaluation of training conducted.
October '89	*	Informal assessment of project conducted.
	*	Project focused on the establishment and strengthening of Village Supervision Team (VSTs) with the priority on immunization.
December '89	*	Staff training conducted in each field office.
January '90	*	Village leadership organizations focused on (TBAs, religious leaders, teachers) to increase their involvement in PHC activities.
	*	Monitoring instruments revised.
March '90	*	RTA orientation and assessment
May '90	*	Internal project review by Deputy Director, PHC Unit, CARE/NY
	*	Project Officers meeting held
June'90	*	New monitoring system implemented (HIC)
October '90	*	Project's Mid Term Evaluation Conducted
November'90	*	Plans made for implementing the evaluation's recommendations.

G. DIP FINANCIAL PLAN

45

SECTION G: FORM G: EST. COUNTRY PROJECT BUDGET (IN 1984)

COUNTRY/PVO: Indonesia/CARE (Year 1)

LINE ITEMS:	Person Months	YEAR 1 A.I.D.	YEAR 1 PVO	YEAR 2 A.I.D.	YEAR 2 PVO	YEAR 3 A.I.D.	YEAR 3 PVO	YEAR 4 (6 MONTHS ONLY) A.I.D.	YEAR 4 (6 MONTHS ONLY) PVO	TOTAL A.I.D.	TOTAL PVO	TOTAL
PERSONNEL												
-Technical												
Health Coord. *	9.0	35,670	8,920	30,790	20,530	27,960	18,640	14,680	9,785	109,100	57,875	166,975
Chief Repr., NTB*	3.60	10,300	2,570	9,190	6,130	8,060	5,370	4,230	2,820	31,780	16,890	48,670
Data Collector	72.0	7,130	1,780	5,620	3,740	5,900	3,930	3,100	2,065	21,750	11,515	33,265
Prog. Off. (WJ,EJ)	10.8	4,640	1,160	3,650	2,440	3,830	2,560	2,010	1,345	14,130	7,505	21,635
Field Staff	144.0	38,690	9,670	30,470	20,310	31,990	21,330	16,795	11,200	117,945	62,510	180,455
Eval. Officer *	12.0	12,000	0	7,560	7,040	7,940	7,390	4,170	3,880	31,670	18,310	49,980
SUB TOTAL (TECH.)	251.4	108,430	24,100	87,280	60,190	85,680	59,220	44,985	31,095	326,375	174,605	500,980
-Administration												
Country Director *	2.4	12,390	3,100	10,470	6,990	9,710	6,490	5,100	3,405	37,670	19,985	57,655
Asst. Country Dir.	2.4	3,560	890	2,800	1,870	2,940	1,960	1,545	1,030	10,845	5,750	16,595
Chief Repr.(WJ*,EJ)	10.8	22,450	5,620	17,680	11,780	18,560	12,370	8,100	5,790	66,790	35,560	102,350
Asst. Chief Repr., NTB	3.6	2,780	690	2,180	1,460	2,290	1,530	1,200	805	8,450	4,485	12,935
Admin. (WJ,NTB,JKT)	18.0	4,700	1,170	3,700	2,470	3,890	2,590	2,040	1,360	14,330	7,590	21,920
Acct. (WJ,EJ,NTB,JKT)	28.8	11,310	2,830	8,910	5,930	9,360	6,230	4,915	3,270	34,495	18,260	52,755
SUB-TOTAL (ADMIN)	66.0	57,190	14,300	45,740	30,500	46,750	31,170	22,900	15,660	172,580	91,630	264,210
-Support												
Secr. (WJ,EJ,NTB,JKT)	34.8	7,680	1,920	6,040	4,020	6,340	4,220	3,330	2,215	23,390	12,375	35,765
Driver (WJ,EJ,NTB,JKT)	30.0	3,710	930	2,930	1,950	3,080	2,050	1,615	1,075	11,335	6,005	17,340
Other (WJ,EJ,NTB,JKT)	72.0	8,580	2,140	6,750	4,490	7,090	4,710	3,720	2,475	26,140	13,815	39,955
SUB-TOTAL (SUPPORT)	136.8	19,970	4,990	15,720	10,460	16,510	10,980	8,665	5,765	60,865	32,195	93,060
SUB-TOTAL (PERS.)	454.2	185,590	43,390	148,740	101,150	148,940	101,370	76,550	52,520	559,820	298,430	858,250
CONSULTANT												
-Local												
Technical Consultant	4.0	7,400	0	0	6,000	0	6,300	0	0	7,400	12,300	19,700
Monitoring		6,000	0	900	6,000	940	6,300	2,600	3,300	10,440	15,600	26,040
-Expatriate												
ETA (20 days)		0	4,190	0	4,600	0	4,600	0	0	0	13,390	13,390
SUB-TOTAL		13,400	4,190	900	16,600	940	17,200	2,600	3,300	17,840	41,290	59,130
TRAVEL AND PER DIEM												
Int'l Prof. Training		1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	6,000	6,000	12,000
-In-country												
GOI Proj. Site Support		1,000	0	450	1,100	470	1,160	490	1,220	2,410	3,480	5,890
Proj Staff Travel & Per diem		13,500	4,990	9,680	14,180	10,160	14,890	5,335	7,815	38,675	41,875	80,550
Vehicle Maint./purchased		7,050	1,760	5,350	11,900	5,620	4,500	2,950	2,365	20,970	20,525	41,495
SUB-TOTAL		23,050	8,250	16,980	28,680	17,750	22,050	10,280	12,900	68,060	71,880	139,940
EQUIPMENT & SUPPLIES												
-Technical Equipment												
Cold Chain Box		1,400	0	960	1,287	997	1,358	0	0	3,357	2,645	6,002
Syringes		0	0	500	780	530	820	0	0	1,030	1,600	2,630
Scales		1,200	0	800	920	840	970	0	0	2,840	1,890	4,730
Training Materials		2,200	640	1,580	1,933	1,660	2,030	640	1,030	6,080	5,633	11,713
Training Support		2,700	0	2,040	2,300	2,140	2,420	1,290	1,590	8,170	6,310	14,480
Village Leader Workshop		4,100	0	2,000	2,375	2,100	2,490	2,210	2,610	10,410	7,475	17,885
AV Aids, first yr only		900	0	0	0	0	0	0	0	900	0	900
District Training		815	0	860	850	900	890	950	930	3,525	2,670	6,195
CARE Staff Training		4,000	0	0	0	0	0		0	4,000	0	4,000
-Equipment												
Office Equipment		410	230	400	400	420	420	440	440	1,670	1,490	3,160
-Supplies												
Computer Supplies		815	200	610	460	640	480	640	618	2,705	1,758	4,463
Office Supplies		2,000	800	1,600	1,340	1,680	1,410	1,760	1,480	7,040	5,030	12,070
SUB-TOTAL		20,540	1,870	11,350	12,645	11,907	13,288	7,930	8,698	51,727	36,501	88,228
OTHER DIRECT COSTS		42,980	6,300	23,630	9,120	24,810	9,580	26,050	10,955	117,470	35,955	153,425
PROJECT EVALUATION		0	0	6,000	6,000	0	0	6,300	6,300	12,300	12,300	24,600
TOTAL FIELD COSTS		285,560	64,000	207,600	174,195	204,347	163,488	129,710	94,673	827,217	496,356	1,323,573
OVERHEAD COST 9.24%		26,390	0	19,180	0	18,880	0	11,990	0	76,440	0	76,440
HDQS/HQ COSTS												
- Personnel										0	0	0
- Consultant										0	0	0
- Travel and Per diem		0		0		0		0		0	0	0
- Equipment & Supplies										0	0	0
Other direct costs										0	0	0
SUB-TOTAL		0	0	0	0	0	0	0	0	0	0	0
OVERHEAD ON HQ/HQ COSTS 9.24%		0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL		311,950	64,000	226,780	174,195	223,227	163,488	141,700	94,673	903,657	496,356	1,400,013
cent AID/CARE:		83%	17%	57%	43%	58%	42%	60%	40%	65%	35%	

H. DIP SUSTAINABILITY STRATEGY

H.1 The CARE VPHC II project is designed to maximize the communities' involvement. Training and planning sessions with both Government of Indonesia subdistrict officials and village leaders will be conducted to ensure that the communities' interests and priorities are considered. Project activities will be carried out by the Village Supervision Teams themselves.

CARE staff will not be operational at the village level. Rather CARE project officers will facilitate change by working with community leaders and kader groups. Implementation of planned activities is the village leaders and kaders responsibility. CARE will monitor project impact and continually explore how to solve problems that interfere with successful implementation of project intervention.

H.2 In each province a detailed implementation plan was prepared that was specifically created to fit the needs of that particular area. The provincial plan was based on this overall DIP document. The provincial plans were drafted by CARE project management staff and formally reviewed by the appropriate provincial and subdistrict government counterparts. The provincial plans were approved by the local governments in January 1989.

H.3 Every effort will be made by CARE Indonesia to train national staff to take over full operation of the project. After the recommendations made by the Mid-Term Evaluation team are implemented, there will be 22 national staff directly responsible for implementation of VPHC II project activities. At present, there is only one expatriate (Project Coordinator) involved in the project on a full time basis as well as a British volunteer. Two expatriate senior management staff are associated part time with the VPHC project. A national assistant project health coordinator joined CARE Indonesia in February '89.

H.4 CARE will continue to explore resource generation approaches in order to sustain activities at both the village and subdistrict levels. To facilitate these efforts CARE will seek assistance from CARE's Regional Technical Advisor for Small Enterprise Development (SED). It is also planned that CARE Indonesia staff will participate in SED training.

CARE is planning as much as possible to promote only those activities that can eventually be carried out by the subdistrict government staff. CARE's major contribution is well trained staff, capable of implementing and following up routine as well as innovative strategies. CARE is not providing direct health services but instead is focussing on facilitating the better utilization of existing resources.

41

The project's objective is to have the villagers eventually provide most of the services required themselves. CARE's role is only to provide guidance. During 1988, CARE's VPHC project coordinated with specific villages pre-payment of Puskesmas doctor services. This system worked satisfactorily for short periods of time [six months] but was difficult to maintain.

Puskesmas doctors frequently agree to provide active kader and their families with free health care in return for their voluntary work in their home villages. Again, this approach is effective if monitored closely and there is a degree of trust developed between the doctor and community.

During the second half of the project, an effort will be made to identify incentives that the communities can provide themselves to kader in return for their services. The VPHC II project will encourage community participation by involving local people in the implementation and supervision of the Posyandu. The community's understanding of their role in the Posyandu will be made clearer. Also, the limits of the Puskesmas staff's ability to serve them through the Posyandu will be more apparent thereby highlighting the need for self reliance. Through this better understanding, the project will teach the community the skills necessary to have greater control over the Posyandu and more responsibility for its success.

H.5 Recurrent costs within the project primarily include those involved in the supervision and monitoring of Posyandu, kader teams as well as inservice training for these health workers, village leaders and related subdistrict government officials. The training, supervision and monitoring that CARE will conduct is supplementary to the monthly visits and training conducted by the health center staff and therefore are already included in the MOH budget. It is expected that the health staff and related government department will continue to fund inservice training and supervision activities for Posyandu after VPHC II funding ends.

H.6 CARE's VPHC II project supports the Government of Indonesia's existing primary health care program. CARE's function is to assist local governments and village leaders develop the skills necessary to independently upgrade the quality of services in their communities. The VPHC project is not providing direct health care services. Therefore, there is no possibility that specific health services will not be provided after CARE's support is withdrawn. CARE's role is to assist subdistrict government officials better utilize existing resources and guide village leaders and kaders to implement basic primary health care activities independently.

Dsk.68/VPHCDIP

COUNTRY INFORMATION FOR A.I.D. SUPPORTED PVO PROJECTS

Organization: CARE

Project/Grant No.:

Grant Dates: 1988 - 1992

Funding Mechanism:

(i.e., MG, OPG, Contract, CA, Etc.)

*Country Name or Headquarters: Indonesia

Project Purpose: (limit to 40 words or less)

Maintain sustainability of health service delivery and management system in selected villages; Increase immunization coverage; Reduce severity of dehydration associated with diarrhea and severity of ARI among children under 5 and also improve their nutritional status; Improve prenatal practice of women. The final goal is to reduce the rate of child morbidity and mortality in the selected area.

Project Implementation:

Start Date: September 1988 Estimate Completion Date: September 1992

Status: (limit to 25 words or less)

Project Funding:

	YEAR 1	YEAR 2	YEAR 3	YEAR 4 (6 mos.)	TOTAL
AID$	311,950	226,780	223,227	141,700	903,657
PVO$	64,000	174,195	163,488	94,673	496,356
OTHER					
INKIND					
LOCAL					
TOTAL	375,950	400,975	386,715	236,373	1,400,013

Location in County: (Region, District, Village - Be Specific)

3 provinces (West Java, East Java, Nusa Tenggara Barat) 4 subdistricts.

PVO Representative in Country: (if any) or Program Manger for Headquarters:

(Name) Peter C.A. Middlemiss - CARE Indonesia

(Address) Jl. Bangka I/34, Kemang, Jakarta Selatan

(Phone) 799 6479

Local Counterpart/Host Country Agency: (if no PVO representative)

Provincial Government of West Java, East Java and Nusa Tenggara Barat.

*Complete Separate sheet for each country program and headquarters.

AID 9-26-88 AT

49

FORMAT E: COUNTRY SCHEDULE OF ACTIVITIES (Cont'd)

SCHEDULE OF ACTIVITIES BY QUARTER - (check the box to specify quarter and year)

	YEAR 1				YEAR 2				YEAR 3				YEAR 4							
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4				
6 SERVICES DELIVERY INITIATED																				
- Area 1 Existing services																				
- ORT				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Immunization				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Nutrition				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
Growth Monitoring Promotion				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
Nutrition Education																				
Other																				
- Vitamin A (specify) None																				
- Child Spacing Limited					✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Area 2 Existing services																				
- ORT					✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Immunization					✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Nutrition					✓	✓	✓	✓	✓	✓	✓	✓	✓							
Growth Monitoring Promotion					✓	✓	✓	✓	✓	✓	✓	✓								
Nutrition Education																				
Other ARI, Prenatal Care						✓	✓	✓	✓	✓	✓	✓	✓	✓						
- Vitamin A (specify) None																				
- Child Spacing Limited																				
7 TECHNICAL ASSISTANCE																				
HQ HQ Regional office visits				✓				✓			✓									
Local consultants						✓														
External technical assistance (RTA)				✓				✓												
8 PROGRESS REPORTS																				
Midterm Evaluation										✓										
Annual project reviews/ report						✓														
Final eval/report																✓				

FORMAT E: COUNTRY SCHEDULE OF ACTIVITIES (Cont'd)

SCHEDULE OF ACTIVITIES BY QUARTER - (check the box to specify quarter and year)

	YEAR 1				YEAR 2				YEAR 3				YEAR 4							
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4				
6 SERVICES DELIVERY INITIATED																				
- Area 1 Existing services																				
- ORT				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Immunization				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Nutrition				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
Growth Monitoring Promotion				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							
Nutrition Education																				
Other																				
- Vitamin A (specify) None																				
- Child Spacing Limited					✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Area 2 Existing services																				
- ORT					✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Immunization					✓	✓	✓	✓	✓	✓	✓	✓	✓							
- Nutrition					✓	✓	✓	✓	✓	✓	✓	✓	✓							
Growth Monitoring Promotion					✓	✓	✓	✓	✓	✓	✓	✓								
Nutrition Education																				
Other ARI, Prenatal Care						✓	✓	✓	✓	✓	✓	✓	✓	✓						
- Vitamin A (specify) None																				
- Child Spacing Limited																				
7 TECHNICAL ASSISTANCE																				
HQ HQ Regional office visits				✓				✓			✓									
Local consultants						✓														
External technical assistance (RTA)				✓				✓												
8 PROGRESS REPORTS																				
Midterm Evaluation										✓										
Annual project reviews/ report						✓														
Final eval/report																✓				

Attachment #1

CARE - INDONESIA

VILLAGE PRIMARY HEALTH CARE PROJECT

GRANT APPLICATION FOR THE DEVELOPMENT OF MATERIAL AND EDUCATIONAL AIDS WHICH WILL IMPROVE THE SUSTAINABILITY OF VILLAGE PRIMARY HEALTH CARE PROGRAMS

JAKARTA
DECEMBER 1988

C O N T E N T S

1. INTRODUCTION

2. BACKGROUND

3. PROPOSAL FOR THE DEVELOPMENT OF MATERIALS AND EDUCATIONAL AIDS

4. TECHNICAL ASSISTANCE

5. TIMESCALE

6. MANAGEMENT OF THE PROJECT

7. PRELIMINARY BUDGET

APPENDIX A. Possible posyandu and community health promotion activities.

APPENDIX B. Initial discussions held during the development of the grant application.

1. INTRODUCTION

This application is made in order to undertake the development of materials and educational aids for use within CARE Indonesia's Village Primary Health Care project. It is hoped that leadership management materials and health educational aids which are found to be effective, could be made available beyond the project's immediate target areas.

2. BACKGROUND

2.1 CARE Indonesia's Village Primary Health Care project is now entering its second, four year phase of implementation. A target subdistrict has been identified in each of the three participating provinces, which are Nusa Tenggara Barat, West Java and East Java. Areas of most need have been chosen, and the project will cover all villages within the three subdistricts. The project will focus on the following areas of maternal and child health:

- dehydration treatment and referral (ORT)
- growth monitoring and nutrition counselling
- immunization promotion
- prenatal counselling and referral
- acute respiratory infection counselling and referral

2.2 CARE's project proposal has been agreed with Provincial Government representatives, and the work will be carried out in close cooperation with subdistrict government staff and the staff of the Puskesmas (community health centres). CARE's intervention aims to establish, at village level, an independent, sustainable, primary health care delivery system. CARE staff will concentrate on promoting the involvement of village leaders in the primary health care project and assisting kader supervisors and kader (village voluntary health workers) to develop and carry out their work. It is crucial that the project approach encourages the development of village structures, educational methods, and self-management and evaluation techniques which will enable the kader to sustain the project in the long term. The approach should also be such that it can be replicated in other subdistricts.

2.3 Evaluation of the first phase of CARE Indonesia's Village Primary Health Care project, and experience elsewhere with kader and Posyandu (village or hamlet integrated health post) development, suggests that several issues need to be addressed if programs are to be sustained at the village level.

- account needs to be taken of the differing levels of educational attainment of kader when training materials and reference documents are produced

- individual counselling of mothers at Posyandu is not well developed and ways need to be found of assisting village kader and supervisors with this role

- there is potential for using the time mothers wait at Posyandu for educational activities with mothers and children.

- support for the kader needs to be developed through kader supervisors and village leaders, and ways need to be found of encouraging the active participation of village leadership in promoting, monitoring and sustaining village-level primary health care programs.

3. PROPOSAL FOR THE DEVELOPMENT OF MATERIALS AND EDUCATIONAL AIDS

3.1 This application is made with the aim of improving the sustainability of village primary health care programs.

3.2 Materials will be made available and methods of work developed which will
a) assist the active participation of village leaders in promoting, monitoring and sustaining Posyandu and
b) increase the confidence, skills and management abilities of kader, kader supervisors and village leaders.

3.3 There are many existing materials available for reference by kader and village leaders and for use with mothers. The Ministry of Health, UNICEF and other agencies have produced materials, and further educational aids and creative ways of working are being developed at a local level. This project will collect examples of good practice and identify perceived gaps in materials available. The project will concentrate on making available, and developing, materials and methods which are appropriate for use in villages where kader have received only basic school education and have limited experience of using formal educational materials. Materials should be capable of adaptation to suit local requirements. Low cost materials are required, as there are currently many problems in making existing materials widely available. Materials that can be made within the villages will also be sought.

3.4 Priority will be given to assessing the need for developing the following materials and educational aids, which focus on assisting inexperienced kader and village leaders.

3.4.1 <u>Basic reference cards of health messages for kader</u>

The cards will contain essential information for kader. Simple language will be used, and the design will be such that the cards can be used for quick reference when kader are counselling mothers at Posyandu or during home visits. It may be possible to develop a way of enabling kader to make their own cards, to increase their participation and reduce costs. The health messages are currently being drafted by CARE staff.

3.4.2 Aids to assist village leaders manage posyandu

The existing government booklets for village leaders will be used for training. Aids will be developed that can assist village leaders implement what they have learnt. The aids should assist villages to sustain Posyandu and kader activities without the support of CARE.

3.4.3 Activity Calendar for kader supervisors

The calendar will help kader supervisors structure their program of work and record progress, and will provide ideas for new activities. It aims to sustain the interest of both kader and mothers in the project by increasing the variety of activities undertaken and by helping kader supervisors monitor the effectiveness of their work.

3.4.4 Guidebook to activities that can be promoted at Posyandu/resources catalogue

This guidebook will bring together examples of good practice and illustrate how these activities can be developed within villages. The guidebook will focus on low cost activities and materials that can be developed locally. It may also be useful to catalogue materials available that can be purchased. In the process of developing the guidebook, activities and materials will be tried and tested at CARE project sites. Appendix A lists a number of activities which might be considered for evaluation. The guidebook would be made available to other agencies involved in promoting Posyandu.

3.5 The proposals listed under 3.4. need further evaluation before a firm commitment is made to their development. Consultation with a number of agencies and individuals has already taken place (see Appendix B), but further discussions will be undertaken before a final decision is made on how the grant monies will be expended. A further report will be submitted, identifying any variations in the proposal. This initial consultation period will be concluded by 28th February 1989.

4. TECHNICAL ASSISTANCE

CARE will employ yayasan, and other Indonesian specialist agencies, to undertake technical aspects of the design and production of materials and educational aids. CARE already has experience of working with several specialist agencies in Indonesia.

56

5. TIMESCALE

All materials and aids should be completed by 31 March 1990. The second phase of CARE Indonesia's Village Primary Health Care project is a four year program, 1989 - 1992. During the year 1989/90 materials and aids will be developed at the CARE project sites, and in following years should be brought into regular use.

6. MANAGEMENT OF THE PROJECT

Margaret Newens, a volunteer with Voluntary Service Overseas, has recently arrived in Indonesia to assist with CARE's Village Primary Health Care project in NTB. As one of her tasks, she will coordinate the implementation of this project to develop materials and educational aids. She will be supervised by Rick Henning, CARE Indonesia's National Health Program Coordinator. There will be full participation of CARE's national Project Managers and Project Officers at all stages of the development and implementation of the project.

7. PRELIMINARY BUDGET

Exchange rate: 1 pound = Rp.3,199.54

		Rupiah	Poundsterling
7.1	Reference Cards		
	Design and Reproduction	3,000,000	937.63
7.2	Aids to assist village leaders		
	Consultants' fees	4,500,000	1,406.45
	Initial printing and testing	1,000,000	312.54
	Revision	1,000,000	312.54
	Reproduction	3,500,000	1,093.91
	Sub total	10,000,000	3,125.45
7.3	Activity Calendar		
	Consultant's fees	1,500,000	468.82
	Initial printing and testing	1,000,000	312.54
	Revision	500,000	156.27
	Reproduction	2,000,000	625.09
	Sub total	5,000,000	1,562.72

7.4	Guidebook to Activities		
	Purchase of materials	2,500,000	781.36
	Testing of materials	2,000,000	625.09
	Development of low cost activities	2,500,000	781.36
	Design of guidebook	2,000,000	625.09
	Reproduction	3,400,000	1,062.65
		12,400,000	3,875.55
7.5	Travel and Administrative Costs	1,500,000	468.82
7.6	Grand Total	31,900,000	9,970.17

58

APPENDIX A

Possible Posyandu and Community Health Promotion Activities

1. Locally developed games.

2. Demonstration methods e.g., for nutrition.

3. Ways of facilitating group discussion e.g., taped stories.

4. Activities while mothers and children wait at Posyandu e.g., play group, aerobics, wayang puppets with taped stories.

5. Collection of local information, e.g., through photographs, to stimulate kaders' and mothers' discussion of health issues.

6. Visual materials such as flip charts and flannel graphs.

7. Story telling, using traditional media e.g., wayang, ketoprak (traditional drama performed by women), local story tellers.

8. Cerdas cermat. This quiz game could be developed to cover health related issues.

9. Local newspaper or comic to transmit ideas and information between hamlets and to the local community.

10. Special occasions, such as Independence Day, during which competitions are organized and developed related to health issues.

11. Teaching through mosques (using UNICEF materials).

12. Use of public address systems, e.g., from mosques and village systems where available, to transmit messages.

59

APPENDIX B

Initial Discussions Held During The Development of The Grant Application

1. UNICEF Jakarta

   Daniel Dravet - Project Officer, Health Education
   Jacqueline Peters - Project Officer, Nutrition Education

2. Bandung Provincial MOH.

   dr. Dadi S. Argadiredja - Head of Programming and Evaluation Section.

3. Dinas Kesehatan, Bandung.

   Kepala Dinas Kesehatan Kabupaten Bandung.
   dr. Etty - Community and Education Counselling.
   dr. Suparman - Community and Education Counselling.
   dr. Murty - Family Nutrition Improvement Program.

4. Dinas Kesehatan, Bandung. PKK.

5. Cibodas Village.

   Representative of village leadership, kader and staff member from Puskesmas.

6. CARE Project Officers from NTB, Jawa Timur and Jawa Barat.

Attachment #2

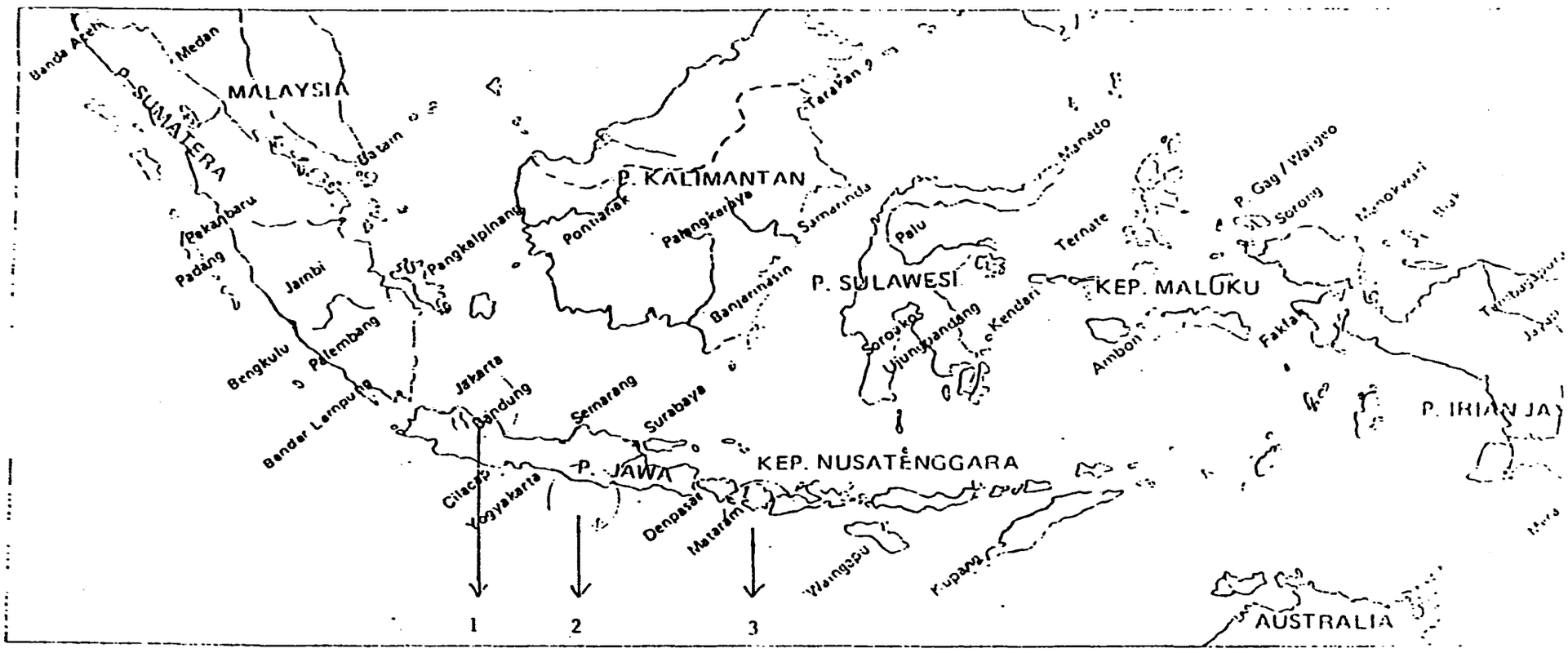
MAP OF PROJECT LOCATION

VPHC II

Attachment #2

PROJECT LOCATION - VPHC II

CARE INDONESIA



NOTE: Province	# of Village	Subdistrict	# of Total Population	IMR
1. West Java	17	Gunung Halu	90,297	74 /1,000
2. East Java	24	Tulakan, Bandar	107,395	70 /1,000
3. NTB	10	Gunung Sari	66,750	126 /1,000

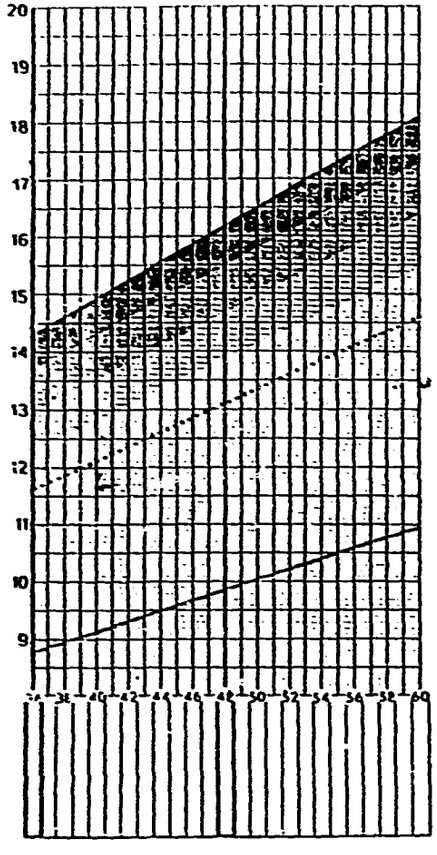
62

Attachment #3

CHILD GROWTH CARD AND

PREGNANT WOMEN CARD

Umur 3-4 tahun Umur 4-5 tahun



CATATAN PEMBERIAN IMUNISASI

Bayi umur 3 – 14 bulan	Tgl. diberikan Imunisasi		
	I	II	III
B.C.G.			
D.P.T.			
Polio			
Campak			

- Mintakan Imunisasi untuk anak umur 3 sampai 14 bulan.
- Setiap anak membutuhkan Imunisasi untuk menjaga kesehatannya.

Mintalah Imunisasi pada waktunya.

KAPSUL VITAMIN A-DOSIS TINGGI:

(Diberikan hanya kepada anak balita kecuali bayi sampai umur 1 tahun, satu capsul setiap 6 bulan).

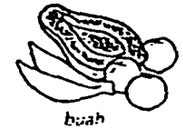
Tanggal diberikan ke 1:
ke 2:
ke 3:
ke 4:
ke 5:
ke 6:

PETUNJUK PEMBERIAN MAKANAN YANG SEHAT

Selain Air Susu Ibu berikanlah makanan tambahan

umur 4-6 Bulan

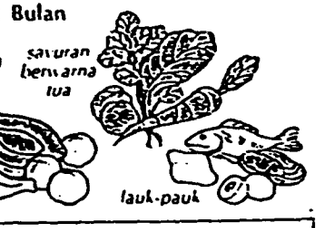
makanan lumat



buah

umur 7-12 Bulan

makanan lembik



sayuran berwarna tua

buah

lauk-pauk

CONTOH BAHAN MAKANAN SEHAT

TIDAK DIPERDAGANGKAN

KMS

KARTU MENUJU SEHAT

Nama Anak: .....

AIR SUSU IBU
makanan bayi terbaik

Diperbanyak oleh
Yayasan Indonesia Sejahtera
dengan izin Departemen Kesehatan Republik Indonesia
1985

64

DIISI OLEH PETUGAS

Pos Penimbangan	
Tanggal Pendaftaran	No. Pendaftaran

Nama Anak			
Laki-laki		Anak yang ke	Tanggal Lahir
Perempuan			
Berat Badan Waktu Lahir			gram
Nama Ayah Pekerjaan			
Nama Ibu Pekerjaan			
Alamat			

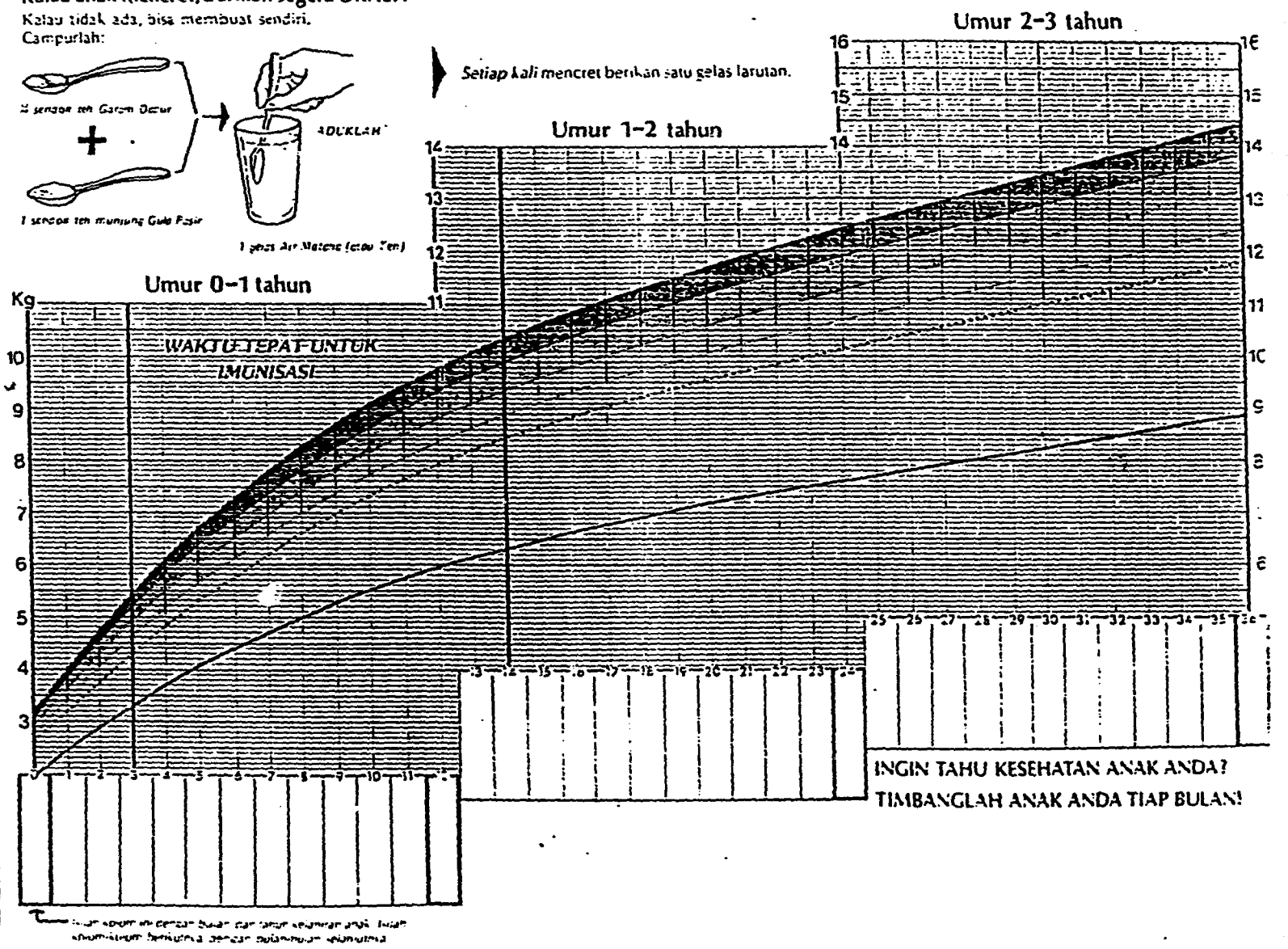
CATATAN PENYAKIT YANG DIDERITA

No.	Tanggal	Gejala

Kalau anak mencret, berikan segera ORALIT

Kalau tidak ada, bisa membuat sendiri.
Campurlah:

Setiap kali mencret berikan satu gelas larutan.



BERIKAN PERHATIAN DAN PENJELASAN APABILA ADA SATU ATAU LEBIH TANDA V PADA FAKTOR RESIKO

Berilah tanda v kalau benar, o kalau tidak, jangan disi jika tidak diketahui

FAKTOR RESIKO

1. TB < 140 cm ☐
2. Umur < 15 tahun ☐
3. Umur ≥ 35 tahun ☐
4. Tidak pernah sekolah atau SD 1-3 tahun. ☐
5. Pernah sakit menahun ☐
6. Jarak kehamilan terakhir < 6 bulan ☐
7. Tekanan darah diastole ≥ 90 mm Hg. ☐
8. Anemia berat (Hb < 8 g/dl) ☐

KELAHIRAN INI

Lahir : hidup/mati/keguguran*

Tanggal : Lk/Pr*

Ditolong : dokter/bidan/dukun*

Tempat : Rumah Sakit/Klinik bersalin/Rumah Bidan/Rumah sendiri*

Berat lahir : gram

Panjang lahir : cm

* Coretlah yang tidak sesuai.

PUSKESMAS :

No. pendaftaran :

Nama suami :

Pekerjaan suami :

Umur ibu :

Pendidikan ibu :

Pekerjaan ibu :

Tanggal hari pertama haid terakhir :

Tanggal perkiraan melahirkan :

RIWAYAT KEHAMILAN

No.	Kelamin*	Umur	Hidup	Mati	Catatan
1.					
2.					
3.					
4.					
5.					
6.					
7.					

G ☐ F ☐ A ☐

* Pada kolom ini, kalau keguguran ditulis keguguran disertai umur kehamilan.

Pernah sakit menahun : ya / tidak*

Kalau ya : Tbc, kuning, ginjal, kencing manis*

Jarak kehamilan terakhir . . . . . bulan.

Pernah ikut KB : ya / tidak*

Dengan cara : pil/spiral/kondom/pantang berkala/mop/mow*

Berhenti ikut KB : . . . . . tahun yang lalu

* Coretlah yang tidak sesuai

MAKANLAH LEBIH BANYAK DAN BERANEKA - RAGAM SUPAYA BERAT BADAN IBU NAIK DAN JANIN TUMBUH DENGAN SEHAT

ANJURAN KHUSUS :

- Minumlah tablet tambah darah pada waktu hamil
- Minumlah vitamin A dosis tinggi setelah melahirkan
- Vaksinasi BCG untuk bayi sebelum berumur 2 bulan
- Ikutilah program KB, segera setelah bayi lahir

KMS

(KARTU MENUJU SEHAT)

IBU HAMIL

Nama ibu :

Alamat :

IBU HAMIL DENGAN KESEHATAN DAN GIZI BAIK, AKAN MELAHIRKAN BAYI YANG SEHAT

PUSAT PENELITIAN DAN PENGEMBANGAN GIZI

Badan Penelitian dan Pengembangan Kesehatan
Departemen Kesehatan R.I.
Jalan Dr. Sumeru - Bogor.
1985

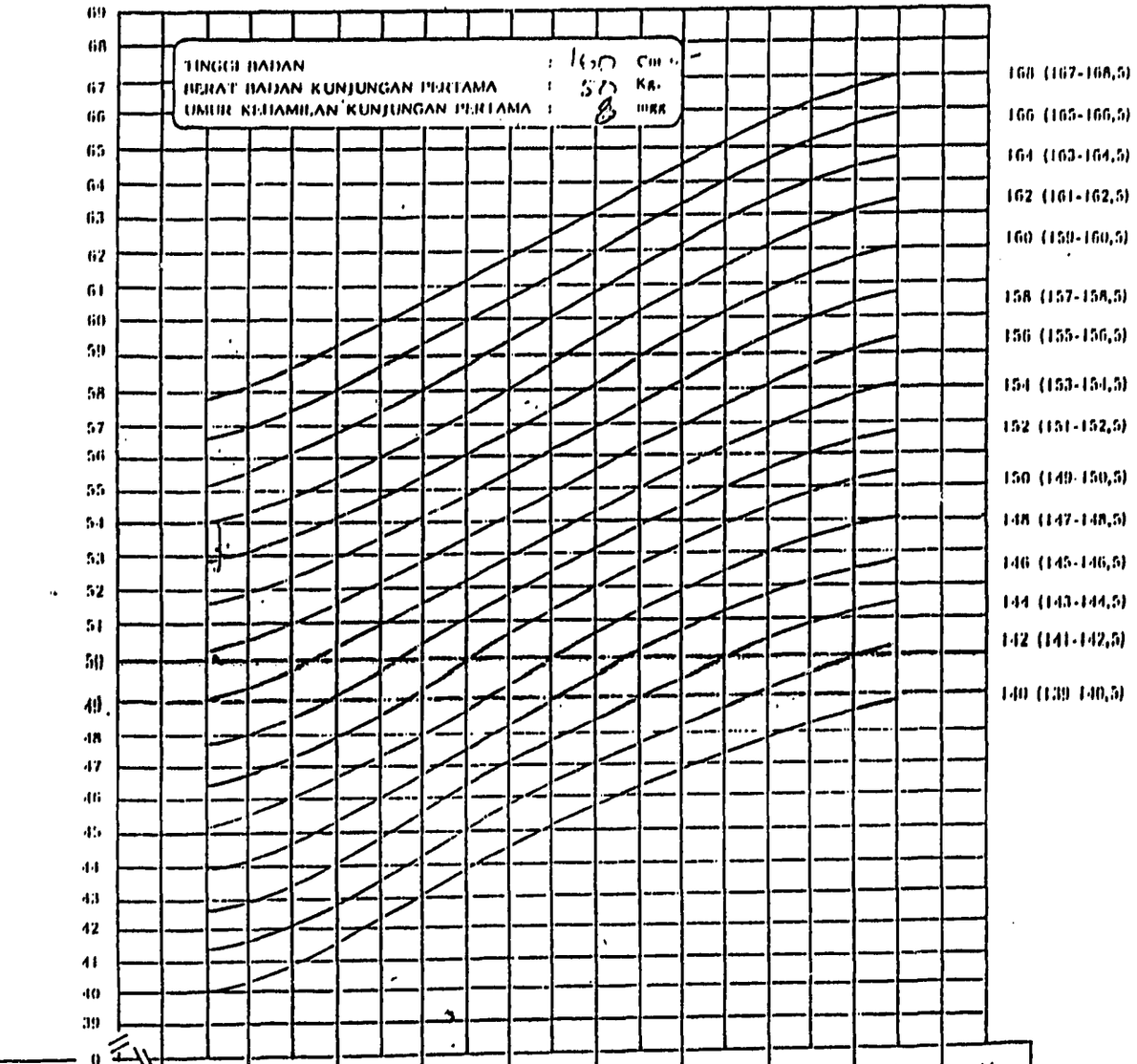
BERTAMBAH UMUR KEHAMILAN, BERTAMBAH BERAT BADAN IBU.

PETUNJUK MENGISI KMS

1. Tebalkanlah garis kurva yang sesuai dengan tinggi badan ibu.
2. Cantumkanlah berat badan (BB) ibu menurut umur kehamilan dengan tanda titik (.).
3. Bila titik BB terletak di atas garis kurva tebal maka ini berarti baik. Bila terletak di bawah garis kurva tebal maka kehamilan ibu kurang baik, berarti ibu harus lebih sering memeriksakan kehamilannya.
4. Hubungkanlah titik BB hasil pendahulunya pada saat ini dengan hasil pemanjangan BB sebelumnya.

KURVE BERAT BADAN IBU HAMIL

TINGGI BADAN : 160 cm
BERAT BADAN KUNJUNGAN PERTAMA : 57 Kg.
UMUR KEHAMILAN KUNJUNGAN PERTAMA : 8 mgg



Umur kehamilan (mgg)	8	12	16	20	24	28	32	36	40	41
Tanggal pemeriksaan										
Berat badan										
Letak janin										
Detil jantung janin										
Tekanan darah										
Edema										
Hemoglobin										
Vaksinasi TT										
Tablet tambah darah										

Attachment #4

Project Implementation Report

(PIR)

Major Project Activities

FY 1991

Fiscal Year: 1991

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AID 1.2

PN: 33

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
INPUTS										
PERSONNEL INPUTS:										
Management staff: 43.68 mos.(Int'l:13.32, Nat'l:30.36)	21.84	21.98	- 0.14	21.84			43.68			
Sta.:136.08 mos.(WI:32.4), EI:22.68,NTB:38.88,JKT:42.12)	68.04	67.68	- 0.36	68.04			136.08			
Field staff:192.0 mos.(FD:36.0, FC:156.0)	96	96	0	96			192			
OUTPUTS										
GOALS, INDICATORS, AND PROJECT ACTIVITY TARGETS (PATs):										
INTERMEDIATE GOAL #1										
Village Supervision Team (Tim Pembina Desa) operates independently to improve and maintain village health system.										
INDICATORS:										
- 70% of VSTs meet regularly in accordance with agreed schedule.	70%	67%	-3%	70%			70%			
- 70% of Posyandu sessions held are supervised by VSTs.	-			70%			70%			
- 70% of VSTs conduct training for kader.				70%			70%			
- 70% of TBAs trained by the project are active in promoting the Posyandu and relaying health messages and referring high risk pregnancies.	-			70%			70%			
- 70% of informal community leaders (religious leaders and/or teachers) trained by the project are actively involved in promoting the Posyandu and relaying health messages.	-			70%			70%			
- 70% of villages have at least 2 oralit posts distributing and restocking their supplies.	-			70%			70%			

69

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
PROJECT ACTIVITY TARGETS:										NOTE: All numbers refer to the number of villages involved in the activity.
- Refresher training held for VST on Posyandu management.	-			43			43			
- Project is expanded into 6 new villages in new subdistrict in East Java.	-			6			6			
- VST's develop workplan for second intervention.	10	13	+3	33			43			
- Refresher training held for Kader Pembina in West Java only.	2	1	-1	15			17			
- VST trained in the establishment of Posyandu evaluation sessions during monthly meeting.	10	15	+5	33			43			
- VST trained in the establishment and administration of health costs during monthly meeting.	10	23	+13	33			43			
- VST trained in the establishment and administration of nutrition feeding education program during monthly meeting.	10	8	-2	33			43			
- VST trained and/or assisted in developing/implementing immunization target list during monthly meeting.	10	24	+14	33			43			
- Train new kader in NTB (10) and East Java (1) only.	11	11	0	-			11			
- Community self-survey in East Java only.	8	8	0	-			8			
INTERMEDIATE GOAL # 2										
Comprehensive and convenient posyandu services are regularly functioning in all villages.										
INDICATORS:										
- 80% of posyandus hold sessions monthly.	80%	90%	+10%	80%			80%			
- 43% of children under 5 weighed Posyandu.	25%	45%	+20%	43%			43%			
- Kader at 70% of Posyandu are making home visits.	42%	45%	+5%	70%			70%			
- 50% of Posyandu complete F1 form monthly.	-			70%			70%			
- 70% of Posyandu have referral system to Puskesmas operating.	-			50%			50%			
- 50% of Posyandu have feedback sessions. (FY92 - 70%)	25%	52%	+27%	50%			50%			
- Children 0 to 12 months receive immunizations as follows:										
BCG 90%	-			90%			90%			
DPT 1 90%	-			90%			90%			
Polio 80%	-			80%			80%			
Measles 80%	-			80%			80%			
- 80% of pregnant women receive 2 TT immunizations				80%			80%			
PROJECT ACTIVITY TARGETS:										
- Develop system for the referral of sick children from Posyandu to Puskesmas.	-			3			3			

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
- Guidelines developed for sustainable community based Posyandu	-			1			1			
- Follow-up action taken on guidelines developed for sustainable community based Posyandu.	-			3			3			
- Establish beginning PHC services in underserved/ isolated areas of NTB.				5			5			
INTERMEDIATE GOAL # 3										
Subdistrict Team and Puskesmas staff adopt a community participatory approach to village primary health care services.										
INDICATORS:										
- 100% of SDTs develop written plans to supervise and support Posyandu activities.	100%	100%	0	100%			100%			
- SDT/Puskesmas staff provide immunization services to 70% of Posyandu, as required.	70%	90%	+20%	70%			70%			
- 100% of SDTs conduct quarterly supervision visits to VST.				100%			100%			
- 100% of SDTs implement participatory training events which have as outputs action plans which are followed.	-			100%			100%			
PROJECT ACTIVITY TARGETS:										
- TBAs trained in promoting posyandu in NTB (40) and East Java (12) only.	40	77	+37	12			52			
- CARE/SDT workshop at subdistrict and village level for religious leaders and/or teachers in NTB and East Java only.	2	1	-3	-			2			
- Baseline survey conducted in new subdistrict in East Java.	-			1			1			
- Workshop on VPHC project held in new subdistrict in East Java.	-			1			1			
- Phase out survey conducted in old subdistrict in East Java.	-			1			1			
- Joint quarterly visits between CARE and subdistrict to VST and/or Posyandu (2 x 43 villages per semester).	86	35	-51	86			86			
- Subdistrict planning and evaluation workshop (NTB - 1, East Java and West Java - 2 each).	2	5	+3	3			5			
- Joint visit between CARE and provincial/district staff to subdistrict (1 per subdistrict).	2	5	+2	3			11			
- Puskesmas staff trained by CARE/Puskesmas management staff on EPI in West Java only.	1	1	0	0			2			
- PKK training in NTB villages.	10	10	0	-			10			

Fiscal Year: 1991

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 30

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
INTERMEDIATE GOAL # 4										
Information, materials and media to support the PHC program developed and utilized.										
INDICATORS:										
All indicators will not be measured until FY 93.										
PROJECT ACTIVITY TARGETS:										
- IPVC partnership investigated and report prepared.	1	0	-1	-			1			
- Study conducted and report prepared in kader incentives including review of literature.	1	1	0	-			2			
- Meeting held with SDT and Puskesmas staff to discuss results and future use of Nilai System.	-			3			3			
- Meeting held with appropriate officials regarding future use of materials developed.	-			3			3			
- Plan developed and implemented for further testing and/or implementation of selected materials.	-			1			1			
- Draw performance on health messages in East Java only.	2	3	+1	0			5			
Staff Development Project Activity Targets										NOTE: Numbers refer to the number of staff involved.
- External training	12	11	-1	4			27			
- In-service training	17	17	0	17			51			
- Cross Visit				6			6			

Attachment #5

SCHEDULE OF TRAINING ACTIVITIES

FOR CARE VPHC II STAFF

Attachment #5

SCHEDULE OF TRAINING ACTIVITIES

FOR CARE VPHC II STAFF

Dates	Topic	Duration
November 1988	PHC knowledge & training skill a. project strategy b. develop project workplan	14 days
December 1988	Review project workplan	4 days
January 1989	KAP Surveys	3 days
June 1989	Training for Trainers a. Integrated FP-Health b. Kader's role c. PVO & GOI relationship	4 days
April 1990	Immunization Training	4 days
May 1990	Project Review	3 days
March 1991	Orientation and Skills Building for new staff	4 days
September 1991	Staff refresher training	5 days

Attachment #6

Village Primary Health Care II (VPHC)

MONITORING SYSTEM

15

VILLAGE PRIMARY HEALTH CARE II

MONITORING SYSTEM

(English)

CARE INDONESIA

March 1991

76

CONTENTS

I. Introduction to CARE-Indonesia's Monitoring System

II. VPHC II Monitoring System

III. Installation and Maintenance the Computer Program of VPHC II Monitoring System

IV. VPHC II Monitoring Flowchart

V. Monitoring Framework

VI. Activity Monitoring Form (AMF)

VII. Health Information for CARE (HIC)

VIII. Village Report Form (VRF)

IX. Field Office Summary Form (FOSF)

I. INTRODUCTION TO CARE INDONESIA'S MONITORING SYSTEM

CARE Indonesia's goal is to have a monitoring system which is similar in methodology for all projects. To reach this goal CARE Indonesia is adopting a simple and easy to use methodology. The essentials of this monitoring system are an activity monitoring form and a summary sheet around which discussions can take place between management and field staff. Additional monitoring tools relate to the specific requirements of individual projects.

The system has five main purposes:

1. Activity guide for field staff
2. Planning tool
3. Indication of project progress/problems
4. Material for discussion at the monthly meetings between field staff and management.
5. Reporting information, particularly for the PIR.

The basic elements of the VPHC monitoring system are described in Section II and are illustrated in the flowchart in Section IV.

II. VPHC II MONITORING SYSTEM

The Village Primary Health Care II (VPHC II) monitoring system has a number of components:

1. Activity Monitoring Form (AMF)
2. Health Information for CARE (HIC)
3. Village Report Form (VRF)
4. Field Office Summary Form (FOSF)
5. AIP 1.2 of PIR (Project Implementation Report)

These components will be considered in turn.

1. Activity Monitoring Form (AMF)

a. This form is to assist field staff to plan and monitor activities at the village and subdistrict level. The progress made in each village and at the subdistrict level should be reviewed and recorded <u>every month</u>. For each activity being/already implemented, the field staff should justify whether the Village Supervision Team (VST) or Subdistrict Team (SDT):

A = able to conduct the activity independently
B = still need supervision/facilitation from CARE staff
C = fully dependent on CARE staff

This scoring is to decide whether further assistance is required to improve the quality of work of the VST or SDT. Field staff, however, are allowed to add significant activities conducted by VST or SDT that are not specified on the form but which indicate progress, on the blank lines provided.

b At the end of each section, the relevant goal indicators are listed. At the close of each semester, the concerned field staff should score them as follows:

V Achieved
O Not Achieved yet

These goal indicators are consistent with the AIP 1.2 and PIR. These goal indicators are used to summarize progress in each village and at the subdistrict level.

c. At the village level, this form is to be completed by Field Officers for goals 1 and 2 under supervision of Project Manager/Officer. Unless the FO is working with the SDT, the section under goals 3 and 4 will remain blank.

19

d. For the subdistrict level, goals 3 and 4, the AMF should be completed by the concerned staff working with the subdistrict, either PM, PO, JPO or FO. The sections under Goal 1 and 2 will remain blank and only Goals 3 and 4 will be completed. If more than one staff member is working with the subdistrict, all concerned staff should complete the AMF for goals 3 and 4 and discuss their differences in scoring. The PM should discuss any differences in scoring and obtain a final summary score.

e. This form is to be used in the Field Office only, not for submission to CARE International Indonesia Headquarters (CIIHQ).

2. **Health Information for CARE (HIC3 and HIC4)**

a. These forms provide information on the indicators achieved in terms of the level of VST establishment, Posyandu services and the impact in the community.

b. HIC3 contains information at the village level. The Field Officer should aim to collect information at the village level, with the assistance of the VST. The Field Officer should assist the VST to <u>display</u> important items of information, to encourage them to use information to review and plan activities.

c. It is <u>important</u> that the Field Officer works with members of the VST in collecting this information, so that they understand the data and are concerned to make it accurate. If the Field Officer is aware of inaccuracies in the data, correct it as much as possible before submitting to CIIHQ. Ensure that the Field Officer discuss inaccuracies with the VST, so that they learn how to improve the quality of the data.

d. The information should be collected every three months, and summary figures for the three month period will be calculated where shown, using the Lotus 1-2-3 program.

e. Data from the HIC3 of each village will be accumulated on to one HIC4 for the Subdistrict using the Lotus 1-2-3 program.

f. HIC 4 should be sent to CIIHQ every three months. It is, due in CIIHQ within 2 weeks after the close of the quarter i.e. by 15 April, 15 July, 15 October and 15 January.

g. The HIC4 will also automatically summarize data at the end of each semester. This information can be utilized directly by the field office to produce their PIR.

80

h. Some notes on completing HIC3 and HIC4.

i. At the head of the form:
Total Under Fives (0 < 60 month) [$]
Total Babies (0 < 12 month) [H]
Total 1-4 years old (12 < 60 month) [J]
Total Pregnant women [G]

These should be the best estimates available for the total number of children under five in the villages. The figures entered here will be used as denominator to calculate Posyandu attendance rate and immunization coverage.

Jumlah Ibu Hamil should be the best estimate available for the total women pregnant during the year. It will be used as denominator to calculate TT immunization coverage.

ii. No. 8.1 and 8.2, these figure for:
Number of children <5 years (0 < 60 month) [S]
Number of children weighed [D]
should be taken from the F1/Gizi (Laporan Bulanan Kelompok Penimbangan) forms submitted from the Posyandu meetings that month.

iii. Field Officers should encourage the VST to maintain an up-to-date register of all children <5 years in each hamlet. New born babies should be regularly added. Children <5 years who have died or moved away should be regularly deleted. Children reaching five years of age should be regularly deleted. An up-to-date register is essential in order to know the target group for services such as immunization, as well as for monitoring community participation.

3. **Village Report Form (VRF)**

a. Once every two months, a Village Report Form should be completed for each village. This should be done after the supervision meeting between the Project Manager/Officer and Field Officers to review the Activity Monitoring Forms. The VRF should be used to summarize the main areas of progress, issues needing attention and constraints, and planned action.

b. The form is for use in the Field Office, but may be requested by CIIHQ occasionally.

4. **Field Office Summary Form (FOSF)**

a. The Field Office Summary Form is to keep CIIHQ informed about progress towards meeting Project Activity Targets and goals, issues needing attention and constraints, and planned action in the VPHC program.

-91

b. It should be completed by the Project Manager and sent to CIIHQ by the 5th working day following the end of each month. This form must be in English. In the first section, Areas of Progress, list all Project Activity Targets (PATs) accomplished that month. List the field office's target as well as the actual for that month only. Do not list actuals from other months. This should not be cumulative.

Example:

PAT

		Plan	Actual
1.	VSTs develop workplan for 2nd intervention	10	2
2.	Joint quarterly visit between CARE and SDT	32	10

Reporting this information on a monthly basis will assist the field office to prepare their PIR at the end of the semester. It will also enable CIIHQ to monitor field office progress towards reaching their goals.

Also include in this section a general discussion of progress towards overall achievement of project goals.

5. **AIP 1.2 of Project Implementation Report (PIR)**

a. The information required for the AIP 1.2 of the PIR is consistent with that included on the AMF and HIC. Therefore, the data reported in the PIR should be consistent with the information supplied through the AMF and HIC.

b. In addition, a Baseline and Close-out KAP Survey, with a limited number of questions, will be used to measure mothers' knowledge, attitudes and practice in relation to the Posyandu programs. A close-out survey will be implemented in all sites. Information from the Close-out KAP survey will be used to measure achievement of some of the goal indicators.

92

III. INSTALLATION AND MAINTENANCE OF THE COMPUTER PROGRAMS OF VPHC II MONITORING SYSTEM

1. Software
The computer software used is Lotus 123 (2.01)

2. Installation
The village (HIC3) and Sub-district (HIC4) forms and the 123 configuration file are contained on the enclosed diskettes. The village forms have file names HICXXXX, where XXXX is three or four letters from the village name.

The sub-district form has a file name SDHICYYY where YYY is the Province (WJ, EJ or NTB).

3. HIC3 and HIC4 back-up
Make two back-up copies of the HIC3 and HIC4 diskettes.

4. Data entry HIC3

4.a. Retrieve the village form you require (HICXXXX)

4.b Begin by entering the data required at the head of the form. In order to do this you will need to "clear" any "titles" which have been set (/WTC).

4.c When you are ready to enter data in the body of the form, you will need to set vertical and horizontal titles. Place the cursor at the top left-hand corner of the first data entry cell. Set titles (/WTB).

4.d You can now use "Quick data entry" (Alt Q) or move around the screen freely in the normal fashion.

5. Data Save HIC3 and Print
Do not forget to save data you have entered on the village forms. Print HIC3 for each village, review and file.

6. HIC4 Accumulation

6.a Do not enter any data into HIC4. When you are ready to accumulate data from all the villages, retrieve HIC4 (SDHICYYY), call the menu (Alt C), move the cursor to "sum all villages" and press enter.

6.b When call up HIC4 please choose: i) "view" the data in the file, or ii) "sum all villages" which revises the subdistrict totals to reflect changes made in the village level forms.

7. Data Save HIC4 and Print
Do not forget to save the data accumulated on HIC4. Print HIC4, review data and file one copy. Send another copy to CIIHQ within 2 weeks of the end of the quarter.

8. Data Back-up
When you have entered data for a "quarter" (3 month period), copy on to diskettes. Keep these diskettes up dated each time you revise or enter new data. Make two back-up copies of your data.

9. End of year back-up, and new-year start-up

9.1 When you have completed data entry for the year update your back-up diskettes and store for future reference. Keep two copies.

9.2 Take your blank Monitoring System HIC3 and HIC4 diskettes change the year at the top of the form to the new year. Replace the old-year file on hard disk with the new-year file.

instrc-e.wp

94

VPHC II VILLAGE REPORT FORM (VRF)

VILLAGE:
SUBDISTRICT:
FIELD OFFICE:
REPORT PERIOD:

FIELD OFFICER/PROJECT MANAGER:

MAIN AREAS OF PROGRESS	DESCRIBE ACTIVITIES AND ACHIEVEMENTS
ISSUES NEEDING ATTENTION/CONSTRAINTS	**DESCRIBE ACTION PLANNED AND TIME SCALE**
ASSISTANCE REQUIRED	**PM RECOMMENDATIONS**

VRF-E.wp:03/91

95

VPHC II VILLAGE REPORT FORM (VRF)

VILLAGE:
SUBDISTRICT:
FIELD OFFICE:
REPORT PERIOD:

FIELD OFFICER/PROJECT MANAGER:

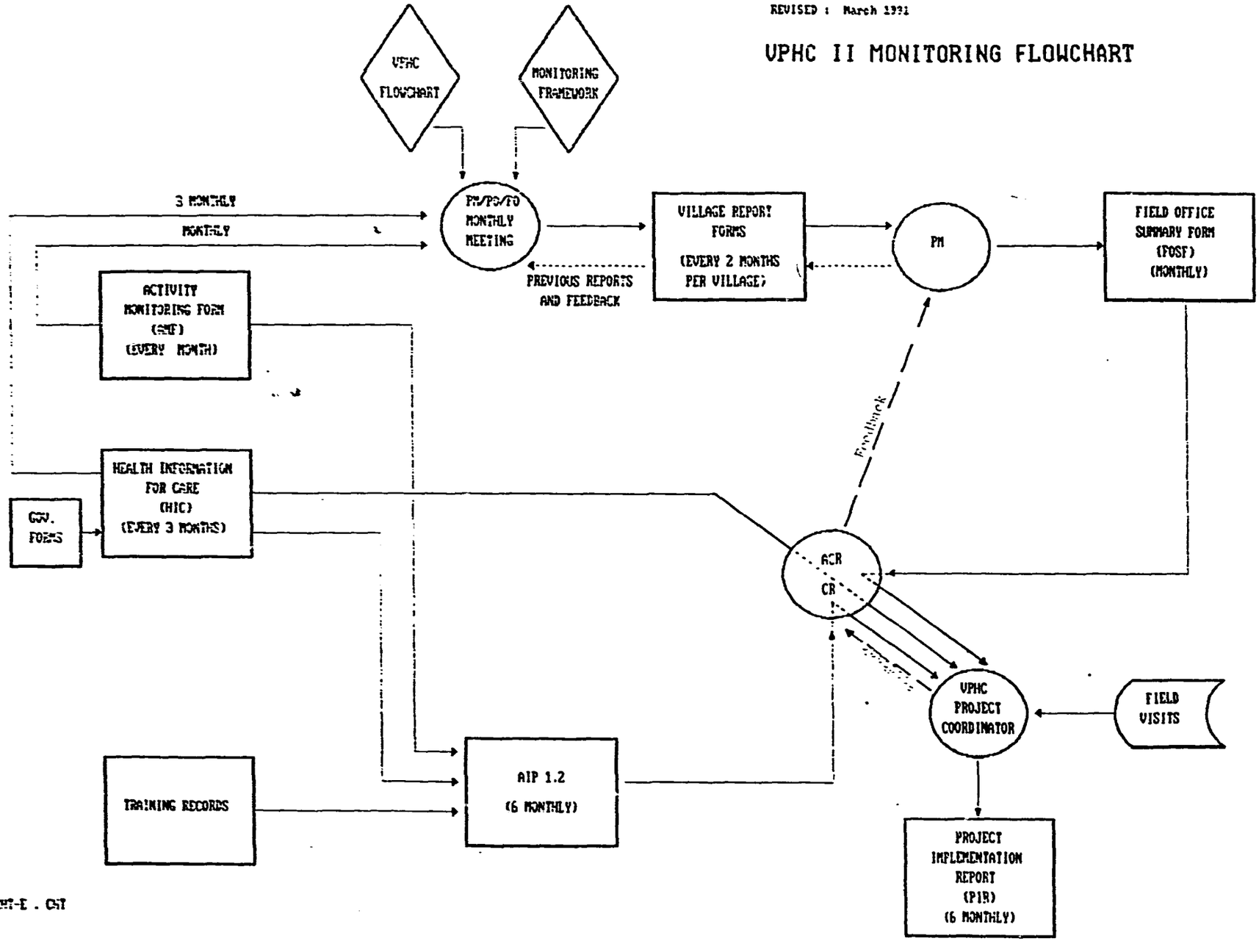
MAIN AREAS OF PROGRESS	DESCRIBE ACTIVITIES AND ACHIEVEMENTS
ISSUES NEEDING ATTENTION/CONSTRAINTS	DESCRIBE ACTION PLANNED AND TIME SCALE
ASSISTANCE REQUIRED	PM RECOMMENDATIONS

VRF-E.wp:03/91

86

REVISED : March 1991

VPHC II MONITORING FLOWCHART



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87

Attachment #7

VPHC FY 89

BASELINE AND CLOSE-OUT SURVEY

VPHC II 1989 METHODOLOGY

Working Paper

88

Attachment #7

VPHC FY 89

BASELINE AND CLOSE-OUT SURVEY - VPHC II 1989 METHODOLOGY

Working Paper

1. **Background**

During 1989, CARE will be implementing a Village Primary Health Care project in three provinces: West Java, East Java and NTB. In each province, CARE will work in one subdistrict and the target population will be all mothers with a child under five years of age in the subdistrict. It is important to note that most of the health messages contained in the project relate particularly to mothers with a child under one year old.

Estimated population figures for the three subdistricts are as follows:

	No. of village	Total Population	Mothers with Child < 1yr[1]	Mothers with children < 5yr
West Java	17	90,297	3,346	7,345[2]
East Java	16	69,436	1,680	9,653[3]
NTB	10	66,750	2,525	8,500[4]

2. **Objectives of the Survey**

Objectives of the survey are to provide:

2.1 baseline data on knowledge, attitude and practices of mothers (caretakers) with a child under five years of age.

2.2 information which will assist the government in identifying problems related to Posyandu operations.

2.3 an indication of the VPHC project's overall impact as determined by achievement of the intermediate goals.

---

1 Equal with the total number of infants 0-11 months old.
2 Estimated as about 60% of total number of children under 5 year
3 Estimated as 90% of total number of children under 5 years.
4 Estimate based on the provincial and kecamatan information.

Comments Welcome!

89

3. **Sampling for the Baseline Survey FY 89**

3.1 Lists of mothers with children less than five years will need to be compiled. Each province has to identify the most reliable source, e.g. BKKBN, Dinkes, Puskesmas, RW, or RT. Names and addresses of women will be included in the list if they fall into the required categories. Separate lists will be compiled for a) mothers with children under 5 years, and b) mothers with a child less than 1 year. If a women falls into both categories, she will be included in the list of mothers with a child less than one year; not in the list for mothers with children under five.

The lists will be prepared village by village, so that the sample drawn can be stratified by village.

3.2 If necessary lists of mothers with children under 5 years and mothers with a child less than 1 year will have to drawn up from Posyandu records and village leaders/kader. These lists would be less complete, and this approach should only be used if other more reliable data are not available.

3.3 The sample size in each province will have to be determined as follows:

a) The table of sample sizes contained in Dep.Dikbud's "Dasar-dasar Metodologi Riset Ilmu Kedokteran" can be used to determine your respective sample sizes. However, a more accurate size could be calculated by using the formula:

$$n = \frac{n_o}{1 + \frac{n_o - 1}{N}}$$

n = sample size
n_o = 400 (fixed)
N = target population

A province, for example, with 5,130 mothers with children under 5 years, calculates their sample size as follows:

$$\frac{400}{1 + \frac{400 - 1}{N}} = \frac{400}{1 + \frac{399}{5130}} = 371$$

b) The sample size will be increased by 20% to allow for women who move away from their village, or became unavailable for other reasons, during the next year i.e. the period of CARE's intervention. This is to ensure that a sufficiently large sample is available for the close out survey, assuming that the same women will be interviewed again. Again an example for the above mentioned number of sample size:

371 + 20% = 445

90

c1) New sample size 445 should be increased by 20% again. This extra 20% is used to replace those women that cannot be located when conducting the actual baseline survey. [See section below for details]. This new sample list will be

445 + 89 (or 20%) = 534

c2) At the time of the baseline survey it will be found that some women on the sample list cannot be interviewed (may be ill, left the village, not at home when the interviewer calls, etc.). If a woman is not at home when the interviewer calls, the interviewer should return to the house on two further occasions (at different times of day) to try and interview the women unless it is known she will not be available. The interviewer should report to the survey supervisor if any woman is not available to be interviewed. The survey supervisor will then give the interviewer the name of another woman to be interviewed from a supplementary list, compiled to allow for replacements in the sample as just described. **It is important to stop interviewing after 445 interviews are conducted.**

3.4 **The method of compiling the sample should therefore be as follows:**

a) For each village obtain two lists:

- List of mothers with children under 5 years
- List of mothers with a child under 1 year
  (If the woman is in both lists, delete her name from the list of mothers with a child under five years).

b) For each list, number the women in sequence i.e. one, two, three, etc.

c) Total the lists for all villages in the subdistrict.

d) Calculate the percentage of women to be drawn from the lists to give a sample of 445 in West Java case, as follows:

$$\frac{445}{\text{[Total women on lists in all villages]}} \times 100 \approx \%$$ of women to be included in sample (sampling proportion)

(If a total of 5,130 women are listed for the subdistrict, the percentage to be included in the sample will be:

$$\frac{445}{5{,}130} \times 100 = 8.67\%)$$

91

e) For <u>each</u> separate list per village, calculate how many women should be randomly chosen to be included in the sample, [i.e. sample size of mothers with children under 5 years in Village A =

sampling proportion X total number of mothers listed for village A.

(For village A, with 210 mothers, where the percentage to be included in the sample is 8.67%, the sample size should be:
8.67/100 X 210 = 18.2 or 18 corrected to the highest whole number).

When the sample size for the lists of mothers with children under 5 years and mothers with a child under five has been calculated for <u>each</u> village, add them all together to check that you have a total of approximately 445 (it may be a little above or below 445 because of the correction of samples to the nearest whole number).

e1) <u>Mothers with Children 0-1 Percentage Required</u>

1. Total number of mothers with children 0-5 years [Example: 5,130].

2. Determine desired sample size [Example: sample size is 445 20% added].

3. Total number of mothers with children 0-1 year [Example: 275].

4. Must determine what proportion is 0-1 year group from total population of mother 0-5 years. 5% [275 : 5130 X 100]

5. Therefore 5% or 22 of the sample mothers should be mothers with children 0-1 year.

f) For specific instruction on selecting a sample, refer to pages 15-17 of the <u>Monitoring and Evaluation Packet</u> prepared last year. I have also attached a table of random numbers but it would be easier to use the instructions provided in the Evaluation Packet. [Suggest you review again the entire Evaluation Packet before proceeding with the survey].
<u>or</u>
Draw the sample from each list, using random number tables, i.e. for the list of 210 mothers in village A, where we want a sample of 18 women, start with the last three digit number from the random number tables and take the next numbers listed in sequence until you have 18 which fall between 1 and 210. Any number between 211 and 999 is ignored, and the next number is taken.

g) It is very important to make sure that the names and addresses of all mothers or caretakers are properly recorded. This pre/post test procedure requires that we return for the post test to the same people on both the target and control sites.

Control Sites

It has been decided that control sites will be surveyed, five in East Java and West Java, and four in NTB. To select the control villages you must match villages in a neighboring subdistrict. Select target villages [example: NTB 4] that can be matched against 4 control villages. [Example: 4 NTB sites matched with 4 control villages].

Suggested criteria to be considered:

1. GOI classification of villages into Swadaya, Swasembada, Swakarya.

2. Villages have established, working clean water systems and electricity.

3. Similar status of Posyandu and kader activities.

4. Similar Puskesmas status and Puskesmas [in minutes] from surveyed village.

5. Religious and educational facilities in the village.

6. Proximity to main roads.

7. Level of estimated income.

8. Equivalent population men, women and children 0-5 years.

Sample in Control Sites

Selected control villages are be compared to selected CARE target villages. The sample size from the control sites and target villages should be 10% each [10% control villages, 10% target villages] from the total number of mothers with children 0-5 years. Follow the same procedures previously described to get the numbers of mothers to be interviewed. Please recall that the sample size must be increased by 20% for replacement. The baseline list of mothers must be again increased by 20% in case mothers cannot be found during the baseline survey.

Tentative Instruction for NTB (or where no list of mothers are available) for Selecting Sample

If list of mothers are not available, select two RTs from every village. From these two RTs you collect with the village representatives a list of all children 0-5 years. Then proceed to follow the instructions provided above.

APPENDIX B

JOB DESCRIPTION

Position Title:	VPHC Project Manager
Responsible to:	Chief Representative/Assistant Chief Representative
Supervisory Capacity:	Project Officer Junior Project Officer Field Officers

Basic Function:

The basic function of this position is to plan and coordinate with the Chief Representative or his/her designate all activities associated with the administration, implementation, monitoring and evaluation of the VPHC program.

Major Responsibilities:

Project Manager should maintain an average of 10 field days per month in order to fulfill the following:

I. Field Work

1. Planning and Follow-Up

   a. Travel on a regular basis to project sites to supervise FO activities and to ensure all activities are being effectively implemented. Identify field problems and provide field staff with feedback, as required, for successful project operation.

   b. Assist field staff to prepare work schedules and all project related assignments.

2. Training

   a. Prepare training curriculums suitable for the participating trainees focussing on management and quality of posyandu services. Work as a trainer, when required.

3. Monitoring and Evaluation

   a. Establish project monitoring procedures that are consistent with VPHC's monitoring system and that ensure goals and targets are achieved. Submit the HIC4 CIHQ according to the agreed schedule.

   b. Assist with all project evaluation activities.

94

4. **Recording and Reporting**

Prepare written reports on all field trips and counterpart meetings, as required.

II. Collaboration with Counterpart

1. Establish and maintain all provincial and district government contacts as required for effective VPHC project implementation.

2. Maintain a working knowledge of the government's existing project and planning priorities as the relate to CARE.

3. Actively seek provincial and district government counterpart participation in the planning and implementation of all project activities. Accompany provincial and district officials on field visits to project sites. Emphasis should be on establishing cooperations with government health care agencies, e.g., Dinas Kesehatan.

4. On a regular basis provide the provincial and district government counterparts with appropriate project progress reports.

III. General

1. Actively assist in the development of new projects including the preparation of specific project proposals and strategies when requested.

2. Assist in the preparation of long range project planning document (i.e. DIP).

3. Ensure that the project goals and activities are attainable and clearly described and understood by all project staff.

4. Assist the Chief Representative/Assistant Chief Representative prepare annual project budget projections.

5. Maintain appropriate controls that ensure proper utilization of resources and establishment of cost effective project activities.

6. Review and analyze all monthly expenditures to ensure they are consistent with the planned budget.

7. Coordinate the hiring of all staff as approved by the Project Coordinator and the Chief Representative

8. Contribute to the evaluation of all staff concerning work performance according to established organizational guidelines

9. Organize staff in-service training.

10. Maintain contact with all non-government counterpart organizations as required for efficient project implementation and strategy development.

11. Coordinate with the Chief Representative/Assistant Chief Representative all major report writing. Prepare the VPHC PIR and all other related project reporting documents in a timely fashion.

Qualifications Required:

a. A minimum of three years of administrative experience in management of rural primary health projects.

b. Basic technical knowledge in primary health care and interest in teaching.

c. Ability to manage and work cooperatively with CARE staff

d. Willingness to undertake extensive field trips.

e. Ability to work independently and solve problems effectively.

f. Ability to communicate effectively in both written and spoken English.

dskJD/pm-vphc
March, 1991

JOB DESCRIPTION

Position Title: VPHC Field Officer

Responsible to: Project Manager/Project Officer

Supervisory Capacity: None

Basic Function:

The basic function of this position is to implement and monitor all Village Primary Health Care (VPHC) project activities at the village level. This includes conducting workshops, training, solving specific project related field problems, providing guidance to the Village Supervision Teams and monitoring and collecting data to assess the progress and impact of the project.

Major Responsibilities:

I. Field Work

Field Officer should maintain an average of 17 field days per month in order to fulfill the following:

1. Planning and Follow-up

   a. Plan village-level project activities.

   b. Provide required guidance to Village Supervision Team in their efforts to develop and improve the village health activities and assist in problem solving as needed.

   c. Help to implement all VPHC related village level workshops and required meetings for the Village Supervision Team (both management and technical aspects), TBAs and informal community leaders (religious leaders and teachers).

   d. Promote the strengthening of village institutions as necessary for the implementation of Posyandu service.

2. Training

   a. Identify government, Village Supervision teams, TBAs, religious leaders, teachers and other concerned groups' training requirements.

   b. Collaborate with government officials, Project Manager and other project staff to design, organize and facilitate training programs to meet the target groups needs.

91

c. Ensure that participatory methods are used in training and that all training activities are related to practical problem solving in the community.

d. Assess existing health education materials and ensure that appropriate materials are made available to the Posyandu.

3. Monitoring and Evaluation

a. Plan and implement all village-level monitoring and evaluation procedures.

b. Monitor project implementation and collect information from:
- Village Supervision Team
- Posyandu
- Hamlet groups
- Kecamatan
- Puskesmas
using standard CARE-VPHC monitoring system forms.

c. Assist to formally evaluate all training and facilitation sessions and their impact and help prepare recommendations on how to improve the quality of project interventions.

4. Recording and Reporting

a. Establish and maintain well organized records on all village-related project activities conducted

b. Provide regular written and verbal (as required) accurate information and feedback to the Project Manager/Officer on status of the project, problems identified and possible solutions.

II. <u>Collaboration with Counterpart</u>

1. Actively participate in establishing and maintaining positive working relationships, cooperation and coordination with related government officials, community groups and leaders, Village Supervision Teams and other related individuals.

2. Organize and conduct active learning sessions for those mentioned above that will enhance their ability to effectively improve and support PHC activities particularly Posyandus.

3. Keep fully informed and involved as required in all Government activities related to primary health care within the project sites.

Qualification

a. Good primary health care and community development knowledge.

b. Ability to identify project related problems and issues at the village level.

c. Some training experience.

d. Ability to work as a member of a team.

e. Ability to adjust into rural situation and communicate effectively with villagers.

f. Excellent verbal and written communication skills (willing to learn English).

g. Willing to travel and live in rural areas.

h. Can ride motorcycle or is willing to learn.

dskJD/fo-vphc
March 1991

JOB DESCRIPTION

Position Title: VPHC Project Officer

Responsible to: Project Manager

Supervisory Capacity: Junior Project Officers
Field Officers

Basic Function:

The basic function of this position is to implement the Village Primary Health Care Project activities. This includes: conducting workshops and training sessions designed to promote primary health care services at the village level, monitor project impact and solving project related problems in the villages.

Major Responsibilities:

Project Officer should maintain an average of 13 field days per month in order to fulfill the following:

I. Field Work

1. Planning and Follow Up

a. Together with the Project Manager plan all individual work schedules and prepare special assignments.

b. Travel to on a regular basis to project sites to supervise FOs and to ensure all activities are being effectively implemented. Identify field problems and provide field staff with feed back, as required, for successful project operation.

c. Plan and conduct subdistrict and village leader workshops on management and supervision of posyandu and kader services.

d. Organize and conduct workshops for kader coordination on posyandu supervision, kader training and health follow up services.

e. Work with subdistrict staff regularly to assist in implementing VPHC's subdistrict related activities. Assist in problem solving, as required.

2. Training

a. Prepare training curriculums suitable for the participating trainees focussing on management and quality of posyandu services. Work as a trainer, when required.

100

3. Monitoring and Evaluation

Assist with all project monitoring and evaluation activities and maintain up-to-date project records.

4. Reporting and Recording

a. Insure all project data are accurately recorded and easily accessible.

b. Provide regular written (if required) and oral reports on field trip activities to the Project Manager.

II. Collaboration with Counterpart

1. Establish and maintain working relationship with subdistrict (Kecamatan) government counterparts as required for effective VPHC project implementation.

2. Ensure that local community leaders understand of CARE's project activities and work strategies.

3. Be informed of related government departments and community program plans and priorities as they relate to the VPHC project.

4. Actively seek subdistrict government participation in the planning and implementation of all project activities. Accompany subdistrict officials on field visits to project sites.

5. Organize active learning opportunities for related government officials that will enhance their ability to effectively promote and guide Posyandu services.

III. CARE Mission

1. Assist in the préparation of long range project planning documents (i.e. DIP)

2. Contribute to the evaluation of all staff supervised concerning work performance, according to establish organizational guidelines.

3. Assist in organizing staff in-service training.

4. Maintain contact with project related non government organizations.

5. Assist in drafting all Project Implementation Reports (PIR).

Qualifications Required:

a. At least two years experience in implementing primary health care activities.

b. Basic technical knowledge in primary health care and interest in training.

c. Demonstrated ability to work cooperatively with others.

d. Willing to travel extensively in rural areas.

e. Ability to work independently and solve problems effectively.

f. Good written and spoken English.

dskJD/po-vphc
March 1991

JOB DESCRIPTION

Position Title: VPHC Junior Project Officer

Responsible to: Project Manager/Project Officer

Supervisory Capacity: None

Basic Function:

The basic function of this position is to work with Project Officers to implement all Village Primary Health Care (VPHC) project activities specifically related to the subdistrict team. This includes conducting workshop, training, and solving specific project related problems.

Major Responsibilities:

Junior Project Officer should maintain an average of 13 field days per month in order to fulfill the following:

I. Field Work

1. Planning and Follow-up

a. Assist with the planning of monthly project activities.

b. Travel on a regular basis to project villages to assist FOs in the development of Village Supervision Teams. Coordinate all work with FOs.

c. Work with subdistrict staff regularly to assist in implementing VPHC's subdistrict related activities. Assist in problem solving, as required.

d. Plan and conduct subdistrict and village leader workshops on management and supervision of posyandu and kader services.

e. Organize and conduct workshops for kader coordination on posyandu supervision, kader training and health follow up services.

2. Training

Prepare training curriculums suitable for the participating trainees focussing on management and quality of posyandu services. Work as a trainer, when required.

3. Monitoring and Evaluation

Assist with the all project monitoring and evaluation activities.

4. Recording and Reporting

a. Maintain a well organized record system of all project activities conducted.

b. Assist with preparation, recording and maintenance all project related records.

II. Collaboration with Counterpart

1. Establish and maintain positive relationships with subdistrict officials and community leaders as required for effective VPHC project implementation.

2. Ensure that local community leaders understand of CARE's project activities and work strategies.

3. Be informed of related government departments and community program plans and priorities as they relate to the VPHC project.

4. Actively seek subdistrict government participation in the planning and implementation of all project activities. Accompany subdistrict officials on field visits to project sites.

III. CARE Mission

1. Assist in the preparation of long range project planning document (i.e. DIP)

2. Assist in organizing staff in-services training.

3. Maintain contact with project related non-government organizations.

Qualifications Required

a. At least one years experience in implementing primary health care activities.

b. Basic technical knowledge in primary health care and interest in training.

c. Ability to work as a member of a team.

d. Willing to travel and live in rural areas.

e. Ability to work independently and solve problems effectively.

f. Excellent verbal and oral communication skills (willing to learn English).

g. Can ride motorcycle or is willing to learn.

dskJD/jpo-vphc
March 1991

APPENDIX C

ANNE LYNAM GODDARD
277 LAUREL AVENUE
Kearny, N.J. 07032
(201) 991 - 1498

EDUCATIONAL QUALIFICATIONS

1983 Masters of Public Health
University of North Carolina
Chapel Hill, N.C. 27514

Major field: Health Education with focus in international health; Recipient of University Scholarship.

1977 Bachelor of Arts, Magna cum Laude
Assumption College
Worcester, MA 01609

Double major in Social and Rehabilitation Services and in Psychology; Top 10% of class; President - National Rehabilitation Association, 1975, 1976, 1977; 1977 Who's Who in American Colleges and Universities; Recipient of 3 scholarships.

1973 High school salutatorian; President - National Honor Society; Editor-in-Chief school newspaper; 1973 Who's Who in American High Schools; math award; basketball award.

PROFESSIONAL EXPERIENCE

1987 to 1990 Women's Development Project and
Women's Health Education Project
CARE-International
Dhaka, Bangladesh

As Project Coordinator, responsible for overall project planning, implementation and evaluation for two staff intensive women's primary health care/community development/income generating projects funded by NORAD, ODA, SIDA, Ford Foundation and several CARE members countries.

Developed project proposals which successfully lead to both projects being fully funded at a combined yearly budget exceeding one million USD. Developed evaluation plans to assess if project achievements had been sustained after project withdrew from villages. Project successfully reduced child malnutrition rates, sustained an increased contraceptive prevalence rate, increased health knowledge, changed health practices and contributed to increased family assets among the poorest village women.

Contributed to overall mission management including planning yearly senior staff conferences, designing an emergency mother and child health and feeding program after Bangladesh's disastrous 1988 flood, serving as Disaster Coordinator after 1987 flood, assisting in the establishment of an in-house training unit for 1400 staff and developing a mechanism for a yearly inflation adjustment to staff housing benefits.

1986 Urban Basic Services Project
UNICEF
Mogadishu, Somalia

As Consultant, designed and implemented needs assessment and feasibility study for pre-primary services project. Planned group discussions with mothers and interviews with community leaders.

1984 to 1986 Management Training Project
Experiment in International Living
Mogadishu, Somalia

As Project Director, responsible for overall program implementation and evaluation, fiscal management and supervision of expatriate and national staff for USAID/National Refugee Commission training project. Developed and wrote proposal for program extension which was approved. Coordinated development of training manual.

As Training Officer, trained and supervised national staff engaged in Training of Trainers program. Directed and provided technical assistance for the design and implementation of all field-based training conducted nationwide.

1983 School of Public Health
University of North Carolina, Chapel Hill, N.C. 27514

As Research Assistant, participated in studies of caretakers of stroke victims, focusing on their coping strategies; and parents of pre-school children, focusing on their attitudes and use of child car safety seats.

1981 and 1983 International Short Course -
Community Health and Development: Program Plan & Design
University of North Carolina, Chapel Hill, N.C. 27514

As Technical Materials Coordinator, designed small group exercises for 30 health professionals from developing countries. Trained group facilitators in case study methods. Organized all technical materials. Taught sessions on "Training Design and Methods" and "Program Plan and Design". Directed group work in program planning and evaluation.

1981 to 1983 School of Public Health
Department of Health Education
University of North Carolina, Chapel Hill, N.C. 27514

Member of research group which provided consultation on the design and implementation of research projects. As Graduate Teaching Assistant, taught graduate level research methods class in sampling methodology.

Developed and administered a community health assessment for the Franklin Country Risk Reduction Project. Surveyed over 250 residents. Analyzed data and wrote summary report. Conducted community meetings to report results to county residents.

1979 to 1981 Rural Women's Development Project
Ministry of Health
Isiolo District, Kenya

As Peace Corps Volunteer, facilitated the formation of women's groups and the establishment of income generating projects. Trained group leaders in leadership skills and group members in health related topics, including nutrition, ORT, family planning and maternal and child health.

Developed and administered extensive nutrition research project for the Ministry of Health in collaboration with the Dutch Medical Research Center. Surveyed over 1,000 semi-nomadic people suffering through a drought and famine period. Gathered data on socio-economic status, breast-feeding patterns, dietary habits and water/sanitation conditions. Collected height, weight, and skin fold measurements as well as blood, urine and stool samples. Trained and supervised survey field staff.

1978 to 1979 — Children's Protective Services
Worcester, MA 01609

As Social Worker, assessed potential abusive and neglectful situations and provided social services to families. Conducted inservice training for teachers as well as community education on the problems related with child abuse and neglect.

1978 — Becker Junior College
Worcester, MA 01609

As Instructor, developed curriculum and taught undergraduate courses in Communication Skills and Introductory Psychology.

1977 to 1978 — Doctors Hospital
Worcester, MA 01609

As Social Worker, provided social services to patients. Co-ordinated a weekly educational group for alcoholics in rehabilitation program.

1976 to 1977 — Office of Social Services
Fitchburg Welfare Office
Fitchburg, MA

Utilized as staff social worker. Involved in both Children in Need of Services (CINS) and Care & Protection (C&P) Cases.

1975 to 1976 — Social Service Department
Rutland Heights Hospital
Rutland, MA

Interviewed prospective clients for admission into alcoholic rehabilitation program. Provided variety of social services.

1974 to 1977 — Assumption College
Worcester, MA

As Resident Advisor, counseled students in dorms on academic and personal problems.

PUBLICATIONS

1. "The Sustainability of Growth Monitoring Efforts : A Case Study", submitted to World Health co-author with Laura J. Sloss, publication pending, 1990.

2. "Women's Development in Rural Bangldesh : Lasting Changes', submitted to International Journal of Health Education, co-author with Laura J. Sloss and Barbara parker Ph.D, publication pending, 1990.

3. Management in Action - Participatory Training for Development, The Experiment in International Living, Battleboro, Vermont, funded by USAID, 1986.

4. "Guardian Services for Abused and Neglected Children: Social Workers Evaluate the Performance of Volunteers', University of North Carolina, Master's Thesis, Public Health Department, 1983.

PROFESSIONAL AFFILIATIONS

American Public Health Association
National Council for International Health

PERSONAL INFORMATION

Languages: Swahili
Married with 1 child

APPENDIX D

CURRICULUM VITAE

N A M E: PUJI ASWATI

Address:

Place/Date of birth:

EDUCATION:

- SMEA Tarakanita, graduated in 1976
- Universitas Nasional (English Literature) graduated in 1986
- Universitas Indonesia (post graduate in American Area Studies), graduated in February 1990, major in American Foreign Policy

WORKING EXPERIENCE:

October 1990	CARE Indonesia - East Java as Project Manager VPHC (Pacitan)
October 1989 - 1990	CARE Indonesia - West Java as Management Trainee (Bandung)
1985 - 1981	British Embassy as an Information Clerk
1981 - 1984	Polish Commercial Counsellor's Office
1978 - 1981	Polish Embassy a s Clerk

INTERNATIONAL EXPERIENCE:

1985	Participant of International Youth Year Celebration in Tokyo
1985	Participant of Conference for Alumni Youth Exchange Program in Tokyo
1984	Participant of Pancasila upgrading (P4)
1983	Participant of Youth Exchange

APPENDIX E

REVISED BASELINE REPORT

CARE INDONESIA

VILLAGE PRIMARY HEALTH CARE

BASELINE SURVEY SUMMARY REPORT

WEST JAVA, EAST JAVA

NUSA TENGGARA BARAT (NTB)

CARE INDONESIA

October 1991

113

List of Acronyms and Common Terms

Dukun	Traditional healer
FO	Field Officer
GMC	Growth Monitoring Card
GOI	Government of Indonesia
Kader	Community Voluntary Health Worker
Kader Leader	Superviser of Community Volunteer Health Worker
KAP	Knowledge Attitudes and Practice
KMS	Growth Monitoring Card in Indonesia
LGG	Home made sugar salt solution for rehydration therapy
NGO	Non-Government Organization
NTB	Nusa Tenggara Barat
Oralit	Oral electrolyte formula for Rehydration therapy
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PKK	Family Welfare Education
Posyandu	Integrated Health Service Post
Puskesmas	Community Health Center
TBA	Traditional Birth Attendant (Dukun Bayi)

TABLE OF CONTENT

Page

I. OVERVIEW 1

I.1 Introduction 1
I.2 Evaluation Research Design 1
I.3 Survey Limitations 4
I.4 Summary and Specific Recommendations 4

II. WEST JAVA - GUNUNGHALU MOTHERS SURVEY.....

II.1 Description of Project Site in Gununghalu, West Java 7
II.2 Immunization 7
II.3 Nutrition 8
II.4 Diarrhea 9
II.5 Pregnancy Care 10
II.6 Acute Respiratory Infection 11
II.7 Respondents Overall Health Knowledge..... 12
Appendix II 13

III. EAST JAVA - TULAKAN MOTHERS SURVEY..... 21

III.1 Description of Project Site in Tulakan, East Java 21
III.2 Immunization 21
III.3 Nutrition 22
III.4 Diarrhea 23
III.5 Pregnancy Care 24
III.6 Acute Respiratory Infection 26
III.7 Respondents Overall Health Knowledge..... 26
Appendix III 27

IV. NUSA TENGGARA BARAT (NTB) - GUNUNG SARI MOTHERS SURVEY... 35

IV.1 Description of Project Site in Gunung Sari, Nusa Tenggara Barat 35
IV.2 Immunization 35
IV.3 Nutrition 36
IV.4 Diarrhea 37
IV.5 Pregnancy Care 39
IV.6 Acute Respiratory Infection 40
IV.7 Respondents Overall Health Knowledge 40
Appendix IV 41

V. EAST JAVA - BANDAR MOTHERS SURVEY 49
V.1 Description of project site in Bandar, East Java ... 49
V.2 Immunization 49
V.3 Nutrition 49
V.4 Diarrhea 50
V.5 Pregnancy Care 50
V.6 Acute Respiratory Infection 51
V.7 Respondents Overall Health Knowledge 51
Appendix V 52

115

Page

VI. COMPARISON OF MOTHERS KNOWLEDGE, ATTITUDES 59
AND PRACTICES IN CARE PROJECT AND CONTROL SITES. .....
Appendix VI..... 60

VII. KADER SURVEY 63
Appendix VII 64

VIII. APPENDICES
Appendix A - Baseline Survey Methodology
Appendix B - KAP Questionnaire - Mothers
Appendix C - KAP Questionnaire - Kader
Appendix D - Mothers Control Sites Tables
Appendix E - Kader Tables.

I. OVERVIEW

I. OVERVIEW

I.1 Introduction

This report constitutes the findings of a comprehensive survey under-taken in three CARE Indonesia Village Primary Health Care/Child Survival (VPHC) subdistrict project sites between February and March 1989 and in a fourth site in February 1991. The information represents the primary health care knowledge, attitude, and self-reported practices of women with children under-four years of age and of volunteer health workers (Kader). The survey was implemented prior to the commencement of CARE, Village Primary Health Care Project (VPHC) interventions.

It should be noted that the information presented may not necessarily depict district or provincial norms. The subdistricts where CARE works are predicated upon having a low quality of life index relative to the other subdistricts in the province.

In cooperation with the Government of Indonesia, in order to improve the rural health care delivery system, CARE Indonesia has implemented its FY89 Village Primary Health Care project in the subdistrict of Gununghalu, West Java; Tulakan, East Java; and Gunung Sari, Nusa Tenggara Barat. As a result of the good progress made in Tulakan by the end of 1990, a second subdistrict, Bandar, was selected in East Java, and field work implementation began in 1991. The primary target recipients are mothers with a child under five years of age and pregnant women, with special attention given to mothers with a child under one year old. Project focus is:

- dehydration treatment and referral (ORT)
- growth monitoring and nutrition counselling
- immunization promotion
- prenatal counselling and referral
- acute respiratory infection counselling and referral

CARE staff have been working in consultation with both subdistrict government and community health center personnel (Puskesmas) to help establish an independent and sustainable primary health care delivery system at the village level. CARE programming focuses on the effective dissemination of primary health care messages and the delivery of health services deemed necessary to improve the quality of life for pregnant women and children under five years of age. The developmental approach to actualize these goals includes subdistrict and village health team training, assisting these teams in conducting subsequent volunteer village health workers (Kader) and village leader training, and the monitoring and supporting of Puskesmas, village, and Posyandu activities.

I.2 Evaluation Research Design

To measure the impact of CARE's Village Primary Health Care program a Quasi-Experimental Test was designed (Gay 1970). The survey measurements are the knowledge, attitudes, and practices (KAP) of the target recipients. The baseline survey also serves

118

to assist CARE staff and GOI health officials focus project resources and indirectly identify potential weak and strong areas in Posyandu services. A Kader baseline survey was also administered to further the aims mentioned above.

The target populations for the survey are mothers with children under 48 months, and Kader. Target population lists were compiled using one or a combination the following methods:

- lists from village, hamlet or neighborhood leaders,
- names taken from Posyandu or Puskesmas registers,
- CARE project site census. CARE NTB conducted a census because reliable demographic information did not exist in the target subdistrict.

Respondent lists were created using a proportionate stratified random sample method (Black and Champion 1976). Stratification was undertaken for mothers with children 1 to 11 months and those with children 12 to 48 months. A random numbers table was used to compile respondent lists in West Java and NTB. CARE East Java used the nth number method (Ibid 1976).

Sample size was determined with a proportion sampling statistic formula (Cochran). (Refer to Table 1, 2 and 3 for the specific formula).

A missing respondent list of 20 percent was added to the original survey list in preparation for respondents who could not be located in the close out survey. (It has since been decided to select a new sample for close-out).

Through consultation with Government counterparts and analysis of Government statistics, sub-districts were selected as control sites that showed similar characteristics to the CARE sites. In West Java and East Java five villages were chosen and in NTB four villages chosen which matched most closely the villages from the CARE site. A stratified, random sample was chosen in each village of mothers with children 0-11 months and children 12-48 months.

Table 1: Sample Sizes for CARE Survey

Location	Target Population	Required Sample Size Mothers	Project Site Mother Sample	Control Site Mother Sample	Project Site Kader Sample	Control Site Kader Sample
West Java	5,250	372	376	205	40	40
East Java, Tulakan	3,542	354	540	141	38	40
East Java, Bandar	2,300	341	340	-	-	-
NTB	6,682	377	449	161	50	20
Total	15,474	1,444	1,705	507	240	100

119

Table 2

$$n = \frac{No.}{1 + \frac{No. - 1}{N}}$$

n = sample size

$No = \frac{pq}{V}$

N = target population size

Sample size based on the formula for n in sampling for Proportions (Cochran 1953)

Table 3

$$n = \frac{n_o}{1 + \frac{n_o - 1}{N}}$$

n = sample size

n_o = 400 (fixed)

N = target population

Sample size based on the formula for n in sampling for Proportions (Cochran 1953)

A questionnaire was developed by the VPHC Project Coordinator, two representatives from the West Java office, and one representative from both East Java and NTB. Questions were formulated in direct relation to the VPHC project objectives and indicators listed in the VPHC FY89 Detailed Implementation Plan.

The questionnaire was initially pre-tested for three days in West Java. After modification, the questionnaire was translated into local languages and tested in NTB, West Java and East Java. The final pre-test was conducted in West Java. (Refer to Appendix V.1 for Questionnaire).

University students were hired to administer the questionnaire. It was felt that by using non-CARE personnel bias due to staff expectation would be minimized. CARE field staff supervised the surveyors. The criteria for selecting surveyors were: prior rural survey experience; language competence in local dialect; and willingness to live in a rural setting.

Surveyors attended a three day orientation training session to review survey techniques, learn questionnaire particulars, and to practise the required recording skills.

One questionnaire took respondents an average of 40 to 45 minutes to complete. The survey was completed within eight days in NTB, seven days in West Java, and 18 days in East Java.

Data was analyzed by an independent Social Scientist and CARE's Assistant Evaluation Officer. DBase IV was used to tabulate data.

The survey data have been analyzed using descriptive statistical techniques. Social information concerning respondent age, education and occupation is used for background or descriptive information only.

120

In preparation for the baseline and closeout survey analysis, Project and Control site data have undergone comparability tests. Tests for statistically significant differences were done using the Chi-Square test, at a 95% confidence level.

I.3 Survey Limitations

A number of problems were experienced in the process of implementing the survey. The range of missing data for most questions is between 1.2% and 0.0% (the mean is below 0.5%). A notable exception is question number 22 - Nutrition status of under-five children recorded from the KMS card. The nutrition status was recorded from only the respondents who had a KMS card at home during the interview: NTB was missing 81 percent; West Java 66 percent; and East Java 33 percent. As the potential bias is unknown, the question was discarded.

Verifiability of questions number 11 and 12C - the immunization status of under-one and under-five children - is in question due to response relying upon respondent recall.

I.4 Summary and Specific Recommendations

Project priority will be placed on increasing the immunization rates for children under five - with special attention given to those under 12 months - and pregnant women. CARE staff believe that a primary cause of low immunization coverage is the lack of parental awareness as to its necessity. Secondary problems include the marginal support from Traditional Birth Attendants and the inadequate number of subdistrict immunizers. For example the two Immunizers from Tulakan are responsible for 65 Posyandu. As a result, they have had to select a limited number of Posyandu per village as immunization stations. While this allows Immunizers to set realistic schedules it means that mothers have to travel greater distances. The choice for a women is not made any easier considering the number of hours she has to work each day.

In an attempt to address these problems CARE staff will try to introduce a priority health message scheme. The campaign will stress the importance of immunization through the recruited assistance of leading community members such as religious leaders, health Kader, TBA's, and school teachers.

Discussions on measures to prevent diarrhea need to incorporate environmental sanitation issues. In each subdistrict respondents stressed preventative measures which tend to compensate for underlying environmental sanitation problems. For example, protecting drinking water from flies by covering it was mentioned as opposed to controlling the fly population by reducing breeding sites or examining what attracts the flies to living quarters. While to drink boiled water was a method commonly thought to prevent diarrhea few respondents mentioned that the water source itself needs to be protected from contamination.

121

Treatment of diarrhea and Acute Respiratory Infection often includes a respondent buying over-the-counter medicine from local vendors. Where appropriate, it is suggested that CARE field staff discuss with Puskesmas staff the possibility of offering a mini-training course to vendors about the use of various over-the-counter drugs for treating common community illnesses. The training should also include the identification of diseases warranting referral to the Puskesmas. It is likely that mothers and their children would benefit if Kader were given similar training.

In general, the primary health care knowledge for Kader in each subdistrict is higher than that of mothers for every indicator tested. This finding is not surprising considering the health care training that most Kader have received from Ministry of Health staff. Even those Kader who have not received formal MOH training have undergone an informal Kader apprentice training system. More senior Kader believe this on the job training is often adequate for most new Kader to perform up to expectation within six months. No one has suggested that the informal apprentice training can replace formal MOH training only that it is a way for new Kader to participate in Posyandu activities before the next MOH training session is held.

Future Kader trainings may need to focus on primary health care issues in greater depth. For example in Gununghalu, West Java Kader that have been Kader for a number of years often express interest in more specific information concerning primary health care issues. The request stems from an increasing number of mothers asking questions that the kader are unable to answer. Kader want to know the vitamin content of foods they are instructed to tell mothers to feed their children. Mothers are also asking Kader about the pro's and con's of contraceptive methods available to them.

Part II - V is a summary description from the results of CARE Indonesia's VPHC baseline survey of mothers knowledge attitudes and practices. The intention is to familiarize the reader with what the knowledge, attitudes and practice of the target recipients was when CARE entered the region. The reader is advised to refer to Appendix II - IV for further information on specific topics.

Part VI is a comparison of the knowledge, attitudes and practices of mothers in the CARE project sites and control sites.

Part VII reviews the results of the Kader survey in CARE project and control sites and compares the results with those for the mothers.

The tables have been numbered so that they correspond to questionnaire numbers. This was done so that the reader can easily refer to the questionnaire for specific wording (Refer to Appendix I.1).

-122-

The revised questionnaire to be used at close-out is attached in the Appendix.

The numbering of the questions in the questionnaire, as printed here, is not complete. This is because the original questionnaire was revised after the analysis of this baseline data in order to delete questions that were of no value due to reliability and validity concerns, and therefore were not analyzed.

The original kader questionnaire is also attached for reference.

II. W E S T J A V A

GUNUNG HALU MOTHERS SURVEY

II. WEST JAVA - GUNUNG HALU, MOTHERS SURVEY

II.1 Description of Project Site in Gunung Halu, West Java

The subdistrict of Gununghalu is located in the province of Bandung, West Java. The total population of Gununghalu's 17 villages is estimated at over 90,000. There are approximately 5,250 women with children under 48 months of age. Three percent of the respondents report no formal education; 36% under grade six; and 60% equal or greater than grade six. Seventy percent of the respondents report no income generating activities. Eight percent work in the family business; 12% as seasonal laborer; and 4% are merchants. (Refer to Appendix II tables 5A, 6A.)

II.2 Immunisation

When respondents were asked why immunization is important for children under five years of age 15% could give a proper reason such as it makes the body immune to certain diseases or it helps maintain a child's health. The proportion of respondents that report that their one to 11 month old child has received at least the first immunization is 46%. The percentage of children 12 to 48 months old who are reported to have completed immunization is 33%. (Refer to Appendix II Tables 9, 11, 12C).

The most common reasons women report for why their child has not completed immunization were the immunization station is too far away or non-existent. There is a strong clustering among women who state that their child is not fully immunized due to Posyandu/Puskesmas being too far away, Posyandu not active or present, or have yet to participate in Posyandu activities.

Almost one quarter (24%) of the women could not state a reason why their child had not completed their immunization series. Mothers also reported they or their child was sick when the immunization session was held. An immunizer not being present during the last immunization session was also cited as a problem. Respondents also said that there is no need to bring her child for immunization because s/he is already healthy or that it is inadvisable to do so because of the sickness immunization can cause (Refer to Appendix II Table 12D).

Recommendations

The data collected indicates that children are frequently not completing their required immunization series. A majority of the mothers have their child start the series but do not continue to return to immunization sessions.

It is recommended that the West Java VPHC staff focus on the following:

125

1. Ensure that when mothers do attend a Posyandu immunization session they receive education on the importance of completing the immunization series.

2. A kader follow-up system is required that notifies or reminds mothers to attend the next immunization session and date. [NTB has developed such a system].

3. Mothers at immunization sessions should be warned that some types of immunization may cause a fever but the fever is a good sign that the baby is being protected and that the fever will stop in 24 hours.

4. Village leadership should be involved in helping to encourage mothers with young children to attend the immunization sessions.

5. Immunization sessions should be conducted in village centers or in locations close to the majority of the residents homes. This location may not be the site selected for the Posyandu.

6. Possibly immunization sessions should be conducted in two locations on the same day.

7. Times that immunizations are conducted should be explored with the Puskesmas staff to determine if alternative schedules can be arranged.

8. If immunization is selected as a priority, VPHC secondary data should be collected from local resources (Puskesmas) to confirm that immunization coverage is low and support is required.

II.3 Nutrition

When respondents were asked their opinion of whether or not they agree with a mother giving colostrum to her infant 52% responded that it is good. When the 35 respondents with children between the ages of one to three months where asked what they had fed their child yesterday 91% stated breast milk and boiled water only. When the 29 respondents with children four to seven months old were asked the same question 69% said some type of mashed food or fruit juice. Those that had given some other type of inappropriate food was 31% so all children had been started on some kind of weaning food. (Refer to Appendix II Tables 14, 17A, 17B).

Respondents who said night blindness can be prevented by giving a child green leafy vegetables, orange fruit, or Vitamin A capsules was 23% (Refer to Appendix II Table 19).

More than 28% of the respondents' youngest children have never been weighed. 67% of the respondents stated that their youngest child had been weighed at least once. Almost 5% of the respondents did not know if their child had ever been weighed (Refer to Appendix II Table 20).

126

Recommendations

The majority of mothers appear to follow acceptable feeding practices. However, a full 28% of the youngest children had never been weighed.

1. Feeding colostrum to all new born infants should be stressed by kader at all Posyandu sessions and a general community message should be developed.

2. Providing weaning foods at four to six months of age must be stressed. Mothers should be encouraged to:
   - Breast feed until at least 18 months
   - Start porridge at four months, do not give rice or bananas to a baby younger than four months
   - Fruit juice is good food as well as rice, wheat, potatoes. Cassava, bananas and sago are not good basic foods
   - Add peas, beans, soy beans, fish, milk, eggs, meat to porridge
   - Give children four good meals a day
   - Give fruits and vegetables to children over four months old
   - Sick children need feeding

3. Regular weighing of children (growth monitoring) should be stressed.

II.4 Diarrhea

The percentage of families reported to have had a child with diarrhea during the month of February 1989 (one month prior the survey) was 24%. Over 77% of the respondents could give at least one correct sign of severe dehydration. The common ways mothers detect severe dehydration include fast breathing, pale and restlessness, and sunken eyes (Refer to Appendix II Tables 25,28).

If a respondent's child was to contract diarrhea the majority said they would do one or a combination of the following: 1. Give oral rehydration solution; 2. give a local herbal diarreal remedy or seek the advice of a traditional healer; and 3. buy an over-the-counter medicine. The percentage of respondents who specifically stated at least one correct answer was 71% (Refer to Appendix II Table 26).

Of the respondents asked to show the enumerator the materials needed to prepare a home-made salt and sugar solution only 27% were able to do so. When asked to make ORS, under five percent of the respondents used the proper amount of boiled water, salt and sugar. The greatest problem was with the proportion of salt. When asked how much ORS a child with diarrhea should be given 38% said either one glass per diarrhea episode or as much as they will drink (Refer to Appendix II Tables 30B, 31).

The proportion of respondents who could state at least one practice to help prevent diarrhea was 28%. Among the more common practices were to drink boiled water, serve unspoiled foods, and protect food and drinking water from flies and dust. The least referred to methods to help prevent diarrhea included, washing hands after using the latrine or before preparing foods, and defecating in latrines (Refer to Appendix II Table 27).

Recommendations

The survey results show that diarrhea is still a problem and that mothers have only a general knowledge of how to recognize the signs of dehydration and what should be done. The data also indicates that the mothers do not know how to mix ORS correctly or how much ORS should be given to a child with diarrhea.

1. Basic hygiene practices need to be reinforced. Village leaders should be involved in identifying the most common hygiene practices that are adversely affecting health. The general population should be informed through various gate keepers to:
   - wash hands, (with soap) before handling food
   - use latrines
   - drink boiled water
   - food storage

2. Oral Rehydration training should be continued to be reinforced at the Posyandu with emphasis on using ORS packets. ORS packets should be in every home.

3. ORS depots should be established in each village and monitored regularly by the assigned village leaders.

4. Latrine construction and use should be advocated in each village.

5. Clean water (CSFW) should also be promoted.

II.5 Pregnancy Care

The percentage of women who had a Traditional Birth Attendant deliver her last child was 88%. A family member delivered 5% and a Puskesmas midwife or doctor 6% (Refer to Appendix II Table 32).

When asked to state ways to help maintain a healthy pregnancy 25% of the respondents were able to mention at least two correct practices. The two common responses were eat nutritious foods and visit the Puskesmas for four examinations. (Refer to Appendix II Table 34.)

128

Almost 40% of mothers were examined during their last pregnancy by a traditional caretaker. The percentage of women who had a doctor or Puskesmas staff member examine them was only 19%. Almost forty percent of the respondents had received no examination during their last pregnancy (Refer to Appendix II Table 35).

Recommendations

1. The TBA plays an important role in the delivery. They should be taught to promote TT immunizations for all pregnant women.

2. All TBAs should be encouraged to attend Puskesmas training. Refresher training opportunities should also be encouraged. CARE staff should work with the Puskesmas mid-wife to set up appropriate TBA training sessions that are conducted in a practical manner and completed in a reasonable amount of time (2 months).

3. Community leaders should be encouraged to support and encourage TBA training. The leaders should be guided in how to evaluate TBAs performance.

4. Simple one time delivery kits could possibly be produced by kader for mothers. Production of the sterile kits can be an income activity for the kader. The kits should include:
   - razor
   - antiseptic
   - gauze
   - string or thread

5. All pregnant women should be encouraged, through village gate keeper groups, to go to the Puskesmas at least four times during the pregnancy period.

6. Posyandu should encourage pregnant women's attendance and provide appropriate education on diet, rest, medical check ups and information on warning signs.

II.6 Acute Respiratory Infections

When respondents were asked what they would do if their child was suspected of having a serious cough and cold over 72 % of the respondents said they would take him or her to the Puskesmas. Other responses included buying over-the-counter medicine, consultation with a Traditional Healer or Traditional Birth Attendant, or giving a local herbal remedy. When respondents were asked to state at least one sympton they would worry about if their child already had a cough or cold, almost one half of the respondents could not offer at least one correct answer. (Refer to Appendix II Tables 44, 45).

124

Recommendations

ARI is a common problem in many rural communities. Mothers should be taught at Posyandu.

1. Refer to Puskesmas.

2. Take prescribed medication, as instructed.

3. Feed sick child

4. Provide cleanfluids from a clean source.

No action on ARI should be taken until village leadership is fully active in the health activities in the village. Specific educational messages need to be identified.

II.7 Respondents Overall Health Knowledge

In order to obtain an indicator of the respondents overall health knowledge, five questions were selected to compose a "test" of mothers' health knowledge. These questions are as follows:

Question 9:	Knows reasons for immunization
Question 14:	Agrees to give colostrum to babies
Question 27:	Knowledge of diarrhea prevention
Question 34:	Knows how to maintain healthy pregnancy
Question 45:	Knowledge ARI symptoms

With a possible maximum score of 5,

The average score of respondents was very low - only 1.73. Knowledge was lowest about immunization and the prevention of diarrhea. Symptoms of coughs and colds that would be a cause for concern and colostrum were the areas in which respondents demonstrated the greatest knowledge.

APPENDIX II

CARE WEST JAVA
Gununghalu Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: **Gununghalu, West Java.** n = 376.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	12	3.2
2.	Under Grade Six	137	36.4
3.	Equal Grade Six	189	50.3
4.	Greater than Grade Six	38	10.1
	Total	376	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Gununghalu, West Java.** n = 376.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	265	70.5
2.	Private Business (family)	30	8.0
3.	Merchant	16	4.3
4.	Seasonal Laborer	46	12.2
5.	Civil Servant or Domestic worker	7	1.9
6.	Other (mainly agriculture related)	12	3.2
	Total	376	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Gununghalu, West Java.** n = 376.

	Category	Frequency	Percentage
1.	Could give proper reason	57	15.2
2.	Could not give proper reason	319	84.8
	Total	376	100.0

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: Gununghalu, West Java. n = 104.

	Immunization Status:	Frequency	Percentage
1.	In the process or at least first series	48	46.2
2.	Never been immunized	56	53.8
	Total	104	100.0

Table 12C: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). Frequency distribution. Gununghalu, West Java. n = 268.

	Immunization Status:	Frequency	Percentage
1.	Series complete	88	32.8
2.	Series not complete	180	67.2
	Total	268	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized. Frequency distribution. Gununghalu, West Java. n = 169.

	Why Child Has Not Been Fully Immunized:	Frequency	Percentage
1.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go)	5	3.0
2.	Mother could not give a reason	41	24.3
3.	Mother or child was sick when the last immunization session was held	16	9.5
4.	The Immunizer was not present during the last immunization session	9	5.3
5.	Other	98	58.0
	Total number of statements	169	100.0

132

Table 14: Respondents' opinion on whether colostrum should be given to an infant. Frequency distribution. Gununghalu, West Java. n = 376.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	194	51.6
2.	Colostrum should not be given to an infant	88	23.4
3.	Does not know	94	25.0
	Total	376	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: Gununghalu, West Java. n = 35.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	32	91.4
2.	Respondent mentioned any other type of food	3	8.6
	Total	35	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: Gununghalu, West Java. n = 29.

	Category	Frequency	Percentage
1.	Mother is giving proper food	20	69.0
2.	Weaning foods have not been started	0	0.0
3.	Proper food is not being given	9	31.0
	Total	29	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: Gununghalu, West Java. n = 370.

	Category	Frequency	Percentage
1.	Respondents who stated either proper foods or Vitamin A	84	22.7
2.	Respondents who do not know	286	77.3
	Total	370	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: Gununghalu, West Java. n = 376.

	Category	Frequency	Percentage
1.	Has been weighed at least once	253	67.3
2.	Has never been weighed	106	28.2
3.	Don't know	17	4.5
	Total	376	100.0

Table 25: Respondents with children that had diarrhea in the month prior to the survey. Frequency distribution: Gununghalu, West Java. n = 374.

	Category	Frequency	Percentage
1.	Had diarrhea that month	88	23.5
2.	Did not have diarrhea	286	76.5
	Total	374	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: Gununghalu, West Java. n = 376.

	One or More Correct Response	Frequency	Percentage
1.	Correct	267	71.0
2.	Incorrect	109	29.0
	Total	376	100.0

134

Table 27: Respondents who know one or more practices to help prevent diarrhea disease. Frequency distribution: Gununghalu, West Java. n = 376.

	Response	Frequency	Percentage
1.	Respondent knew one method	51	13.6
2.	Respondent knew two methods	33	8.8
3.	Respondent knew three or more methods	22	5.9
4.	Respondent could not state a method	270	71.8
	Total	376	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: Gununghalu, West Java. n = 376.

	Could repondent state one sign of severe dehydration:	Frequency	Percentage
1.	Yes	290	77.1
2.	No	86	22.9
	Total	376	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: Gununghalu, West Java. n = 376.

	Category	Frequency	Percentage
1.	Mothers used the proper proportions of boiled water, salt, and sugar	16	4.3
2.	Mothers knew ORS ingredient but did not know proper proportions	84	22.3
3.	Mothers did not know ORS ingredients	276	73.4
	Total	376	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: Gununghalu, West Java. n = 376.

	Amount Given	Frequency	Percentage
1.	Correct amount	143	38.0
2.	Correct amount for a baby under 12 months	63	16.8
3.	Incorrect amount	54	14.4
4.	Did not know	116	30.9
	Total	376	100.0

Table 32: Who assisted mother during last birthing. Frequency distribution: Gununghalu, West Java. n = 376.

	Category	Frequency	Percentage
1.	Traditional birth attendant	332	88.3
2.	Family	19	5.1
3.	Puskesmas midwife or doctor	22	5.9
4.	Other	3	0.8
	Total	376	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy: Frequency distribution: Gununghalu, West Java. n = 376.

	Number of Correct	Frequency	Percentage
1.	Stated two	51	13.6
2.	Stated three	31	8.2
3.	Stated four or more	13	3.5
4.	Could not state at least two	281	74.7
	Total	376	100.0

136

Table 35: Who examined mother during last pregnancy. Frequency distribution: Gununghalu, West Java. n = 321.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	124	38.6
2.	Doctor	2	0.6
3.	Puskesmas staff	60	18.7
4.	Other	14	4.4
5.	No examination	121	37.7
	Total	321	100.0

Table 44: To whom a respondent would go for help if their child had a serious cough or cold (ARI symptoms). Frequency distribution: Gununghalu, West Java. n = 373.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	30	7.3
2.	Go to Puskesmas health staff	271	66.1
3.	Go to Kader/Posyandu	2	0.5
4.	Do not know	29	7.1
5.	Other	78	19.0
	Total number of responses	410	100.0

Table 45: Respondents who could state at least one symptom they would worry about if their child already had a cough or cold. Frequency distribution: Gununghalu, West Java. n = 376.

	Number correct	Frequency	Percentage
1.	One correct	124	33.0
2.	Two or more correct	76	20.2
3.	Could not offer at least one correct	176	46.8
	Total	376	100.0

135

Table 46: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Gununghalu, West Java.** n = 376.

	Number of Correct Responses	Frequency	Percentage
1.	No correct answers	64	17.0
2.	One correct answer	140	37.2
3.	Two correct answers	97	25.8
4.	Three correct answers	46	12.2
5.	Four correct answers	16	4.3
6.	Five correct answers	13	3.5
	Total	376	100.0

Average score = 1.60.

135

III. E A S T J A V A

TULAKAN MOTHERS SURVEY

III. EAST JAVA - TULAKAN, MOTHERS SURVEY

III.1 Description of Project Site in Tulakan, East Java

The subdistrict of Tulakan is located in the province of Pacitan, East Java. The total population of Tulakan's 16 villages is estimated at over 58,000. There are approximately 3,550 women with a child under 48 months. Just over half of the respondents have received six or more years of formal education. Many (nearly 40%) of the respondents report their primary occupation is agriculture related. Family businesses account for another 27% of respondent employment. 23% of the respondents report no wage labor earnings. (Refer to Appendix III Tables 5A, 6A).

III.2 Immunization

When respondents were asked why a child should be immunized, approximately 22% responded correctly stating that it protects the body against certain diseases. At the same time, 61% of mothers with a child between one and four reported immunization to be complete. Over 80 % of mothers with a baby under-one said they had taken their child to be immunized at least once. (Refer to Appendix III Tables 11, 12B).

Although many respondents (22%) could not give a reason, the lack of information concerning the necessity of immunization appears to be the main cause leading to incomplete immunization. An analysis of responses coded as others shows many which fall into the following categories "my child is presently healthy, s/he became sick after the first series so I did not return; my child is too old or I do not know why I should go." (Refer to Appendix III Table 12D).

Recommendations

The data collected in East Java on immunization indicates that most mothers do not have an understanding of why immunizations are important. It appears that mothers do not follow-up to ensure that their children complete the immunization series.

It is recommended that the East Java VPHC staff focus on the following:

1. Basic education should be provided on the importance of immunization at each Posyandu meeting.

2. Village leadership should be involved in helping to encourage mothers with young children to attend the immunization sessions.

3. A kader follow-up system is required that notifies or reminds mothers to attend the next immunization session and date.

140

4. Immunization sessions should be conducted in village centers or in locations close to majority of the residents homes. This location may not be the site selected for the Posyandu.

5. Times that immunizations are conducted should be explored with the Puskesmas staff to determine if alternative schedules can be arranged.

6. Mothers who have their children immunized should be encouraged to contact mothers with a child in the same age range to join the immunization sessions.

East Java CARE staff are also assisting Immunizers review scheduling to determine if a more advantageous arrangement can be devised. A proposal is being drafted that will give non-medical Puskesmas technical staff training as Immunizers.

III.3 Nutrition

When respondents were asked whether they agree or not with a mother giving colostrum to her infant, 50% said it is all right. Of the 14 respondents that were asked what they had fed to their one to three month old child yesterday 93% said breast milk and boiled water only. When the 21 respondents with four to seven month old children were asked what they fed their child yesterday everyone said, mashed rice or banana, or some type of fruit juice. (Refer to Appendix III Tables 14, 17A, 17B).

Nearly 50 % of the respondents were able to state a food to help prevent night-blindness. (Refer to Appendix III Table 19).

88% of the respondents had had their youngest child weighed at least once. Almost 9% of the respondents had never had their youngest child weighed while the remaining respondents did not know if their youngest child had been weighed (Refer to Appendix III Table 20).

Recommendations

Most children in East Java appear to be receiving an adequate diet to ensure their proper growth.

It is not recommended that nutrition be advocated as the first VPHC project priority. Instead the VPHC project through the local village leaders should strive to reinforce the Posyandu nutrition activities.

141

Mother education should stress:

1. Providing weaning foods at four to six months of age:

   - Breast feed until at least 18 months
   - Start porridge at four months. Do not give rice or bananas to a baby younger than four months
   - Fruit juice is good food as well as rice, wheat, potatoes. Cassava, bananas and sago are not good basic foods
   - Add peas, beans, soy beans, fish, milk, eggs, meat to porridge
   - Give children four good meals a day
   - Give fruits and vegetables to children over four months old
   - Sick children need frequent feeding

2. Education about the importance of vitamin rich foods should be given at the Posyandu.

III.4 Diarrhea

The percentage of families that reported having a child with diarrhea during the month of February 1989 (one month prior the survey) was 12%. Respondents who were able to mention at least one sign of severe dehydration was 68% (Refer to Appendix III Table 25, 28).

Over 58% of the respondents were able to give one or more practices to prevent diarrhea. Among the most common responses were feed child fresh and unspoiled foods, cover foods and drinking water from flies and dust, and drink boiled water. When respondents were asked what would they do if their child had diarrhea 87 percent said give him or her Oral Rehydration Solution (ORS), seek medical advice, or similar correct action. (Refer to Appendix III Tables 27, 26).

During the interview, respondents were asked to prepare a home made salt and sugar solution (ORS). Enumerators were to check that one glass of boiled water, one-quarter of a level teaspoon of salt, and one heaped teaspoon of sugar was used. Of the 540 respondents tested only 39 or 7% had the necessary items and were able to prepare the ORS correctly. The most common mistake was the amount of salt used. When asked how much ORS should be given to a child with diarrhea under 27% said one glass per diarrhea episode or as much as they will drink. (Refer to Appendix III Table 30B, 31).

It also appears that there is a general lack of environmental sanitation awareness. Few respondents mentioned the need to protect water sources from human or animal waste.

197

Recommendations

Diarrhea during the time the survey was conducted did not appear to be a major problem. Diarrhea is however still occurring which is probably caused by poor basic hygiene practices. The knowledge about how to prevent and treat diarrhea episodes appears to be good. Unfortunately, most mothers do not know how to mix the home ORS correctly or do not have the proper utensils.

1. As in West Java, basic good hygiene practices need to be reinforced. Village leaders and kader should be encouraged to identify the current hygiene practices and determine how the general community members can be better informed. All existing groups in the community should be encouraged to participate in advocating such practices as:
   - washing hands (with soap) before handling food
   - using latrines
   - keeping chickens out of the kitchen
   - drinking boiled water

2. ORS depots should be established in each village and monitored by village leaders.

3. Use of ORS packets <u>not</u> home mix should be advocated. Village leaders must be involved in ensuring that an adequate supply of packets is available in the village. In addition, all community members, especially mothers with young children, should be taught to properly use the ORS packets.

4. ORT/promotion should be reinforced at all Posyandus by village leaders.

5. Latrine construction and or use should be advocated in each village.

6. Clean water use should also be promoted through the CSFW approach.

III.5 Pregnancy Care

Over 93% of the respondents said that their last delivery was performed by a Traditional Birth Attendant (TBA). When asked to state practices that will help maintain a healthy pregnancy 57% gave two or more correct responses. Among the responses given were: receive at least four check-ups by qualified Puskesmas staff and maintain a proper diet. Complete Tetanus Toxoid immunization was mentioned by some of the respondents. Approximately one quarter (23%) of the respondents had been examined by a doctor or Puskesmas staff member during their last pregnancy. The majority of the respondents (67%) were examined by a traditional caretaker while 6% of the women had received no examination. (Refer to Appendix III Tables 32, 34, 35).

Recommendations

Based on the information collected most children in East Java are delivered with the assistance of a traditional birth attendant. This fact, coupled with low rate of response concerning the importance of tetanus toxoid immunizations for pregnant women strongly indicates a need to insure TBAs are properly trained and TT immunizations are promoted.

It is recommended that East Java VPHC staff concentrate on the following activities.

1. With the Puskesmas staff organize training or as required refresher training for all TBAs. In this training the importance of TT immunizations should be stressed. In addition, training for TBAs should strongly promote proper sterilization techniques.

   Quality of training is very important. Appropriate practical training techniques must be used. Training should also be efficiently conducted and avoid the necessity for TBAs to travel long distances over a period of many months.

2. A list of the local TBAs should be prepared in each village and local leaders should ensure that the TBAs are trained.

3. Follow-up on actual deliveries conducted by the TBAs is important. Regular small group TBA meetings should be coordinated with the Puskesmas staff to review procedures and discuss problem deliveries. This is not formal training rather a review - updating or checking on practices. These meetings should be conducted in strategic locations in each village.

4. Existing village groups should be encouraged to promote TT immunizations and advocate the importance for pregnant women.

5. Tracking of TBAs delivery record should be established. Simple check off forms for the TBAs use are available. These forms should be handed over to the kepala desa monthly.

6. Management and replacement of TBA items is a major complication. An appropriate pregnant women kit containing sterilized razor and disinfectant may need to be produced. This kit could be presented to the TBA by the expecting mother, at time of delivery.

7. CARE East Java staff should consider visiting PCI project in Kendari, Southeast Sulawesi to learn how they support TBA training.

III.6 Acute Respiratory Infection

When respondents were asked to state symptoms that they would worry about if their child had a cough or cold almost 50% where able to mention two or more. If their child is suspected of having ARI 77% of the respondents said they would take their child to the Puskesmas for an examination. (Refer to Appendix III Tables 44, 45).

Recommendations

Acute Respiratory Infection (ARI) is a difficult problem to deal with at present. We suspect that ARI is a major health hazard for children in most villages. The responses indicated by the mothers (visit Puskesmas when child is sick) is an answer they undoubtedly feel is correct to provide but in fact may not be their actual practice. To deal with the ARI problems the CARE staff should:

1. Discuss with the local Puskesmas doctor how they would like to see village members manage ARI (i.e. basis of referral).

2. Be sure the Puskesmas has the appropriate medicines to provide, if patients are referred to the clinic.

3. Continue to promote and insure immunizations are provided which, in part, attack ARI diseases.

4. CIHQ, when EJ is ready and if needed, will consider hiring a professional consultant to teach CARE staff village level practical/management for ARI cases.

III.7 Respondents Overall Health Knowledge

In order to obtain an indicator of the respondents overall health knowledge, five questions were selected to compose a "test" of mothers' health knowledge. These questions are as follows:

Question 9:	Knows reasons for immunization
Question 14:	Agrees to give colostrum to babies
Question 27:	Knowledge of diarrhea prevention
Question 34:	Knows how to maintain healthy pregnancy
Question 45:	Knowledge ARI symptoms

With a possible maximum score of 5,

The average score of respondents was 2.79. Knowledge was lowest about immunization and highest about symptoms of coughs and colds that would be a cause for concern.

145

CARE EAST JAVA
Tulakan Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: **Tulakan, East Java.** n = 540.

	Education Level	**Frequency**	**Percentage**
1.	None (does not have to equal illiteracy)	61	11.3
2.	Under Grade Six	200	37.0
3.	Equal Grade Six	239	44.3
4.	Greater than Grade Six	40	7.4
	Total	540	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Tulakan, East Java.** n = 540.

	Occupation	**Frequency**	**Percentage**
1.	No Wage Labor Reported	125	23.1
2.	Private Business (family)	148	27.4
3.	Merchant	16	3.0
4.	Seasonal Laborer	15	2.8
5.	Civil Servant or Domestic worker)	20	3.7
6.	Other (mainly agriculture related)	216	40.0
	Total	540	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Tulakan, East Java.** n = 540.

	Category	**Frequency**	**Percentage**
1.	Could give proper reason	116	21.5
2.	Could not give proper reason	424	78.5
	Total	540	100.0

146

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: Tulakan, East Java. n = 97.

	Immunization Status:	Frequency	Percentage
1.	In the process or at least first series	78	80.4
2.	Never been immunized	19	19.6
	Total	97	100.0

Table 12C: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). **Frequency** distribution. Tulakan, East Java. n = 443.

	Immunization Status:	Frequency	Percentage
1.	Series complete	268	60.5
2.	Series not complete	175	39.5
	Total	443	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized. **Frequency** distribution. Tulakan, East Java. n = 165.

	Why Child Has Not Been Fully Immunized:	Frequency	Percentage
1.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go)	11	6.7
2.	Mother could not give a reason	37	22.4
3.	Mother or child was sick when the last immunization session was held	28	17.0
4.	The Immunizer was not present during the last immunization session	10	6.1
5.	Other	79	47.9
	Total number of statements	165	100.0

Table 14: Respondents' opinion on whether colostrum should be given to an infant. Frequency distribution. Tulakan, East Java. n = 540.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	272	50.4
2.	Colostrum should not be given to an infant	246	45.6
3.	Does not know	22	4.1
	Total	540	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: Tulakan, East Java. n = 14.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	13	92.9
2.	Respondent mentioned any other type of food	1	7.1
	Total	14	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution. Tulakan, East Java. n = 21.

	Category	Frequency	Percentage
1.	Mother is giving proper food	21	100.0
2.	Weaning foods have not been started	0	0.0
3.	Proper food is not being given	0	0.0
	Total	21	100.0

143

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: Tulakan, East Java. n = 538.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	266	49.4
2. Respondents who do not know	272	50.6
Total	538	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: Tulakan, East Java. n = 540.

Category	Frequency	Percentage
1. Has been weighed at least once	475	88.0
2. Has never been weighed	47	8.7
3. Don't know	18	3.3
Total	540	100.0

Table 25: Respondents with children that had diarrhea in the month prior to the survey. Frequency distribution: Tulakan, East Java. n = 537.

Category	Frequency	Percentage
1. Had diarrhea that month	63	11.7
2. Did not have diarrhea	474	88.3
Total	537	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. **Frequency** distribution: Tulakan, East Java. n = 540.

One or More Correct Response	Frequency	Percentage
1. Correct	472	87.4
2. Incorrect	68	12.6
Total	540	100.0

Table 27: Respondents who know one or more practices to help prevent diarrhea disease. Frequency distribution: Tulakan, East Java. n = 540.

	Response	Frequency	Percentage
1.	Respondent knew one method	130	24.1
2.	Respondent knew two methods	120	22.2
3.	Respondent knew three or more methods	66	12.2
4.	Respondent could not state a method	224	41.5
	Total	540	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: Tulakan, East Java. n = 540.

	Could repondent state one sign of severe dehydration:	Frequency	Percentage
1.	Yes	367	68.0
2.	No	173	32.0
	Total	540	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: Tulakan, East Java. n = 540.

	Category	Frequency	Percentage
1.	Mothers used the proper proportions of boiled water, salt, and sugar	39	7.2
2.	Mothers knew ORS ingredient but did not know proper proportions	22	4.1
3.	Mothers did not know ORS ingredients	479	88.7
	Total	540	100.0

130

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: Tulakan, East Java. n = 540.

	Amount Given	Frequency	Percentage
1.	Correct amount	148	27.4
2.	Correct amount for a baby under 12 months	26	4.8
3.	Incorrect amount	196	36.3
4.	Did not know	170	31.5
	Total	540	100.0

Table 32: Who assisted mother during last birthing. Frequency Frequency distribution: Tulakan, East Java. n = 528.

	Category	Frequency	Percentage
1.	Traditional birth attendant	496	93.9
2.	Family	5	0.9
3.	Puskesmus midwife or doctor	26	4.9
4.	Other	1	0.2
	Total	528	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: Tulakan, East Java. n = 540.

	Number of Correct	Frequency	Percentage
1.	Stated two	156	28.9
2.	Stated three	94	17.4
3.	Stated four or more	57	10.6
4.	Could not state at least two	233	43.1
	Total	540	100.0

151

Table 35: Who examined mother during last pregnancy. Frequency distribution: Tulakan, East Java. n = 421.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	283	67.2
2.	Doctor	2	0.5
3.	Puskesmas staff	98	23.3
4.	Other	13	3.1
5.	No examination	25	5.9
	Total	421	100.0

Table 44: To whom a respondent would go for help if their child had a serious cough or cold (ARI symptoms). Frequency distribution: Tulakan, East Java. n = 533.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	38	6.2
2.	Go to Puskesmas health staff	471	76.5
3.	Go to Kader/Posyandu	20	3.2
4.	Do not know	0	0.0
5.	Other	87	14.1
	Total number of responses	616	100.0

Table 45: Respondents who could state at least one symptom they would worry about if their child already had a cough or cold. Frequency distribution: Tulakan, East Java. n = 540.

	Number correct	Frequency	Percentage
1.	One correct	227	42.0
2.	Two or more correct	268	49.6
3.	Could not offer at least one correct	45	8.3
	Total	540	100.0

151

Table 46: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Tulakan, East Java.** n = 540.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	17	3.1
2.	One correct answer	133	24.6
3.	Two correct answers	117	21.7
4.	Three correct answers	130	24.1
5.	Four correct answers	96	17.8
6.	Five correct answers	47	8.7
	Total	540	100.0

Average score = 2.55.

153

IV. NUSA TENGGARA BARAT (N.T.B)

GUNUNG SARI MOTHERS SURVEY

IV. NUSA TENGGARA BARAT - GUNUNG SARI, MOTHERS SURVEY

IV.1 Description at Project site in Gunung Sari, Nusa Tenggara Barat

The subdistrict of Gunung Sari is located in the province of Nusa Tenggara Barat (NTB). The total population of Gunung Sari's 10 villages is estimated at 61,709. The number of women with a child under 48 months is approximately 6,070. Over 60 percent of the respondents report that they have no formal education with a further 27% under grade six. Nearly 40 percent of the respondents report not to be involved in an income generating activity. Another 35% said they worked as merchants or in the family business. The remaining 24% are farmers, seasonal laborers, or work for the government. (Refer to Appendix IV Tables 5A, 6A).

IV.2 Immunisation

When respondents were asked why immunization is important for under-five children 11% said it makes the body immune to certain diseases or help to maintain the child's health. Less than 35% of the 150 respondents with a child one to 11 months reported that their child has received at least the first immunization. The reported rate for children between 12 and 48 months that have complete immunization is 11% (Refer to Appendix IV Tables 11, 12B).

Although more than a third of the respondents could not supply a reason, common responses mothers gave for not immunizing their children were conflicts in work and Posyandu scheduling, or feeling that immunization is unwise due to personal experience or that of a friend with a child becoming sick after immunization. Other mothers stated that immunization is not necessary for health of their child to be maintained (Refer to Appendix IV Table 12D).

Recommendation

As in the other provinces promoting and supporting immunization services is important. The survey indicates that mothers' knowledge about immunization and completion rates are very low.

It is recommended that the NTB VPHC staff complete the following activities:

1. Immunization services and attendance at Posyandu should be promoted by village leaders.

2. CARE should work closely with the local Puskesmas to ensure that appropriate needed materials are available that make it possible to provide regular services.

3. Village leaders and existing groups should be brought into the process of planning how to promote and support immunization services. The community must get involved in the immunization activities rather than be passive recipients.

155

4. The NTB kader follow-up system for notifying or reminding mothers to attend the next immunization session should be implemented.

5. Immunizer refresher training should be encouraged to ensure proper sterilization and cold chain techniques are being followed.

6. Education at Posyandu sessions for mothers on importance of immunizations and side effects must be organized and provided regularly by trained kader.

7. Location and time of immunization services in the villages should be explored to ensure maximum coverage.

It is possible that the Puskesmas without special training support cannot conduct training effectively. Additional training support at village level may be required from CARE.

IV.3 Nutrition

When respondents were asked if they agree or not with a mother giving colostrum to her infant, slightly more than half said it is good. Thirty five percent feel that it is better not to given and the remaining 15% are not sure. (Refer to Appendix IV Table 14).

Of the 32 respondents who were asked what they had fed their one to three month old child yesterday 88% said breast milk and boiled water only. When the 32 respondents with four to seven month old children were asked what they fed their child yesterday 59% said some type of mashed food such as rice or banana, and breast milk. Over 40% of the respondents had either given something other than a mashed food or only breast milk. (Refer to Appendix IV Tables 17A,17B).

Respondents were also asked what foods will help prevent night-blindness. The majority were not sure while 37% said some kind of leafy green vegetable, soy or dairy product, orange fruit or vitamin A capsule. (Refer to Appendix IV Table 19).

More than forty percent of the respondents stated their youngest child had never been weighed. Of the 449 respondents asked, 7% did not know if their youngest child had been weighed while the remaining respondents had their youngest child weighed at least once (Refer to Appendix IV Table 20).

Recommendation

These survey results correlate with other existing studies in that nutrition education for mothers with small children is an important priority in NTB.

It is recommended that the NTB VPHC staff follow the following recommendations.

126

1. Review the Manoff Studies completed in 1988 on feeding practices of children in NTB. This report should provide excellent additional background information.

2. Concentrate nutrition education on children of weaning age.

3. Involve village leaders in identifying the children's nutrition needs and designing a plan to cope with the problems.

4. As part of the plan, village leaders and kader should organize target group mother practical education demonstrations on how and what to feed children at four-six months of age.

5. Early breast feeding and continued breast feeding should be advocated through existing village groups.

6. Posyandu nutrition education should be upgraded. The nilai system should also be considered as an educational approach. The Puskesmas continued training of kader should be encouraged.

7. Growth monitoring records need to be maintained at each Posyandu.

IV.4 Diarrhea

The number of families that reported to have had a child with diarrhea during the month of February 1989 (one month prior the survey) was 28%. Almost 60 percent of the respondents could give at least one sign of severe dehydration. (Refer to Appendix IV Tables 25, 28).

If their child contracted diarrhea most respondents said they would do one or a combination or the following: 1). Bring their child to the doctor (usually the Puskesmas); 2). give a local herbal diarreal remedy or seek the advice of a traditional healer; 3). begin Oral Rehydration Solution (ORS); or 4). buy an over-the-counter medicine. The number of respondents that specifically stated a correct response was 22%. (Refer to Appendix IV Tables 26).

Respondents were asked to show the enumerator the materials needed to prepare a home-made salt and sugar solution. Those that presented boiled water, a glass, a table spoon, and salt and sugar were then asked to prepare an ORS. Of the 449 respondents, only 2% were able to make ORS correctly. Another 7% knew the ORS ingredients but did not know the proper proportions. When asked how much ORS or Oralit should a child with diarrhea be given 18% or the respondents said either one glass per diarrhea episode or as much as they will drink. (Refer to Appendix IV Tables 30B, 31).

157

The number of respondents who could state at least one practice to help prevent diarrhea was 38%. Among the more common practices stated were protect food and drinking water from flies and dust, drink boiled water, serve foods that are unspoiled, and wash hands before preparing food. (Refer to Appendix IV Table 27).

It appears that there is also a general lack of environmental sanitation awareness. Few respondents mentioned protecting water sources from human or animal waste thus linking waste management and diarrhea.

Recommendation

The survey results indicate that diarrhea is still prevalent in NTB. Mothers, are receiving some basic information but their practical skills or ability to mix ORS is extremely low.

Based on the survey results the following activities are recommended.

1. Behavior patterns that influence diarrheal outbreaks must also be identified by village leaders, i.e. chickens in the kitchen, defecating in the path ways, not washing hands before handling food, uncovered food or improper storage of water. The results of simple surveys should be analyzed by the leaders and appropriate work plans developed to cope with the problems identified.

2. ORS depots should be established in each village and maintained by the health team.

3. ORT should be promoted at each Posyandu session by trained kader.

4. Most importantly village leaders and existing village groups must be made aware of the diarrhea related issues in their respective villages and guided through the process of making realistic plans designed to cope with the problems identified.

5. ORS packets should be advocated and distribution supported.

6. Local village leaders should be guided in how to support the Posyandu and solicit assistance from existing village groups to prevent diarrhea.

7. Use of latrines should be promoted through village leaders and existing village groups. Simple latrine construction demonstration should be conducted by village leader groups and supported by CARE.

8. VPHC should advocate CSFW of water and when interest is demonstrated at the community level contact CARE community organizer for assistance.

9. All local kader and village groups should continue to be taught by the Puskesmas the basic diarrhea prevention program.

158

IV.5 Pregnancy Care

The number of women who had a Traditional Birth Attendant deliver her last child was 68%. Another 9% said that a family member performed the delivery while only 4% used a Puskesmas midwife or doctor. The remaining 18% of mothers said that other people assisted their last delivery. (Refer to Appendix IV Table 32).

When asked to state ways to help maintain a healthy pregnancy 20% were able to mention two or more GOI supported practices. The most prevalent response was eat nutritious foods. Completing Tetanus Toxoid immunization was mentioned by only a few of the respondents. A full 50% of the respondents had no examination during their last pregnancy. Almost one quarter of the respondents were examined by a traditional caretaker, while only 21% were examined by a trained health professional. (Refer to Appendix IV Tables 34a,34b, 35).

Recommendation

The KAP survey results clearly indicate that TBAs serve a major role in delivery of infants. In addition, the mothers' knowledge about the importance of TT immunization is very limited.

It is imperative that the VPHC staff in NTB conduct the following:

1. With local Puskesmas staff arrange and support TT training or as required refresher training.

2. Training quality -- practical skills -- sterilization procedures and importance of TT immunizations needs to be stressed in all TBA training sessions. In addition, training duration and provision of delivery materials need to be carefully planned.

3. As advocated for East Java, TBAs' performance after training needs to be followed up by village leaders using sample record forms.

4. NTB staff should also consider sending one CARE and one GOI representative to study PCI, Kendari, Southeast Sulawesi TBA training program.

5. A list of the local TBAs should be prepared in each village and local leaders should ensure that the TBAs are trained.

6. TBA follow-up on actual deliveries by the TBAs is important. Regular small group TBA meetings should be coordinated with the Puskesmas staff to review procedures and discuss problem deliveries. This is not formal training rather review - updating - check on practices. These meetings should be conducted in strategic locations in the villages.

159

7. Existing village groups should be encouraged to promote TT immunizations availability and advocate the importance for pregnant women.

8. Tracking of TBAs' delivery record should be established. Simple check off forms for the TBAs use are available. These forms should be handed over to the kepala desa monthly.

IV.6 Acute Respiratory Infection

The number of respondents who were able to give two or more ARI symptoms that accompany a cough and cold and would cause them to worry was 30%. If their child was suspected of having ARI over 50 percent of the respondents said they would take him or her to the Puskesmas; 22% said they would bring their child to a traditional healer. (Refer to Appendix IV Tables 44, 45).

Recommendations under this section are the same as the list already provided in the West Java and East Java sections of this report.

IV.7 Respondents Overall Health Knowledge

In order to obtain an indicator of the respondents overall health knowledge, five questions were selected to compose a "test" of mothers' health knowledge. These questions are as follows:

Question 9:	Knows reasons for immunization
Question 14:	Agrees to give colostrum to babies
Question 27:	Knowledge of diarrhea prevention
Question 34:	Knows how to maintain healthy pregnancy
Question 45:	Knowledge ARI symptoms

With a possible maximum score of 5,

The average score of respondents was only 2.02. Knowledge was lowest about immunization and maintenance of a healthy pregnancy. Knowledge was highest about symptoms of coughs and colds that would be a cause for concern.

APPENDIX IV

CARE NUSA TENGGARA BARAT
Gunung Sari Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: **Gunung Sari, NTB.** n = 449.

	Education Level	**Frequency**	**Percentage**
1.	None (does not have to equal illiteracy)	273	60.8
2.	Under Grade Six	122	27.2
3.	Equal Grade Six	29	6.5
4.	Greater than Grade Six	25	5.6
	Total	449	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Gunung Sari, NTB.** n = 449.

	Occupation	**Frequency**	**Percentage**
1.	No Wage Labor Reported	176	39.2
2.	Private Business (family)	45	10.0
3.	Merchant	114	25.4
4.	Seasonal Laborer	46	10.2
5.	Civil Servant or Domestic worker)	5	1.1
6.	Other (mainly agriculture related)	63	14.0
	Total	449	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Gunung Sari, NTB.** n = 449.

	Category	**Frequency**	**Percentage**
1.	Could give proper reason	51	11.4
2.	Could not give proper reason	398	88.6
	Total	449	100.0

161

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: Gunung Sari, NTB. n = 150.

	Immunization Status:	Frequency	Percentage
1.	In the process or at least first series	49	32.7
2.	Never been immunized	101	67.3
	Total	150	100.0

Table 12C: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). Frequency distribution. Gunung Sari, NTB. n = 298.

	Immunization Status:	Frequency	Percentage
1.	Series complete	32	10.7
2.	Series not complete	266	89.3
	Total	298	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized. Frequency distribution. Gunung Sari, NTB. n = 256.

	Why Child Has Not Been Fully Immunized:	Frequency	Percentage
1.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go)	21	8.2
2.	Mother could not give a reason	97	37.9
3.	Mother or child was sick when the last immunization session was held	10	3.9
4.	The Immunizer was not present during the last immunization session	8	3.1
5.	Other	120	46.9
	Total number of statements	256	100.0

Table 14: Respondents' opinion on whether colostrum should be given to an infant. Frequency distribution. Gunung Sari, NTB. n = 449.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	226	50.3
2.	Colostrum should not be given to an infant	155	34.5
3.	Does not know	68	15.1
	Total	449	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: Gunung Sari, NTB. n = 32.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	28	87.5
2.	Respondent mentioned any other type of food	4	12.5
	Total	32	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution. Gunung Sari, NTB. n = 32.

	Category	Frequency	Percentage
1.	Mother is giving proper food	19	59.4
2.	Weaning foods have not been started	8	25.0
3.	Proper food is not being given	5	15.6
	Total	32	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: Gunung Sari, NTB. n = 444.

	Category	Frequency	Percentage
1.	Respondents who stated either proper foods or Vitamin A	166	37.4
2.	Respondents who do not know	278	62.6
	Total	444	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: Gunung Sari, NTB. n = 449.

	Category	Frequency	Percentage
1.	Has been weighed at least once	233	51.9
2.	Has never been weighed	185	41.2
3.	Don't know	31	6.9
	Total	449	100.0

Table 25: Respondents with children that had diarrhea in the month prior to the survey. Frequency distribution: Gunung Sari, NTB. n = 442.

	Category	Frequency	Percentage
1.	Had diarrhea that month	122	27.6
2.	Did not have diarrhea	320	72.4
	Total	442	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: Gunung Sari, NTB. n = 449.

	One or More Correct Response	Frequency	Percentage
1.	Correct	277	61.7
2.	Incorrect	172	38.3
	Total	449	100.0

Table 27: Respondents who know one or more practices to help prevent diarrhea disease. Frequency distribution: Gunung Sari, NTB. n = 449.

	Response	Frequency	Percentage
1.	Respondent knew one method	77	17.1
2.	Respondent knew two methods	64	14.3
3.	Respondent knew three or more methods	30	6.7
4.	Respondent could not state a method	278	61.9
	Total	449	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: Gunung Sari, NTB. n = 449.

	Could repondent state one sign of severe dehydration:	Frequency	Percentage
1.	Yes	263	58.6
2.	No	186	41.4
	Total	449	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: Gunung Sari, NTB. n = 449.

	Category	Frequency	Percentage
1.	Mothers used the proper proportions of boiled water, salt, and sugar	10	2.2
2.	Mothers knew ORS ingredient but did not know proper proportions	32	7.1
3.	Mothers did not know ORS ingredients	407	90.6
	Total	449	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: Gunung Sari, NTB. n = 449.

	Amount Given	Frequency	Percentage
1.	Correct amount	79	17.6
2.	Correct amount for a baby under 12 months	24	5.3
3.	Incorrect amount	72	16.0
4.	Did not know	274	61.0
	Total	449	100.0

Table 32: Who assisted mother during last birthing. Frequency distribution: Gunung Sari, NTB. n = 441.

	Category	Frequency	Percentage
1.	Traditional birth attendant	301	68.3
2.	Family	39	8.8
3.	Puskesmas midwife or doctor	18	4.1
4.	Other	83	18.8
	Total	441	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy: Frequency distribution: Gunung Sari, NTB. n = 449.

	Number of Correct	Frequency	Percentage
1.	Stated two	58	12.9
2.	Stated three	18	4.0
3.	Stated four or more	14	3.1
4.	Could not state at least two	359	80.0
	Total	449	100.0

106

Table 35: Who examined mother during last pregnancy. Frequency distribution: Gunung Sari, NTB. n = 436.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	105	24.1
2.	Doctor	8	1.8
3.	Puskesmas staff	83	19.0
4.	Other	20	4.6
5.	No examination	220	50.5
	Total	436	100.0

Table 44: To whom a respondent would go for help if their child had a serious cough or cold (ARI symptoms). Frequency distribution: Gunung Sari, NTB. n = 445.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	98	18.7
2.	Go to Puskesmas health staff	233	44.6
3.	Go to Kader/Posyandu	2	0.4
4.	Do not know	7	1.3
5.	Other	183	35.0
	Total number of responses	523	100.0

Table 45: Respondents who could state at least one symptom they would worry about if their child already had a cough or cold. Frequency distribution: Gunung Sari, NTB. n = 449.

	Number correct	Frequency	Percentage
1.	One correct	231	51.4
2.	Two or more correct	136	30.3
3.	Could not offer at least one correct	82	18.3
	Total	449	100.0

161

Table 46: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Gunung Sari, NTB.** n = 449.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	29	6.5
2.	One correct answer	165	36.7
3.	Two correct answers	153	34.1
4.	Three correct answers	63	14.0
5.	Four correct answers	27	6.0
6.	Five correct answers	12	2.7
	Total	449	100.0

Average score = 1.84.

168

V. EAST JAVA - BANDAR

MOTHERS SURVEY

V. EAST JAVA - BANDAR, MOTHERS SURVEY

V.1. Description of Project Site in Bandar, East Java

Bandar subdistrict is part of Pacitan district in East Java province. The district covers eight villages with a total population of 37,959. There are estimated to be 2,300 women with children under 48 months in the subdistrict. Most of the respondents (73%) have attained six or more schooling years. Over 40% of them are involved in a family business and 21% reported their main occupation as farmers (Refer to Appendix D, Tables 5A and 6A).

V.2. Immunization

The survey found that 68% of babies up to eleven months of age had started their series of immunizations. Of the children aged between 12 and 48 months, 75% have completed their immunization series. About half of the total respondents in Bandar could state proper reasons why immunization is important. The reasons expressed by mothers whose children were not completely immunized vary, but only 2 respondents mentioned difficulty in access to Posyandu/Puskesmas services. (Refer to Appendix D, Tables 9, 11, 12B, and 12D).

Recommendations

The data suggests that the availability of a local Posyandu/Puskesmas for mothers in Bandar to use is no problem. Therefore, a higher proportion of children completing immunization series can be expected. Emphasis on the importance of immunization and proper follow-up with mothers of children undergoing immunization are the activities recommended for the VPHC to strengthen. Women with an educational attainment like those in Bandar are capable of absorbing health-related information, if it is appropriately presented. The specific recommendations listed for Tulakan subdistrict are also applicable in Bandar.

V.3. Nutrition

When mothers were asked their opinion on feeding a baby with colostrum, only 33% of respondents in Bandar agreed that it is all right. It was found that only 72% of respondents were correctly feeding their babies of one to three months of age with breast milk and boiled water only. Other mothers mentioned that they had started to give other foods. Of the babies aged between four and seven months, 73% were fed with proper foods. (Refer to Appendix D, Tables 14, 17A and 17B).

Among the women interviewed in Bandar, 37% could properly state Vitamin A or a kind of food which is useful for night-blindness prevention. (Refer to Appendix D, Table 19).

A full 88% of the respondents stated their youngest child had been weighed at least once. (Refer to Appendix D, Table 20.)

Recommendations

Mother's education for Bandar sites needs to emphasize the importance of colostrum. Improving mothers' knowledge of nutritious foods needed by children of certain ages and importance of different vitamins should be stressed through VPHC's activities in Bandar. All these can be done and promoted through the local Posyandu program.

V.4. Diarrhea

The percentage of families with children suffering from diarrhea during one month prior to the survey was 25%. Of the total respondents, 64% could mention at least one sign of severe dehydration, and 26% knew two or more practices for diarrhea prevention. (Refer to Appendix D, Tables 25, 27 and 28).

On the actions to be taken when a child has diarrhea, 81% of respondents provided at least one correct response. Only 47% of respondents in Bandar knew the right way to make an oralit drink for a child with diarrhea (Refer to Appendix D, Tables 26 and 31).

Recommendations

The high occurrence of diarrhea in Bandar during the month proceeding the survey suggests a major local problem. Knowledge about the causes of diarrhea and the making of Oralit was poor, and needs to be emphasized in education programs.

Providing guidance for the improvement of basic hygiene practices in daily life -- as detailed in the recommendations for Tulakan site -- is recommended for Bandar site as well. Promoting the use of clean water and construction of latrines through village leaders should also be included in the VPHC activities for Bandar.

V.5. Pregnancy Care

Most of the respondents in Bandar (82%) were assisted by a traditional birth attendant (TBA) during their last delivery. A higher percentage (85%) of mothers consulted the TBA for prenatal examinations. Only a few mothers were examined by Puskesmas staff or a doctor during their pregnancy. More than a half of the respondents understand two or more ways of maintaining a healthy pregnancy. (Refer to Appendix D, Tables 32, 34 and 35).

Recommendations

Survey data indicates that the examinations of pregnant women and delivery of babies in Bandar are mostly being handled by traditional caretakers -- a fact which holds true for the

other VPHC site in East Java. Activities for ensuring that the local TBAs are properly trained are therefore recommended. The activities which East Java VPHC staff should concentrate an, as enumerated in the section for Tulakan, are also appropriate and required for Bandar site.

V.6. Acute Respiratory Infection

At least one correct symptom of an acute respiratory infection which would cause the mother worry could be stated by 80% of respondents in Bandar, while the remaining 20% could offer no proper indicators. "Seek treatment from local Puskesmas" was expressed by 79% of respondents when asked what action they would take when suspecting their child was suffering from ARI. 10% of mothers responded that they would consult a traditional healer. (Refer to Appendix D, Tables 44 and 45).

Recommendations

Although the majority of mothers seemed to be aware of some signs that ARI is becoming serious, ARI is a major health problem for children, and several steps are recommended for the VPHC project to take. These have been listed in the previous section for the Tulakan site.

V.7 Respondents Overall Health Knowledge

In order to obtain an indicator of the respondents overall health knowledge, five questions were selected to come a "test" of mothers' health knowledge. These questions are as follows:

Question 9:	Knows reasons for immunization
Question 14:	Agrees to give colostrum to babies
Question 27:	Knowledge of diarrhea prevention
Question 34:	Knows how to maintain healthy pregnancy
Question 45:	Knowledge ARI symptoms

With a possible maximum score of 5,

The average score of respondents was 2.47. Knowledge was lowest about colostrum and the prevention of diarrhea. Coughs and colds was the area in which respondents demonstrated the greatest knowledge.

APPENDIX V

CARE EAST JAVA
Bandar Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: **Bandar.** n = 329.

	Education Level	**Frequency**	**Percentage**
1.	None (does not have to equal illiteracy)	18	5.5
2.	Under Grade Six	72	21.9
3.	Equal Grade Six	190	57.8
4.	Greater than Grade Six	49	14.9
	Total	329	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Bandar.** n = 329.

	Occupation	**Frequency**	**Percentage**
1.	No Wage Labor Reported	45	13.7
2.	Private Business (family)	137	41
3.	Merchant	23	7.0
4.	Seasonal Laborer	44	13.4
5.	Civil Servant or Domestic worker)	8	2.4
6.	Farmer	68	20.7
7.	Other	4	1.2
	Total	329	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Bandar.** n = 329.

	Category	**Frequency**	**Percentage**
1.	Could give proper reason	173	52.6
2.	Could not give proper reason	156	47.4
	Total	329	100.0

113

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: **Bandar.** n = 87.

	Immunization Status:	**Frequency**	**Percentage**
1.	In the process or at least first series	59	67.8
2.	Never been immunized	28	32.2
	Total	87	100.0

Table 12B: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). Frequency distribution. **Bandar.** n = 239.

	Immunization Status:	**Frequency**	**Percentage**
1.	Series complete	180	75.3
2.	Series not complete	59	24.7
	Total	239	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized Frequency distribution. **Bandar.** n = 51.

	Why child Has Not Been Fully Immunized	**Frequency**	**Percentage**
1.	Posyandu/Puskesmas too far away; Posyandu not active or not existent; have yet to participate in Posyandu activities	2	3.9
2.	Mother too busy or Posyandu scheduled during work	3	5.9
3.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go	7	13.7
4.	Mother or child was sick when the last immunization session was held	11	21.6
5.	The Immunizer was not present during the last immunization session	6	11.8
6.	Mother could not give a reason	7	13.7
7.	Other	15	29.4
	Total number of statements	51	100.0

114

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution. **Bandar.** n = 329.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	108	32.8
2.	Colostrum should not be given to an infant/Does not know	221	67.2
	Total	329	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Bandar.** n = 25.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	18	72.0
2.	Respondent mentioned any other type of food	7	28.0
	Total	25	100.0

Table 17B: Feeding practice of mother with child between [illegible] to 7 months of age. Frequency distribution. **Band** n = [illegible].

	Category	Frequency	Percentage
1.	Mother is giving proper food	11	73.3
2.	Weaning foods have not been started/ Proper food is not being given	4	26.7
	Total	15	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Bandar.** n = 329.

	Category	Frequency	Percentage
1.	Respondents that stated either proper foods or Vitamin A	122	37.1
2.	Respondents that do not know	207	62.9
	Total	329	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: **Bandar.** n = 329.

	Category	Frequency	Percentage
1.	Has been weighed at least once	289	87.8
2.	Has never been weighed	40	12.2
	Total	329	100.0

Table 21F: Respondent's ability to read growth charts; number of correct answers out of five. Frequency distribution: **Bandar.** n = 329.

	Number of Correct Responses	Frequency	Percentage
1.	Less than three correct answers	168	51.1
2.	Three or more correct answers	161	48.9
	Total	329	100.0

Table 25: Respondents with children who had diarrhea in month prior to the survey. Frequency distribution: **Bandar.** n = 329.

	Category	Frequency	Percentage
1.	Had diarrhea that month	83	25.2
2.	Did not have diarrhea	246	74.8
	Total	329	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Bandar.** n = 329.

	One or More Correct Response	Frequency	Percentage
1.	Correct	267	81.2
2.	Incorrect	62	18.8
	Total	329	100.0

Table 27: Respondents whot know two or more practices to help prevent diarrhea disease. Frequency distribution: **Bandar.** n = 329.

	Response	**Frequency**	**Percentage**
1.	Respondent knew two or more methods	86	26.1
4.	Respondent could not state two methods	243	73.9
	Total	329	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Bandar.** n = 329.

	Could repondent state one sign of severe dehydration:	**Frequency**	**Percentage**
1.	Yes	212	64.4
2.	No	117	35.6
	Total	329	100.0

Table 30B: Respondent knows the correct way to make Orali olution from a packet. Frequency distribution: **Bandar.** n = 329.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	Correct answer	80	24.3
2.	Incorrect answer or doesn't know	249	75.7
	Total	329	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Bandar.** n = 329.

	Amount Given	**Frequency**	**Percentage**
1.	Correct amount	154	46.8
2.	Incorrect amount	81	24.6
3.	Did not know	94	28.6
	Total	329	100.0

Table 32: Who assisted mother during last birthing. Frequency distribution: **Bandar.** n = 329.

	Category	Frequency	Percentage
1.	Traditional birth attendant	269	81.8
2.	Family	21	6.4
3.	Puskesmas midwife or doctor	36	10.9
4.	Other	3	0.9
	Total	329	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Bandar.** n = 329.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	184	55.9
2.	Could not state at least two	145	44.1
	Total	329	100.0

Table 35: Who examined mother during last pregnancy. Frequency distribution: **Bandar.** n = 329.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	280	85.1
2.	Doctor	4	1.2
3.	Puskesmas staff	30	9.1
4.	Other	0	0.0
5.	No examination	15	4.6
	Total	329	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Bandar.** n = 328.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	33	10.1
2.	Go to Puskesmas health staff	260	79.3
3.	Go to Kader/Posyandu	1	0.3
4.	Do not know	8	2.4
5.	Other	26	7.9
	Total number of responses	328	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Bandar.** n = 329.

	Number correct	Frequency	Percentage
1.	One correct	262	79.6
2.	Could not offer at least one correct	67	20
	Total	329	100.0

Table 46: Respondents' Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Bandar.** n = 329.

	Number of Correct Responses	Frequency	Percentage
1.	No correct answers	19	5.8
2.	One correct answer	50	15.2
3.	Two correct answers	96	29.2
4.	Three correct answers	99	30.1
5.	Four correct answers	51	15.5
6.	Five correct answers	14	4.3
	Total	329	100.0

Average score = 2.47.

119

VI. COMPARISON OF MOTHERS KNOWLEDGE, ATTITUDES AND PRACTICES IN CARE PROJECT AND CONTROL SITES

VI. COMPARISON OF MOTHERS KNOWLEDGE, ATTITUDES AND PRACTICES IN THE PROJECT AND CONTROL SITES

A comparison has been made of the level of knowledge, attitudes and practices of the mothers interviewed in the three 1989 CARE project sites and control sites. By selecting control sites with similar characteristics to the project sites, it was hoped that the mothers had a similar level of knowledge, attitudes and practices at the time of the baseline survey and that comparison could then be made of the level of change in the project and control sites between baseline and close-out surveys. From Tables VI A, B, C, it can be seen that the three project and control sites differ in terms of the similarity of the mothers knoweldge, attitudes and practices as measured in the baseline survey. The highest level of coincidence between a project site and control site was found in East Java, where there was no significant difference in the answers to ten of the nineteen KAP questions. In West Java, significant differences were found for thirteen questions, and no significant difference was found for only six questions. In NTB, significant differences were found for twelve questions and no significant difference for seven questions.

Where significant differences were found for individual questions in East Java, the level of knowledge attitudes and practice was usually lower in the control site than in the project site. In both West Java and NTB, the level of knowledge, attitudes and practice was usually higher in the control site than in the project site.

In all three areas, the educational level of the mothers was significantly higher in the control sites than in the project sites. In West Java, significantly more women engaged in some economic activity in Gunung Halu than in the control site.

Five questions were chosen to form an overall KAP score for mothers. Only small differences were found in any of the three areas between the project sites and control sites for this overall KAP score. However, there were significant differences for individual questions which contributed to the overall KAP score, and positive and negative differences have balanced out in the overall score.

West Java Mothers Summary Comparison of Project and Control Sites

Table VIa **Project Site: Gununghalu, West Java**
Control Site: Sidangkerta, West Java

Table	Description	Project	Control	Diff.	Chi S
5A	Education >= Grade 6	60.4	78.0	17.6*	18.64
6A	No wage labor reported	70.5	59.5	-11.0*	7.17
9	Know why immunization is important	15.2	36.6	21.4*	4.69
11	Baby under 12 months is immunized	46.2	68.4	22.2*	7.35
12B	Child over 12 months fully immunized	32.8	43.1	10.3*	4.23
14	Colostrum should be given to infant	51.6	67.8	16.2*	14.25
17A	Proper feeding, infant 1-3 months	91.4	72.7	-18.7	2.58
17B	Proper feeding, infant 4-7 months	69.0	60.0	- 9.0	0.27
19	Knows how to prevent night blindness	22.7	33.5	10.8*	7.84
20	Child has been weighed once or more	67.3	84.4	17.1*	19.84
25	Child did not have diarrhea recently	76.5	85.7	9.2*	6.96
26	Knows one way to treat diarrhea	71.0	78.0	7.0	3.37
27	Knows two ways to prevent diarrhea	14.6	20.5	5.9	3.28
28	Knows one sign of severe dehydration	77.1	66.3	-10.8*	7.89
30	Knows how to prepare ORS solution	4.3	13.2	8.9*	15.39
31	Knows amount of ORS to give child	54.8	62.4	7.6	3.18
32	Birth assisted by Puskesmas/doctor	5.9	14.8	8.9*	12.85
34A	Knows two ways for healthy pregnancy	25.3	39.0	13.7*	11.93
35	Examined when pregnant	62.3	84.3	22.0	28.39
44	Seek help from Puskesmas for ARI	70.5	78.0	7.5*	3.87
45	Knows one or more symptoms for ARI	53.2	25.8	-27.4*	40.33
	Health Knowledge score: 9,14,27,34,45	1.60	2.12	0.49	

* statistically significant difference at 95% confidence level

East Java Mothers Summary Comparison of Project and Control Sites

Table VIb **Project Site: Tulakan, East Java**
Control Site: Tegalombo, East Java

Table	Description	Project	Control	Diff.	Chi S
5A	Education >= Grade 6	51.7	70.2	18.5*	15.57
6A	No wage labor reported	23.1	22.0	- 1.1	0.09
9	Know why immunization is important	21.5	14.2	- 7.3	3.72
11	Baby under 12 months is immunized	80.4	96.0	16.4	3.52
12B	Child over 12 months fully immunized	60.5	62.9	2.4	0.23
14	Colostrum should be given to infant	50.4	64.5	14.1*	9.02
17A	Proper feeding, infant 1-3 months	92.9	100.0	7.1	0.23
17B	Proper feeding, infant 4-7 months	100.0	75.0	-25.0*	5.47
19	Knows how to prevent night blindness	49.4	56.7	7.3	2.38
20	Child has been weighed once or more	88.0	97.2	9.2*	10.39
25	Child did not have diarrhea recently	88.3	88.6	0.3	0.01
26	Knows one way to treat diarrhea	87.4	85.8	- 1.6	0.25
27	Knows two ways to prevent diarrhea	34.4	17.0	-17.4*	15.91
28	Knows one sign of severe dehydration	68.0	53.2	-14.8*	10.71
30	Knows how to prepare ORS solution	7.2	3.5	- 3.7	2.50
31	Knows amount of ORS to give child	32.2	22.0	-10.2*	5.57
32	Birth assisted by Puskesmas/doctor	4.9	10.0	5.1*	5.06
34	Knows two ways for healthy pregnancy	56.9	45.4	-11.5*	5.92
35	Examined when pregnant	94.1	94.0	- 0.1	0.00
44	Seek help from Puskesmas for ARI	86.1	82.3	- 3.8	1.32
45	Knows one or more symptoms for ARI	91.7	78.7	-13.0*	19.11
	Health Knowledge score: 9,14,27,34,45	2.55	2.46	-0.09	

* statistically significant difference at 95% confidence level

NTB Mothers Summary Comparison of Project and Control Sites

Table VIc **Project Site: Gunung Sari, NTB**
Control Site: Labuapi, NTB

Table	Description	Project	Control	Diff.	Chi S
5A	Education >= Grade 6	12.0	18.6	6.6*	4.36
6A	No wage labor reported	39.2	36.0	- 2.8	0.50
9	Know why immunization is important	11.4	18.6	7.2*	5.45
11	Baby under 12 months is immunized	32.7	53.1	20.4*	6.52
12B	Child over 12 months fully immunized	10.7	35.7	15.0*	35.08
14	Colostrum should be given to infant	50.3	46.6	- 3.7	0.67
17A	Proper feeding, infant 1-3 months	87.5	94.1	6.6	0.53
17B	Proper feeding, infant 4-7 months	59.4	83.3	23.9	2.23
19	Knows how to prevent night blindness	37.4	52.5	15.2*	11.02
20	Child has been weighed once or more	51.9	73.3	21.4*	22.21
25	Child did not have diarrhea recently	72.4	73.6	1.2	0.08
26	Knows one way to treat diarrhea	61.7	86.3	24.6*	33.18
27	Knows two ways to prevent diarrhea	20.9	29.2	8.3*	4.55
28	Knows one sign of severe dehydration	58.6	74.5	15.9*	12.92
30	Knows how to prepare ORS solution	2.2	4.4	2.2	1.97
31	Knows amount of ORS to give child	22.9	47.8	24.9*	35.28
32	Birth assisted by Puskesmas/doctor	4.1	9.5	5.4*	6.54
34A	Knows two ways for healthy pregnancy	20.0	23.0	3.0	0.62
35	Examined when pregnant	49.5	64.7	15.2*	9.36
44	Seek help from Puskesmas for ARI	48.3	74.5	26.2*	32.91
45	Knows one or more symptoms for ARI	81.7	89.2	7.5	3.58
	Health Knowledge score: 9,14,27,34,45	1.84	2.06	0.22	

* statistically significant difference at 95% confidence level

184

VII. KADER SURVEY

VII. KADER SURVEY

The questionnaire used to test kaders knowledge, attitudes and practices was almost identical to that used for the mothers, but the form of a small number of questions was changed, as not all kader have a child under the age of four.

In Tables VII A, B and C results are summarized for the kaders' knowledge, attitudes and practices in the CARE project sites and control sites. In can be seen that there is a good match in all three locations. In West Java, there was no significant difference in the answers to twelve out of the fifteen KAP questions between CARE project and control sites. In East Java and NTB there was no significant difference to thirteen out of the fifteen questions.

In tables VII D and E a comparison is made of mothers and kaders knowledge, attitudes and practices in the CARE sites and control sites. In nearly every instance the kader demonstrated higher scores than the mothers. Their educational attainment was also higher than that of the mothers.

West Java Kader Summary Comparison of Project and Control Sites

Table VIIa **Project Site: Gununghalu, West Java**
Control Site: Sidangkerta, West Java

Table	Description	Project	Control	Diff.	Chi S
5A	Education >= Grade 6	90.0	85.0	-5.0*	0.46
6A	No wage labor reported	55.0	52.5	-2.5	0.05
9	Know why immunization is important	67.5	70.0	2.5	0.06
14	Colostrum should be given to infant	57.5	82.5	25.0*	5.95
17A	Proper feeding, infant 1-3 months	67.5	70.0	2.5	0.06
17B	Proper feeding, infant 4-7 months	90.0	87.5	-2.5	0.13
19	Knows how to prevent night blindness	70.0	52.5	-17.5	2.58
20	Knows age when child should first be weighed	70.0	30.0	-40.0*	12.80
25	Kader whose supervised children did not have diarrhea recently	62.5	85.0	22.5*	5.23
26	Knows one way to treat diarrhea	95.0	92.5	-2.5	0.21
27	Knows two ways to prevent diarrhea	60.0	60.0	0.0	0.00
28	Knows one sign of severe dehydration	82.5	67.5	-15.0	2.40
30	Knows how to prepare ORS solution	22.5	35.0	12.5	1.53
31	Knows amount of ORS to give child	72.5	72.5	0.0	0.00
34	Knows two ways for healthy pregnancy	72.5	67.5	-5.0	0.24
44	Seek help from Puskesmas for ARI	80.0	90.0	10.0	1.57
45	Knows one or more symptoms for ARI	62.5	72.5	10.0	0.91
	Health Knowledge score: 9,14,27,34,45	3.05	3.38	0.33	

* statistically significant difference at 95% confidence level

187

East Java Kader Summary Comparison of Project and Control Sites

Table VIIb **Project Site: Tulakan, East Java**
Control Site: Tegalombo, East Java

Table	Description	Project	Control	Diff.	Chi S
5A	Education >= Grade 6	86.8	95.0	8.2	1.59
6A	No wage labor reported	36.8	12.5	-24.3*	6.27
9	Know why immunization is important	68.4	52.5	-15.9	2.06
14	Colostrum should be given to infant	72.5	57.5	-15.0	1.98
17A	Proper feeding, infant 1-3 months	100.0	85.0	-15.0*	6.18
17B	Proper feeding, infant 4-7 months	97.4	87.5	-9.9	2.67
19	Knows how to prevent night blindness	84.2	85.0	0.8	0.01
20	Knows age when child should first be weighed	68.4	77.5	9.1	0.82
25	Kader whose supervised children did not have diarrhea recently	89.5	87.5	-2.0	0.07
26	Knows one way to treat diarrhea	97.4	97.5	0.1	0.00
27	Knows two ways to prevent diarrhea	65.8	52.5	-13.3	1.42
28	Knows one sign of severe dehydration	84.2	72.5	-11.7	1.57
30	Knows how to prepare ORS solution	26.3	12.5	-13.8	2.39
31	Knows amount of ORS to give child	65.8	55.0	-10.8	0.95
34	Knows two ways for healthy pregnancy	78.9	90.0	11.1	1.83
44	Seek help from Puskesmas for ARI	94.7	85.0	-9.7	2.01
45	Knows one or more symptoms for ARI	97.4	80.0	-17.4*	5.76
	Health Knowledge score: 9,14,27,34,45	3.87	3.33	-.54	

* statistically significant difference at 95% confidence level

188

NTB Kader Summary Comparison of Project and Control Sites

Table VIIc **Project Site: Gunung Sari, NTB**
Control Site: Labuapi, NTB

Table	Description	Project	Control	Diff.	Chi S
5A	Education >= Grade 6	84.0	80.0	-4.0*	0.16
6A	No wage labor reported	26.0	5.0	-21.0*	3.94
9	Know why immunization is important	64.0	45.0	-19.0	2.13
14	Colostrum should be given to infant	64.0	40.0	-24.0	3.63
17A	Proper feeding, infant 1-3 months	90.0	100.0	10.0	2.15
17B	Proper feeding, infant 4-7 months	92.9	100.0	8.0	1.70
19	Knows how to prevent night blindness	78.0	85.0	7.0	0.44
20	Knows age when child should first be weighed	74.0	85.0	11.0	0.98
25	Kader whose supervised children did not have diarrhea recently	76.0	60.0	16.0	1.79
26	Knows one way to treat diarrhea	98.0	95.0	-3.0	0.46
27	Knows two ways to prevent diarrhea	52.0	65.0	13.0	0.98
28	Knows one sign of severe dehydration	80.0	90.0	10.0	1.01
30	Knows how to prepare ORS solution	16.0	15.0	-1.0	0.01
31	Knows amount of ORS to give child	48.0	75.0	27.0*	4.22
34	Knows two ways for healthy pregnancy	68.0	55.0	-13.0	1.05
44	Seek help from Puskesmas for ARI	92.0	85.0	-7.0	0.78
45	Knows one or more symptoms for ARI	82.0	100.0	18.0*	4.13
	Health Knowledge score: 9,14,27,34,45	3.30	3.05	-0.25	

* statistically significant difference at 95% confidence level

VII-D. COMPARISON OF MOTHERS AND KADER KNOWLEDGE ATTITUDE AND PRACTICES IN CARE SITES

Table	Description	West Java		East Java		N.T.B.	
		Mothers	Kader	Mothers	Kader	Mothers	Kader
5A	Education >= Grade 6	60.4	90.0	51.7	86.8	12.0	84.0
6A	No wage labor reported	70.5	55.0	23.1	36.8	39.2	26.0
9	Know why immunization is important	15.2	67.5	21.5	68.4	11.4	64.0
14	Colostrum should be given to infant	51.6	57.5	50.4	72.5	50.3	64.0
17A	Proper feeding, infant 1-3 months	91.4	67.5	92.9	100.0	87.5	90.0
17B	Proper feeding, infant 4-7 months	69.0	90.0	100.0	97.4	59.4	92.9
19	Knows how to prevent night blindness	22.7	70.0	49.4	84.2	37.4	78.0
26	Knows one way to treat diarrhea	71.0	95.0	87.4	97.4	61.7	98.0
27	Knows two ways to prevent diarrhea	14.6	60.0	34.4	65.8	20.9	52.0
28	Knows one sign of severe dehydration	77.1	82.5	68.0	84.2	58.6	80.0
30	Knows how to prepare ORS solution	4.3	22.5	7.2	26.3	2.2	16.0
31	Knows amount of ORS to give child	54.8	72.5	32.2	65.8	22.9	48.0
34	Knows two ways for healthy pregnancy	25.3	72.5	56.9	78.9	20.0	68.0
44	Seek help from Puskesmas for ARI	70.5	80.0	86.1	94.7	48.3	92.0
45	Knows one or more symptoms for ARI	53.2	62.5	91.7	97.4	81.7	82.0
	Health Knowledge score: 9,14,27,34,45	1.60	3.05	2.55	3.87	1.84	3.36

198

VII E. COMPARISON OF MOTHERS AND KADER KNOWLEDGE, ATTITUDES AND PRACTICES IN CONTROL SITES

Table	Description	West Java		East Java		N.T.B.	
		Mothers	Kader	Mothers	Kader	Mothers	Kader
5A	Education >= Grade 6	78.0	85.0	70.2	95.0	18.6	80.0
6A	No wage labor reported	59.5	52.5	22.0	12.5	36.0	5.0
9	Know why immunization is important	36.6	70.0	14.2	52.5	18.6	45.0
14	Colostrum should be given to infant	67.8	82.5	64.5	57.5	46.6	40.0
17A	Proper feeding, infant 1-3 months	72.7	70.0	100.0	85.0	94.1	100.0
17B	Proper feeding, infant 4-7 months	60.0	87.5	75.0	87.5	83.3	100.0
19	Knows how to prevent night blindness	33.5	52.5	56.7	85.0	52.5	85.0
26	Knows one way to treat diarrhea	78.0	92.5	85.8	97.5	86.3	95.0
27	Knows two ways to prevent diarrhea	20.5	60.0	17.0	52.5	29.2	65.0
28	Knows one sign of severe dehydration	66.3	67.5	53.2	72.5	74.5	90.0
30	Knows how to prepare ORS solution	13.2	35.0	3.5	12.5	4.4	15.0
31	Knows amount of ORS to give child	62.4	72.5	22.0	55.0	47.8	75.0
34	Knows two ways for healthy pregnancy	39.0	67.5	45.4	90.0	23.0	55.0
44	Seek help from Puskesmas for ARI	78.0	90.0	82.3	85.0	74.5	85.0
45	Knows one or more symptoms for ARI	25.8	72.5	78.7	80.0	89.2	100.0
	Health Knowledge score: 9,14,27,34,45	2.12	3.38	2.46	3.33	2.06	3.05

191.

APPENDIX A

Baseline Survey Methodology

VIII. APPENDIX A. BASELINE SURVEY METHODOLOGY

VPHC FY 89

BASELINE AND CLOSE-OUT SURVEY - VPHC 1989 METHODOLOGY
If you cannot follow the instruction or :)ed to make major changes you must have Jakarta Headquarters' approval

1. **Background**

During 1989, CARE will be implementing a Village Primary Health Care project is three provinces: West Java, East Java and NTB. In each province, CARE will work in one subdistrict and the target population will be all mothers with a child under five years of age in the subdistrict. It is important to note that most of the health messages contained in the project relate particularly to mothers with a child under one year old.

Estimated population figures for the three subdistrict are as follows:

	No. of Village	Total Population	Mothers with children < 5 yrs
West Java	17	90,359	5,250
East Java	16	58,000	3,542
N.T.B.	10	60,000	6,682

2. **Objectives of the Survey**

Objectives of the survey are to provide:

2.1 baseline data on knowledge, attitude and practices of mothers (caretakers) with a child under four years of age.

2.2 information which will assist the government in identifying problems related to Posyandu operations.

2.3 an indication of the VPHC project's overall impact as determined by achievement of the intermediate goals.

3. **Sampling for the Baseline Survey FY 89**

3.1 Lists of mothers with children less than four years will need to be compiled. Each province has to identify the most reliable source, e.g. BKKBN, Dinkes, Puskesmas, RW, or RT. Names and addresses of women will be included in the list if they fall into the required categories.

Separate lists will be compiled for a) mothers with children under 4 years, and b) mothers with a child less than 1 year. If a women falls into both categories, she will be included in the list of mothers with a child less than one year; not in the list for mothers with children under four.

The lists will be prepared village by village, so that the sample drawn can be stratified by village.

3.2 If necessary lists of mothers with children under 4 years and mothers with a child less than 1 year will have to be drawn up from Posyandu records and village leaders/kader. These lists would be less complete, and this approach should only be used if other more reliable data are not available.

3.3 The sample size in each province will have to be determined as follows:

a) The table of sample sizes contained in Dep.Dikbud's "Dasar-dasar Methodologi Riset Ilmu Kedokteran" can be used to determine your respective sample sizes. However, a more accurate size could be calculated by using the formula:

$$n = \frac{n_0}{1 + \frac{n_0 - 1}{N}}$$

n = sample size
n_0 = 400 (fixed)
N = target population

A province, for example, with 5,130 mothers with children under 5 years, calculates their sample size as follows:

$$\frac{400}{1 + \frac{400 - 1}{} } = \frac{400}{1 + \frac{399}{5130}} = 371$$

b) The sample size will be increased by 20% to allow for women who move away from their village or became unavailable for other reasons, during the next year i.e. the period of CARE's intervention. This is to ensure that a sufficiently large sample is available for the close out survey, assuming that the same women will be interviewed again (This was later changed, and a new sample is being chosen at close-out). Again an example for the above mentioned number of sample size:

371 + 20% = 445

c1) New sample list 445 should be increased by 20% again. This extra 20% is used to replace those women that cannot be located when conducting the actual baseline survey. (See section below for details). This new sample list will be

445 + 89 (or 20%) = 534

c2) At the time of the baseline survey it will be found that some women on the sample list cannot be interviewed (may be ill, left the village, not at home when the interviewer calls, etc.). If a woman is not at home when the interviewer calls, the interviewer should return to the house on two further occasions (at different times of day) to try and interview the woman unless it is known she will not be available. The interviewer should report to the survey supervisor if any woman is not available to be interviewed. The survey supervisor will then give the interviewer the name of another woman to be interviewed from a supplementary list, complied to allow for replacements in the sample as just described. It is important to stop interviewing after 445 interviews are conducted.

3.4 The method of compiling the sample should therefore be as follows:

a) For each village obtain two lists:

- List of mothers with children under 4 years
- List of mothers with a child under 1 year (if the woman is in both lists, delete her name from the list of mothers with a child under four years).

b) For each list, number the women in sequence i.e. one, two, three, etc.

c) Total the lists for all villages in the subdistrict.

d) Calculate the percentage of women to be drawn from the lists to give a sample of 445 in West Java case, as follows:

$\frac{445}{\text{[Total women on lists in all villages]}} \times 100 =$ % of women to be included in sample (sampling proportion)

(If a total of 5,130 women are listed for the subdistrict, the percentage to be included in the sample will be:

$\frac{445}{5130} \times 100 = 8.67\%$

e) For <u>each</u> separate list per village, calculate how many women should be randomly chosen to be included in the sample, (i.e. sample size of mothers with children under 5 years in Village A =

sampling proportion x total number of mothers listed for village A.

(For village A, with 210 mothers, where the percentage to be included in the sample is 8.67%, the sample size should be: 8.67/100 x 210 = 18.2 or 18 corrected to the nearest whole number).

When the sample size for the lists of mothers with children under 4 years and mothers with a child under one has been calculated for <u>each</u> village, add them all together to check that you have a total of approximately 445 (it may be a little above or below 445 because of the correction of samples to the nearest whole number).

e1) <u>Mothers with Children 0-1: Percentage Required</u>

1. Total number of mothers with children 0-4 years [Example: 5,130].

2. Determine desired sample size ([Example: sample size is 445 with 20% added).

3. Total number of mothers with children 0-1 year [Example: 1300].

4. Must determine what proportion is 0-1 year group from total population of mother 0-4 years. [1300 : 5130 x 100] = 25.3%

5. Therefore 25.3% or 113 of the sample mothers should be mothers with children 0-1 year.

f) For specific instruction on selecting a sample, refer to pages 15-17 of the <u>Monitoring and Evaluation Packet</u> prepared last year. I have also attached a table of random numbers but it would be easier to use the instructions provided in the Evaluation Packet. [Suggest you review again the entire Evaluation Packet before proceeding with the survey].
<u>or</u>
Draw the sample from each list, using random number tables, i.e. for the list of 210 mothers in village A, where we want a sample of 18 women, start with the last three digit number from the random number tables and take the next numbers listed in sequence until you have 18 which fall between 1 and 210. Any number between 211 and 999 is ignored, and the next number is taken.

g) It is very important to make sure that the names and addresses of all mothers or caretakers are properly recorded. This pre/post test procedure requires that we return for the post test to the same people on both the target and control sites (later changed and a new sample will be chosen at close-out).

Control Sites

It has been decided that control sites will be surveyed, five in East Java and West Java, and four in NTB. To select the control villages you must match villages in a neighboring subdistrict. Select target villages [example: NTB 4] that can be matched against 4 control villages. [Example: 4 NTB sites matched with 4 control villages).

Suggested criteria to be considered:

1. GOI classification of villages into Swadaya, Swasembada, Swakarya

2. Villages have established, working clean water systems and electricity.

3. Similar status of Posyandu and kader activities.

4. Similar Puskesmas status and distance [in minutes] from surveyed village.

5. Religious and educational facilities in the village

6. Proximity to main roads

7. Level of estimated income.

8. Equivalent population men, women and children 0-5 years.

This is a difficult task, and if it is found to be impossible to do, we will then be forced to drop the control group. In addition, cost of conducting the survey in the control sites must be considered.

Sample in Control Sites

Selected control villages are be compared to selected CARE target villages. The sample size from the control sites and target villages should be 10% each [10% control villages, 10% target villages] from the total number of mothers with children 0-4 years. Follow the same procedures previously described to get the numbers of mothers to be interviewed. Please recall that the sample size must be increased by 20% for replacement. The baseline list of mothers must be again increased by 20% in case mothers cannot be found during the baseline survey.

Tentative Instruction for NTB (or where no list of mothers are available) for Selecting Sample

If list of mothers are not available, I suggest that you randomly select 2 RTs from every village. From these 2 RTs you collect with the village representatives a list of all children 0-4 years. Then proceed to follow the instructions provided above. My guess is that your sample size will be sufficient and the major task of conducting a census can be avoided.

Please do not hesitate to contact me if you need help. I will get someone out to help you immediately.

A P P E N D I X B

KAP Questionnaire - Mothers

VIII. APPENDIX B - KAP QUESTIONNAIRE - MOTHERS (REVISED)

PROGRAM KESEHATAN MASYARAKAT DESA
SURVEI PENGETAHUAN, SIKAP DAN PERILAKU (PSP)
TAHUN 1991

KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) SURVEY
VPHC II - 1991

Nomor Formulir: Form number	1 [ ]
Propinsi Province	2 [ ]
Kecamatan Subdistrict	4 [ ]
Desa Village	6 [ ]
Ibu Hamil/Bayi Mother's code	8 [ ]
Kode: Ibu bayi (1) atau Ibu Balita (2) Code: Mother of infant (1) or Mother of child 1-<4 years (2)	10 [ ]

Nama Ibu :..... **Usia** ..... **tahun**
Mother's name :..... age: ..... years

(Hanya nama tersebut diatas yang dapat diwawancarai. Kecuali ibu bayi telah meninggal, seseorang yang memelihara bayi dapat diwawancarai
(Only the above name can be interviewed, except if the mother has died when the caretaker can be interviewed.)

Alamat:
Address:

RT/RW:.....
Neighborhood/subhamlet:

Dusun:.....
Hamlet:

Desa:.....
Village:

Kecamatan:.....
Subdistrict:

Nama pewawancara: .....
Interviewer's name:

Tanggal wawancara: .../.../.....
Date of interview:

Tanda tangan:
Signature:

100

A. Formulir Pemeriksaan Hasil Wawancara
Interview Supervision Form

Nama Supervisor Supervisor name	Tanggal pemeriksaan Date	Selesai complete	Tidak Selesai incom-plete	Komentar dan nomor2 yang belum dilengkapi Comments and numbers of incomplete responses	Tanda tangan signa-ture

B. Wawancara Ulang
Re-interview check Form

(Bila dikehendaki, sesuai komentar supervisor)
(If needed, in accordance with supervisor's comment)

Tanggal Wawancara date of intv	Hasil Wawancara Selesai*) completed	Tidak Selesai*) incomplete	Alasan Tidak Selesai reason incomplete	Tanda Tangan signature

C. Formulir Pengkode (tidak selesai)
Coding Form (icomplete)

Nama Name	Tanggal Pem-berian kode date of coding	Komentar comments	Tanda Tangan sign.

*) Berikan tanda check list.
Put a check mark (V)

201

PETUNJUK WAWANCARA
INSTRUCTIONS ON INTERVIEW

1. **Tanyakan semua pertanyaan yang terdaftar dalam kuesioner ini tanpa memberi kesempatan kepada responden untuk membaca isi kuesioner.**
   Ask all of these questions without showing the questionnaire to the respondents

2. **Catat semua respon dengan cara sebagai berikut:**
   Record all responses in the following manner:

   2.1 **Bilamana terdapat beberapa alternatif respon pada setiap pertanyaan, berikan tanda silang (X) sesuai respon yang diberikan.**
   If there are several alternative responses to a question, put a cross mark (X) against the answer given.

   2.2 **Bilamana jawaban berupa angka atau nomor misalnya: umur, jumlah kunjungan ke Puskesmas; tuliskan angka atau nomor pada kolom/kotak/titik-titik yang disediakan.**
   If the answer is ranked or numerical (such as: age, number of visits to the health centre) write the rank or number in column/box or on the dotted line.

   2.3 **Berilah tanda "x" untuk setiap jawaban pada kotak atau kolom yang disediakan.**
   Put 'x" for each of the responses in the corresponding box or column.

3. **Jangan isi kotak sebelah kanan kuesioner. Kotak ini disediakan untuk analisa data.**
   Do not write anything in the boxes at the right of the questionnaire. They are intended for data analysis purposes.

-202-

Lanjutkan wawancara bila jawaban 1A atau 1B YA. Bila keduanya TIDAK, HENTIKAN wawancara. Pilih responden lainnya dalam daftar.
If answers to question 1A and 1B are NO, do not continue with the interview. Another respondent should be chosen from the list.

1A. **Apakah Ibu mempunyai anak usia 0 - < 48 bulan?**
Do you have a child age between 0 - < 48 months?

0. [ ] Tidak
No

1. [ ] Ya
Yes

1B. **Apakah Ibu mempunyai anak berusia 0 - < 48 bulan yang meninggal 12 bulan terakhir?**
Do you have a child age 0 - <48 months who died during the past twelve months?

0. [ ] Tidak
No

1. [ ] Ya
Yes

5A. **Pendidikan responden:**
Respondent's education:

0. [ ] **Tidak sekolah**
No education

1. [ ] **SD tidak tamat**
Primary school, not completed

2. [ ] **SD tamat**
Primary school, graduated

3. [ ] **SLTP tidak tamat**
Junior High School, not completed

4. [ ] **SLTP tamat**
Junior High School, graduated

5. [ ] **SLTA tidak tamat**
Senior High School, not completed

6. [ ] **SLTA tamat**
Senior High School, graduated

9. [ ] **Perguruan Tinggi**
University

203

5C Apakah responden mengikuti Kejar Paket-A ?
Has respondent taken part in the Adult Literacy (Packet A) program?

0. [ ] Tidak
No

1. [ ] Ya
Yes

6A. Pekerjaan responden
Respondent's occupation

Di samping mengurus rumah tangga, pekerjaan apa yang Ibu lakukan untuk membantu mencari nafkah?
Apart from housework, what work do you do to help with the family income?

Bacakan setiap pilihan di bawah ini. Responden mungkin:
Read each of the following options. The respondent might be :

---

0. [ ] Tidak bekerja untuk nafkah (ibu rumah tangga)
Does not work for payment (housewife)

1. [ ] Pembantu rumah tangga (di luar rumah sendiri)
House servant (outside her own house)

2. [ ] Membantu pekerjaan keluarga yang menghasilkan pendapatan keluarga
Help in family bussines

3. [ ] Karyawan Pemerintah/ABRI
Civil servant/military

4. [ ] Industri rumah yang menghasilkan pendapatan keluarga
Home industry

5. [ ] Buruh tani musiman
Seasonal laborer

6. [ ] Pedagang
Merchant

9. [ ] Petani
Farmer

7. [ ] Lain², sebutkan:.....
Others, describe:

204

7. DAFTAR BALITA HIDUP
TABLE OF LIVING CHILDREN UNDER UNDER FIVE YEARS OLD

No.	Umur / Age
1.	Balita terkecil berusia .....bulan The youngest child's age.....month
2.	Balita ke2 dari bawah berusia .... bulan The second youngest child's age....month
3.	Balita ke3 dari bawah berusia .... bulan The third youngest child's age.....month
4.	Balita ke4 dari bawah berusia .... bulan The fourth youngest child's age... month
5.	Jumlah balita: ..... orang # of living children <5 ..... people

8A. Apakah ada balita Ibu yang meninggal selama 12 bulan terakhir ?
Do you have a child <5 years old who has died in the last 12 months?

0. [ ] Tidak ada
No

1. [ ] Ya
Yes

IMUNISASI / IMMUNIZATION

9. Apakah ibu dapat menjelaskan arti imunisasi ?
Can you tell me the reason for immunization ?

1. [ ] Memberikan kekebalan tubuh untuk mencegah penyakit tertentu
To make the body immune to certain diseases

0. [ ] Tidak tahu atau Lain²
Don't know or Others

11. Apakah balita Ibu 0 - <12 bulan sudah diimunisasi?
Has your baby (0 - <12 months) already been immunized?

0 [ ] Tidak
No

-1 [ ] Anak sudah >12 bulan
Child age >12 months

1 [ ] Ya
Yes

8 [ ] Tidak tahu
Don't know

205

12C **Apakah imunisasinya lengkap untuk anak terkecil (12<48 bulan)?**
Is immunization complete for the youngest child (12<48 months)?

0. [ ] **Tidak/belum**
No/Not yet

1. [ ] **Ya**
Yes

-1 [ ] Anak belum 12 bulan
Child age <12 months

8. [ ] Tidak tahu
Don't know

Untuk pewawancara:
Bila imunisasi bayi responden belum lengkap, tanyakan pertanyaan berikut:
For the interviewer:
If the respondent says immunization is not complete, ask the following questions:

12D. **Dapatkah ibu menjelaskan mengapa balita ibu belum diimunisasi secara lengkap?**
Can you explain why your child has not yet been fully immunized?

-1 [ ] **Sudah diimunisasi atau sedang dalam process**
Has been immunized or within the process

1. [ ] **Anak menjadi sakit setelah imunisasi pertama**
The child got sick after the first immunization

2. [ ] **Ibu/anak sedang sakit ketika ada imunisasi**
The mother/child was ill when there was immunization

4. [ ] **Juru imunisasi berhalangan hadir ke Posyandu**
The immunizer did not come to Posyandu

5. [ ] **Tidak ada waktu (sibuk)**
Did not have time (busy)

9. [ ] **Anak sudah sehat/Sudah lewat usia/Tidak tahu mengapa harus pergi**
Child is healthy/Child is too old/Don't know why they should go

10. [ ] **Belum pernah ke Posyandu, Puskesmas jauh atau tidak aktif**
Never been to Posyandu, Puskesmas is very far, or not active

7. [ ] **Lain-lain, sebutkan.....**
Others, describe:

8. [ ] **Tidak tahu**
Don't know

206

GIZI
NUTRITION

14. **Jika susu jolong (kolestrum) diberikan ke bayi, bagaimana pendapat ibu ?**
What is your opinion about giving the first milk (colostrum) to a baby?

0. [ ] **Tak setuju/Tidak tahu**
Disagree/Don't know

1. [ ] **Setuju**
Agree

16. **Berapa bulan usia anak ibu yang terkecil ?**
How old is your youngest child

1. [ ] **0 - <4 bulan ---> langsung ke #17A kemudian #18**
0 - <4 months --> go to #17A and then #18

2. [ ] **4 - <7 bulan ---> langsung ke #17B kemudian #18**
4 - <7 months --> go to #17B and then #18

0. [ ] **Tidak ada bayi --> langsung ke #18**
No baby -----> go to #18

17A. **Makanan apakah yang Ibu berikan kemarin kepada bayi Ibu yang bungsu (0 - <4 bulan) ?**
What food did you give yesterday to your youngest child (0-<4 months)

1. [ ] **Air susu ibu (dan air matang)**
(Benar kalau dijawab air matang sebagai tambahan air susu ibu)
Breastmilk and boiled water)
(It is correct if the mother says that she also gives boiled water to the baby)

0. [ ] **Segala makanan/Tidak tahu**
All kinds of food/Don't know

1/0 [ ] Lain-lain: _____
Others:

201

17B. **Makanan apakah yang Ibu berikan kemarin kepada bayi ibu yang bungsu (4 - <7 bulan) ?**
(Sarapan / siang / malam / lainnya)
What food did you give yesterday to your youngest child (4 - <7 months)
(Breakfast / lunch / dinner / other)

1. [ ] **Nasi lumat**
Mashed rice

1. [ ] **Pisang lumat**
Mashed banana

1. [ ] **Sari buah-buahan**
Fruit juice

1. [ ] **Tempe, telur, ikan lumat**
Mashed soybean cake, egg, fish

0. [ ] **Tidak diberi apa-apa**
Gave nothing

1/0. [ ] **Lain-lain, sebutkan** _____
Others, describe:

8. [ ] **Tidak tahu.**
Don't know

(No. 17B diisi oleh Supervisor. Isikan 1 jika ada satu benar)
(No. 17B to be filled in by Supervisor. Put 1 if here is one correct)

19. **Dapatkah Ibu menyebutkan makanan yang dapat mencegah buta ayam (rabun senja)?**
Can you mention foods that prevent "chicken blindness" (twilight blindness)?

1. [ ] **Sayur mayur hijau (bayam, kacang hijau)**
Green vegetables (spinach, mung bean)

1. [ ] **Buah-buahan sayur mayur merah/kuning (Mangga, pepaya, ubi jalar, wortel).**
Red/yellow fruits and vegetables (manggo, papaya, yam, carrot)

1. [ ] **Telur**
Eggs

1. [ ] **Air Susu Ibu**
Breastmilk

1. [ ] **Vitamin A**
Vitamin A

0. [ ] **Tidak tahu atau Lain-lain**
Don't know or Others

(No. 19 diisi oleh Supervisor. Isikan 1 jika ada satu benar)
(No. 19 to be filled in by Supervisor. Put 1 if there is one correct)

20. **Pada usia berapa anak Ibu yang terkecil pertama kali ditimbangkan?**
At what age was your youngest child first weighed ?

0. [ ] **Belum pernah**
Never been weighed

1. [ ] Ya (minimal satu kali ditimbang)
Yes (has been weighed at least once)

DIARE
DIARRHEA

Pengertian diare adalah:
berak cair lebih dari 3 x sehari.
The definition of diarrhea is:
more than three loose stools a day

25. **Apakah selama satu bulan belakangan ini balita Ibu menderita Diare?**
In the last month have your child(ren) <5 years had diarrhea ?

0. [ ] **Tidak**
No

1. [ ] **Ya**
Yes

26. **Apabila anak Ibu menderita diare, apa yang Ibu lakukan?**
If your child has diarrhea, what do you do ?

1. [ ] **Memberikan oralit atau larutan gula-garam**
Give oralit or sugar-salt solution

1. [ ] **Perbanyak minumnya (air kelapa, air tajin)**
Give him/her more drink (coconut or rice water)

1. [ ] **Teruskan memberi ASI**
continue breasfeeding him/her

1. [ ] **Beli obat (diare) dari toko**
Buy medicine (diarrhea) from the store

1. [ ] **Memberikan teh pahit**
give him/her bitter tea

1. [ ] **Membawanya ke Puskesmas/Rumah Sakit/Dokter**
Bring him/her to Puskesmas/Hospital/Doctor

0. [ ] **Membatasi makannya atau minumnya**
Limit his/her eating or drinking

0. [ ] **Hentikan dahulu ASI**
Temporarily stop breastfeeding him/her

0. [ ] **Membawanya ke dukun/memberi jamu/obat tradisional**
Take him/her to traditional healer/give herbal mixture/traditional medicine

0 [ ] Beli obat (umum) dari toko
Buy medicine (General) from the store

0. [ ] **Tidak berbuat apa-apa**
Did not do anything

0. [ ] **Tidak tahu atau Lain-lain**, sebutkan: _____
Don't know or Others, mention: _____

Tanyakan/pancing "Apa lagi Bu ?" 2X
Ask : " Anything else ?"

(No. 26 Diisi oleh Supervisor. Isikan 1 jika ada satu benar)
(No. 26 to be filled in by Supervisor. Put 1 if there is one correct)

27. **Dapatkah Ibu menyebutkan beberapa upaya untuk mencegah diare ?**
Can you mention some ways of preventing diarrhea ?

1. [ ] **Beri makanan segar/yang tidak basi**
Give fresh food/that is not spoiled

1. [ ] **Memberikan ASI pada anak secukupnya**
Give him/her enough breastmilk

1. [ ] **Menghindarkan semua makanan dan air minum dari kotoran (lalat, debu)**
Protect food and water from dirt (flies, dust)

1. [ ] **Minum air matang**
Drink boiled water

1. [ ] **Cuci tangan sebelum masak atau makan**
Wash hands before handling food or eating

1. [ ] **Pergunakan kakus**
Use toilet

1. [ ] **Cuci tangan setelah ke kakus**
Wash hands after using toilet

1. [ ] **Membersihkan kuku dari kotoran atau memperpendek kuku.**
Clean or cut nails

1/0 [ ] **Lain-lain. Sebutkan** _____
Others, mention _____

8. [ ] **Tak tahu**
Don't know

Tanyakan/pancing "Apa lagi Bu ?" 2X
Ask "Anything else?" 2X

(No. 27 Diisi oleh Supervisor. Isikan 1 jika dua benar)
(No. 27 To be filled in by Supervisor. Put 1 if there are two correct)

28. **Dapatkah Ibu menyebutkan tanda-tanda penderita diare yang banyak kehilangan cairan dalam tubuh?**
Can you mention signs that there is dehydration from diarrhea?

1. [ ] **Haus/bibir kering**
Thirsty/dry mouth

1. [ ] **Mata cowong (cekung)**
Sunken eyes

1. [ ] **Kencing sedikit**
Less urine

1. [ ] **Bila kulit ditarik, tak lekas pulih (kekenyalan kulit kurang)**
Lost of elasticity of the skin

1. [ ] **Sangat pucat dan gelisah**
Pale and restless

1. [ ] **Kesadaran berkurang**
Unconscious

1. [ ] **Berat badan turun dengan pesat**
Sudden lost of weight

1. [ ] **Pada bayi ---> ubun-ubun cekung**
Sunken fontanelle of infant

1. [ ] **Pernapasan lebih cepat**
Faster breathing

1/0 [ ] **Lain-lain, sebutkan** ___
Others, mention ___

0. [ ] **Tidak tahu**
Don't know

(No.28 Diisi oleh Supervisor: Isikan 1 jika ada satu benar)
(No.28 To be filled in by supervisor. Put 1 if there is one correct)

211

31. **Berapa banyak biasanya LGG atau oralit Ibu berikan kepada balita yang menderita mencret ?**
How much LGG or oralit would you usually give to an under five who has diarrhea?

1. [ ] **Satu gelas setiap kali mencret.**
One glass each time s/he got loose stool

1. [ ] **Sebanyak mungkin/sebanyak anak bisa minum.**
As much as possible/as much as the child can drink

1. [ ] **Setengah gelas setiap kali mencret** (untuk bayi)
Half glass each time s/he got loose stool (for baby)

7. [ ] **Lain-lain, sebutkan** _____
Others, mention _____

0. [ ] **Tidak tahu**
Don't know

KESEHATAN IBU DAN ANAK
MOTHER AND CHILD HEALTH

---

32. **Siapa yang menolong Ibu pada waktu melahirkan terakhir?**
Who helped you last time you gave birth ?

1. [ ] Dukun beranak
Traditional Birth Attendant

2. [ ] Sanak keluarga
Relatives

3. [ ] Bidan Puskesmas
Health Center's midwife

4. [ ] Dokter
Doctor

7. [ ] Lain-lain
Others

212

34. **Apakah Ibu dapat menjelaskan bagaimana seharusnya cara menjaga diri agar bayi dalam kandungannya tetap sehat?**
Can you explain how to keep your pregnancy healthy?

0. [ ] **Biasa seperti waktu tidak hamil**
Same as when not pregnant

1. [ ] **Makan lebih banyak daripada sewaktu tidak hamil**
Eat more than when not pregnant

1. [ ] **Makan makanan yang bergizi (ada nasi, sayur, tempe, telur, buah)**
Eat nutritional food (rice, vegetable, soyabean cake, egg, fruit)

1. [ ] **Istirahat tidur waktu siang**
Rest by taking a nap midday

1. [ ] **Minum pil tambah darah sesuai anjuran bidan atau dokter**
Take iron tablets as per midwife's or doctor's advice

1. [ ] **Memperoleh imunisasi TT lengkap**
Complete TT immunizations

1. [ ] **Memeriksakan kehamilan sedikitnya 4x ke bidan atau dokter Puskesmas**
Have the pregnancy examined at least 4 x by the midwife or Puskesmas doctor

1. [ ] **Timbang badan secara teratur**
Regularly weigh the body

1/0 [ ] **Lain², sebutkan:** _____
Others, mention: _____

0 [..] **Adat/makanan adat traditional/obat traditional**
Custom/eat traditional food/take traditional medicine.

0. [ ] **Tidak tahu**
Don't know

(No.34 Diisi oleh Supervisor: Isikan 1 jika ada dua benar)
(No.34..To be filled in by Supervisor: Put 1 if there are two correct)

213

35. **Pada kehamilan terakhir siapa yang paling sering memeriksa ibu?**
During your last pregnancy, by whom were you examined most frequently?

1. [ ] **Dukun beranak**
Traditional Birth Attendant

1. [ ] **Bidan Puskesmas**
Puskesmas midwife

1. [ ] **Dokter**
Doctor

0. [ ] **Tidak pernah periksa**
Never examined

1/0. [ ] **Lain², sebutkan:** _____
Others, sebutkan: _____

38. **Apakah Ibu juga mempunyai KARTU MENUJU SEHAT IBU HAMIL pada kehamilan yang terakhir?**
Did you have a HEALTHY PREGNANT MOTHER'S HEALTH CARD for your last pregnancy?

0. [ ] **Tidak punya**
Did not have

1. [ ] **Punya**
[} Had

INFEKSI SALURAN PERNAPASAN AKUT (ISPA)
ACUTE RESPIRATORY INFECTION

---

44. **Kalau anak Ibu menderita batuk & pilek yang berat, Ibu akan minta pertolongan siapa?**
If your child has a bad cough and cold who would you ask to help you?

1. [ ] **Dukun beranak,**
TBA

2. [ ] **Puskesmas**
Puskesmas

3. [ ] **Perawat/Mantri**
Nurse/Paramedic

4. [ ] **Dukun**
Traditional healer

214

5. [ ] **Kader/Posyandu**
Kader/Posyandu

6. [ ] **Dokter**
Doctor

7. [ ] **Lain, sebutkan :** _____
Others, mention: _____

8. [ ] **Tidak tahu**
Don't know

45. **Bila anak ibu menderita batuk dan pilek (demam), tanda-tanda apa yang mengkhawatirkan sehingga ibu mencari pertolongan?**
If your child has a cough and cold, what are the symptoms that cause you worry and make you ask for help?

1. [ ] **Demam**
Fever

1. [ ] **Panas**
Running temperature

1. [ ] **Gelisah**
Restless

1. [ ] **Sesak napas**
Shortbreathing

1. [ ] **Napas cepat**
Quick breathing

1. [ ] **Napas bersuara**
Noisy breathing

1. [ ] **Pernapasan cuping hidung**
Stuffed nose

1/0. [ ] **Lain², sebutkan:**
Others, describe

0. [ ] **Tidak tahu**
Don't know

(No.45 **Diisi oleh Supervisor: Isikan 1 jika ada satu benar)**
(No.45 to be filled in by Supervisor. Put 1 if there is one correct)

* **Test. Jumlah benar " 1 " dari nomor:**
Test. Total number of correct "1" from:

No. 9	1 = [ ]	0 = [ ]
No.14	1 = [ ]	0 = [ ]
No.27	1 = [ ]	0 = [ ]
No.34	1 = [ ]	0 = [ ]
No.45	1 = [ ]	0 = [ ]

Jumlah Benar = _____ x 20 = TsT [ ]

215

ARTI KMS
Meaning of Growth Chart (KMS)

21. **DIISI OLEH SUPERVISOR: Cantumkan jumlah "Benar" dari nomor 21A - 21E. Isikan Kode 1 atau 0 untuk No. 21.**
Count the number of correct answers from numbers 21A - 21E. Fill in Code 1 or 0 for number 21.

1. [ ] Jika 3-5, jawaban benar
0. [ ] Jika 0-2, jawaban benar

Untuk No. 21A-21E Pakai Kartu KMS 21A-21E. Isikan Naik / Turun
For numbers 21A-21E, use the KMS cards 21A-21E. Fill in whether "increase"/"decrease".

21A **Menurut ibu, keadaan gizi anak ini naik atau turun?**
In your opinion, has the child's nutritional statis increased or decreased?

[ ] Naik/Increase [ ] Turun/Decrease
[ ] Tetap/Same [ ] Tidak tahu/Don't know

21B Menurut ibu, keadaan gizi anak ini naik atau turun?

[ ] Naik/Increase [ ] Turun/Decrease
[ ] Tetap/Same [ ] Tidak tahu/Don't know

21C Menurut ibu, keadaan gizi anak ini naik atau turun?

[ ] Naik/Increase [ ] Turun/Decrease
[ ] Tetap/Same [ ] Tidak tahu/Don't know

21D Menurut ibu, keadaan gizi anak ini naik atau turun?

[ ] Naik/Increase [ ] Turun/Decrease
[ ] Tetap/Same [ ] Tidak tahu/Don't know

21E Menurut ibu, keadaan gizi anak ini naik atau turun?

[ ] Naik/Increase [ ] Turun/Decrease
[ ] Tetap/Same [ ] Tidak tahu/Don't know

216

BUAT ORALIT

30B **Maukah ibu membuat oralit dengan paket ini?**
(Berikan oralit paket kepada ibu)

Please will you make oralit using this packet?
(Give a packet of Oralit to the mother)

(Isi setiap kotak di bawah dengan nomor kode berikut:
0 = Salah/tidak tahu; 1 = benar)

(Fill in each box below with the following code numbers:
0 = wrong/don't know; 1 = correct)

1. [ ] Satu gelas belimbing air matang
   [ ] One "Belimbing" glass boiled water
2. [ ] Pakai satu paket per gelas
   [ ] Use one packet per glass
3. [ ] Diaduk hingga larut
   [ ] Stir until dissolved

No. 30B **DIISI OLEH SUPERVISOR: Isikan Kode 1 atau 0 untuk No. 30B:**
TO BE FILLED IN BY SUPERVISOR: Fill in Code 1 or 0 for No. 30B:

1 = Jika, jawaban benar "1" ada 1 - 3 buah
0 = Jika, jawaban salah "0" ada satu buah

JANGAN LUPA!
MEMBACA HALAMAN SELANJUTNYA

DON'T FORGET
READ THE FOLLOWING PAGE

PESAN UNTUK PEWAWANCARA
NOTE FOR THE INTERVIEWER

Harap anda memeriksa kembali
Please recheck the questionnaire

Apakah semua pertanyaan telah terjawab?
Have all questions been answered?

Apakah tulisan anda terbaca dengan jelas?
Can your writing be easily read

247

Sekiranya perlu diadakan perubahan kerjakan sekarang,
selagi anda masih berhadapan dengan responden.
If any changes are needed, do themnow while you
are still with the respondent

Terima kasih untuk kerja samanya.
Thank you for your assistance

PEWAWANCARA KEPADA RESPONDEN
INTERVEIWER TO THE RESPONDENT

Ucapkan terima kasih atas jawaban yang diberikan.
Thank you for answering these questions

Mohon maaf atas kerepotan yang disebabkan.
I'm sorry for any disturbance caused

SANITASI ENVIRONMENT
ENVIRONMENTAL SANITATION

50.1. **Di mana keluarga Ibu membuang air besar?**
Where does your family defecate?

1. [ ] **Kamar mandi sendiri**
   [ ] Have own bathroom
2. [ ] **MCK**
   [ ] Communal bathing, washing and toilet place
3. [ ] **Sungai**
   [ ] River
4. [ ] **Kolam**
   [ ] Pond
7. [ ] **Lain-lain, sebutkan:** .....
   [ ] Other, describe: .....

50.2 **Dari manakah ibu mendapatkan air minum?**
Where do you et your drinking water from?

1. [ ] **Sumur pompa**
   [ ] Well with a pump
2. [ ] **Sumur biasa**
   [ ] Ordinary well
3. [ ] **Sumber air/mata air**
   [ ] Water source
4. [ ] **Sungai**
   [ ] River
5. [ ] **Lain-lain, sebutkan:** .....
   [ ] Other; describe: .....

dsk.KAPSURVY/kap-e-i.wp

APPENDIX C

KAP QUESTIONNAIRE - KADER

VIII. APPENDIX C KAP QUESTIONNAIRE - KADER

PROGRAM KESEHATAN MASYARAKAT DESA
SURVEI PENGETAHUAN, SIKAP DAN PERILAKU (PSP)
TAHUN 1989

Nomor Responden:

Prop.	2	[ ]
Kec.	4	[ ]
Desa	6	[ ]
Kader	8	[ ]
Nomor	10	[ ]

Nama kader : .....

Usia ..... tahun

RT/RW: .....
Dusun: .....
Desa : .....
Kecamatan: .....

Nama pewawancara: .....

Tanggal wawancara: .../.../.....

Tanda tangan :

A. Formulir Pemeriksaan Hasil Wawancara

Nama Supervisor	Tanggal pemeriksaan	Selesai	Tidak Selesai	Komentar dan nomor[2] yang belum dilengkapi	Tanda tangan

B. Wawancara Ulang
(Bila dikehendaki sesuai komentar supervisor)

Tanggal Wawancara	Hasil Wawancara Selesai*)	Tidak Selesai*)	Alasan Tidak Selesai	Tanda Tangan

221

C. Formulir Pengkode (tidak selesai)*)

Nama	Tanggal Pemberian kode	Komentar	Tanda Tangan

) Berikan tanda check list.

PETUNJUK WAWANCARA

1. Sasaran wawancara survei ini adalah para kader

2. Tanyakan semua pertanyaan yang terdaftar dalam kuesioner ini dengan tanpa memberi kesempatan kepada responden untuk membaca isi kuesioner.

3. Catat semua jawaban dengan cara sebagai berikut:

   3.1 Bilamana terdapat beberapa alternatif jawaban pada setiap pertanyaan, berikan tanda silang (X) sesuai jawaban yang diberikan.

   3.2 Bilamana jawaban berupa angka atau nomor misalnya: umur, jumlah kunjungan ke Puskesmas; tuliskan angka atau nomor pada kolom/kotak/titik-titik yang disediakan.

   3.3 Untuk beberapa pertanyaan yang jawabannya diinstruksikan menggunakan nomor koding, tuliskan nomor koding tersebut kedalam kotak atau kolom yang disediakan.

4. Jangan isi kotak sebelah kanan kuesioner. Kotak ini disediakan untuk analisa data.

222

1A. Nama responden : ..... 12 [ ]

1B. Lamanya menjadi kader : ..... 13 [ ]

1C. Jumlah KK yang dibina : ..... 14 [ ]

2. Jumlah anggota keluarga : ... orang 16 [ ]

3. Tanggung jawab responden dalam masyarakat:

Tuliskan jawaban ibu pada garis yang tersedia dan beri tanda silang kotak yang dimaksud

1. [ ] Tokoh formal _____ 18 [ ]

2. [ ] Tokoh non-formal _____

7. [ ] Lain, sebutkan _____

0. [ ] Tidak mempunyai tanggung jawab kemasyarakat _____

4A Pendidikan responden: 20 [ ]

0. [ ] Tidak 1. [ ] SD tidak tamat

2. [ ] SD tamat 3. [ ] SLTP tidak tamat

4. [ ] SLTP tamat 5. [ ] SLTA tidak tamat

6. [ ] SLTA tamat 9. [ ] Perguruan Tinggi

223

4B Pendidikan suami/istri responden: 22 [ ]

0. [ ] Tidak 1. [ ] SD tidak tamat

2. [ ] SD tamat 3. [ ] SLTP tidak tamat

4. [ ] SLTP tamat 5. [ ] SLTA tidak tamat

6. [ ] SLTA tamat 9. [ ] Perguruan Tinggi

3. Responden mengikuti Kejar Paket-A 24 [ ]

0. [ ] Tidak 1. [ ] Ya

4. Suami/isteri responden mengikuti Kejar Paket-A 26 [ ]
0. [ ] Tidak 1. [ ] Ya

5A. Pekerjaan responden

Di samping mengurus rumah tangga/pekerjaan utama pekerjaan apa yang kader lakukan untuk membantu mencari nafkah?

Bacakan setiap pilihan di bawah. Responden mungkin

1. [ ] Pembantu rumah tangga (di luar rumah sendiri) 28 [ ]

2. [ ] Membantu pekerjaan keluarga yang menghasilkan pendapatan keluarga 30 [ ]

3. [ ] Karyawan Pemerintah/ABRI 32 [ ]

4. [ ] Industri rumah yang menghasilkan pendapatan keluarga 34 [ ]

5. [ ] Buruh tani musiman 36 [ ]

6. [ ] Pedagang 38 [ ]

7. [ ] Lain², sebutkan: _____ 40 [ ]

0. [ ] Tidak bekerja untuk nafkah (ibu rumah tangga) 42 [ ]

224

5B. Pekerjaan suami/isteri responden.

Bacakan setiap pilihan di bawah. Responden mungkin menjawab "ya" atas lebih dari satu pilihan.

1.	[ ]	Petani	44 [ ]
2.	[ ]	Nelayan	46 [ ]
3.	[ ]	Buruh	48 [ ]
4.	[ ]	Karyawan pemerintah/ABRI	50 [ ]
5.	[ ]	Pedagang	52 [ ]
7.	[ ]	Lain², sebutkan: _____	54 [ ]
0.	[ ]	Tidak bekerja	56 [ ]

Jika kader sudah menikah
ISI DAFTAR BALITA INI, DENGAN URUTAN DARI BALITA TERKECIL !

6. DAFTAR BALITA HIDUP

No.	Umur	
1.	Balita terkecil berusia ..... bulan	58 [¦]
2.	Balita ke2 dari bawah berusia .... bulan	60 [¦]
3.	Balita ke3 dari bawah berusia .... bulan	62 [¦]
4.	Balita ke4 dari bawah berusia .... bulan	64 [¦]
5.	Jumlah balita: ..... orang	65 [¦]

7. Apakah ada balita binaan kader yang meninggal selama 12 bulan terakhir?

0.	[ ]	Tidak ada ---> lanjutkan #9	66 [ ]
1.	[ ]	Ya isi kolom 8 di bawah ini	

225

8.

No.	Umur Meninggal (bulan)	Sebab Kematian Menurut kader	
1.	.... bulan		68 [¦]
2.	.... bulan		70 [¦]
3.	.... bulan		72 [¦]

IMUNISASI

9. Apakah kader dapat menjelaskan arti imunisasi? 74 [ ]

1. [ ] Memberikan kekebalan tubuh untuk mencegah penyakit tertentu
7. [ ] Lain², sebutkan: _____
8. [ ] Tidak tahu

10 Imunisasi apa yang harus diperoleh bayi sampai usia <12 bulan?

1. [ ] BCG 76 [ ]
2. [ ] DPT (I,II,III) 78 [ ]
3. [ ] Polio (I,II,III) 80 [ ]
4. [ ] Campak 82 [ ]

12A Apakah kader mempunyai catatan keluarga binaan? 89 [ ]

0. [ ] Tidak ada 1. [ ] Ada

226

GIZI

Sekarang kita akan berbicara tentang gizi keluarga.

14. Jika susu jolong (kolestrum) diberikan ke bayi, bagaimana pendapat kader ?

1.	[ ]	Setuju	122 [ ]
0.	[ ]	Tak setuju	
8.	[ ]	Tak tahu	

15. Apakah kader dapat menyebutkan manfaat pemberian susu jolong (kolostrum) pada bayi baru lahir?

Sebutkan:

1.	[ ]	Mencegah penyakit bayi	123 [ ]
2.	[ ]	Makanan yang terbaik bagi bayi	124 [ ]
3.	[ ]	Mempercepat produksi ASI	125 [ ]
4.	[ ]	Mencegah pendarahan setelah melahirkan bayi	126 [ ]
5.	[ ]	Mengandung vitamin	127 [ ]
7.	[ ]	Lain-lain, sebutkan:_____.	128 [ ]
8.	[ ]	Tidak tahu	129 [ ]

227

17A. Makanan apakah yang harus diberikan kepada bayi (0 - <4 bulan)?

1. [ ] Air susu ibu (Air matang juga) (Benar kalau dijawab air matang sebagai tambahan air susu ibu). 131 [ ] 132 [ ]

0. [ ] Segala makanan.

17B. Makanan pendamping apakah yang harus diberikan kepada bayi (4 - <7 bulan?)

(Sarapan/siang/malam/lainnya).

1. [ ] Nasi lumat 133 [ ]

2. [ ] Pisang lumat 134 [ ]

3. [ ] Sari buah-buahan 135 [ ]

4. [ ] Tempe, telur, ikan lumat 136 [ ]

5. [ ] Tidak diberi apa-apa 138 [ ]

7. [ ] Lain-lain, sebutkan _____ 140 [ ]

8. [ ] Tidak tahu. 141 [ ]

17C. Makanan pendamping apakah yang harus diberikan kepada bayi (7 - <12 bulan)?

1. [ ] Nasi Lembik 142 [ ]

2. [ ] Sayuran hijau 144 [ ]

3. [ ] Buah-buahan 146 [ ]

4. [ ] Lauk pauk (tempe, tahu, ikan, daging, sapi/ayam) lembik. 148 [ ]

5. [ ] Tidak diberi apa-apa 149 [ ]

7. [ ] Lain-lain, sebutkan: _____ 150 [ ]

8. [ ] Tidak tahu 152 [ ]

228

18. Menurut kader, berapa usia balita yang paling tepat untuk disapih? Sebutkan!

1. [ ] ..... bulan — 154 [ ]

8. [ ] tidak tahu.

19. Dapatkah kader menyebutkan makanan yang dapat mencegah buta ayam (rabun senja)?

1. [ ] Sayur mayur hijau (bayam, kacang hijau) — 156 [ ]

2. [ ] Buah-buahan dan sayur mayur merah/kuning (Mangga, pepaya, ubi jalar, wortel). — 158 [ ]

3. [ ] Telur — 160 [ ]

4. [ ] Air Susu Ibu — 162 [ ]

5. [ ] Vitamin A — 164 [ ]

7. [ ] Lain-lain, sebutkan _____ — 166 [ ]

8. [ ] Tidak tahu — 168 [ ]

20. Pada usia berapa anak harus ditimbangkan pertama kali

→ 1. [...]..... bulan — 170 [ ]

8. [ ] Tidak tahu/Lupa

22. Bagaimana pendapat ibu jika anak yang ditimbang hasilnya sebagai berikut :

Isi setiap kotak dengan nomer kode berikut 1 = baik 0 = tidak baik 8 = tak tahu

1. Di atas pita warna hijau [ ] — 176 [ ]

2. Di atas garis titik hitam [ ] — 177 [ ]

229

3. Diatas garis merah sampai pada garis titik hitam (2-5) [ ] 178 [ ]

4. Dibawah garis merah (1) [ ] 179 [ ]

DIARE

Marilah sekarang membahas masalah diare atau mencret

Pengertian diare adalah:
berak cair lebih dari 3 x sehari.

24. Apakah menurut kader diare(mencret) merupakan masalah?

1 [ ] Ya 0. [ ] Tidak 182 [ ]

25. Apakah selama satu bulan terakhir ini ada balita binaan kader yang menderita Diare?

1. [ ] Ya 0. [ ] Tidak 184 [ ]

Tanyakan/pancing "Apa lagi Bu ?" 2X

26. Apabila ada anak yang menderita diare, apa yang kader anjurkan?

1. [ ] Memberikan oralit atau larutan gula dan garam 186 [ ]

2. [ ] Memberi ramuan jamu 188 [ ]

3. [ ] Membawanya ke Puskesmas 190 [ ]

4. [ ] Membatasi makannya 192 [ ]

230

5.	[ ]	Membatasi minumnya	194 [ ]
6.	[ ]	Membawanya ke dukun	196 [ ]
9.	[ ]	Hentikan dahulu ASI	198 [ ]
10.	[ ]	Perbanyak minumnya (air, kelapa, air tajin)	200 [ ]
11.	[ ]	Tidak berbuat apa-apa	202 [ ]
12.	[ ]	Teruskan memberi ASI	204 [ ]
13.	[ ]	Memberikan teh pahit	206 [ ]
7.	[ ]	Lain-lain, sebutkan _____	208 [ ]
8.	[ ]	Tidak tahu	210 [ ]

Tanyakan/pancing "Apa lagi Bu ?" 2X

27. Dapatkah kader menyebutkan beberapa upaya untuk mencegah diare?

1.	[ ]	Beri makanan segar/yang tidak basi	214 [ ]
2.	[ ]	Memberikan ASI pada anak secukupnya	216 [ ]
3.	[ ]	Menghindarkan semua makanan dan air air minum dari kotoran (lalat, debu)	218 [ ]
4.	[ ]	Minum air matang	220 [ ]
5.	[ ]	Cuci tangan sebelum masak atau makan	222 [ ]
6.	[ ]	Pergunakan kakus	224 [ ]
9.	[ ]	Cuci tangan setelah ke kakus	226 [ ]
10.	[ ]	Membersihkan kuku dari kotoran atau memperpendek kuku.	228 [ ]
11.	[ ]	Memperhatikan pertumbuhan anak dengan memberikan makanan yang sesuai	230 [ ]
7.	[ ]	Lain-lain. Sebutkan _____	232 [ ]
8.	[ ]	Tak tahu	234 [ ]

231

Tanyakan/pancing "Apa lagi Bu ?" 2X

28. Apakah kader dapat menyebutkan tanda-tanda penderita diare yang banyak kehilangan cairan dalam tubuh?

1.	[ ]	Haus/bibir kering	236 [ ]
2.	[ ]	Mata cowong (cekung)	238 [ ]
3.	[ ]	Kencing sedikit	240 [ ]
4.	[ ]	Bila kulit ditarik, tak lekas pulih (kekenyalan kulit kurang)	242 [ ]
5.	[ ]	Sangat pucat dan gelisah	246 [ ]
6.	[ ]	Kesadaran berkurang	248 [ ]
9.	[ ]	Berat badan turun dengan pesat	250 [ ]
10.	[ ]	Pada bayi ---> ubun-ubun cekung	252 [ ]
11.	[ ]	Pernapasan lebih cepat	254 [ ]
7.	[ ]	Lain-lain. Sebutkan _____	256 [ ]
8.	[ ]	Tidak tahu	258 [ ]

29A. Bagaimana menurut pendapat kader dengan memberikan air tajin kepada penderita diare untuk menambah cairan dalam tubuh?

1. [ ] Setuju 8. [ ] Tak tahu 0. [ ] Tak setuju 260 [ ]

232

29B. Bagaimana menurut pendapat kader dengan memberikan air kelapa kepada penderita diare untuk menambah cairan dalam tubuh?

1. [ ] Setuju 8. [ ] Tak tahu 0. [ ] Tak setuju 262 [ ]

30A. Dapatkah kader menyediakan alat-alat untuk membuat larutan gula garam (LGG) ?

Isi setiap kotak di bawah dengan nomor kode berikut:	
0 = Tak ada	1 = ada (benar)
8 = Tak tahu	2 = ada (tidak benar)

1. [ ] sendok teh ukuran yang benar 264 [ ]
2. [ ] gelas minum ukuran yang benar 266 [ ]
3. [ ] air hangat/matang 268 [ ]
4. [ ] garam 270 [ ]
5. [ ] gula 271 [ ]
6. [ ] air dan tempat cuci tangan 272 [ ]

30B Maukah kader membuat larutan gula garam (LGG)?

Isi setiap kotak di bawah dengan nomor kode berikut:	
0 = Salah	1 = benar
8 = tidak tahu	

1. [ ] Cuci tangan 273 [ ]
2. [ ] satu gelas belimbing air matang 274 [ ]

3. [ ] satu sendok teh munjung gula 276 [ ]

4. [ ] seperempat sendok teh peres garam halus 278 [ ]

5. [ ] diaduk hingga larut 280 [ ]

8. [ ] tidak tahu 281 [ ]

31. Berapa banyak biasanya LGG atau oralit harus diberikan kepada balita yang menderita mencret ?

1. [ ] Satu gelas setiap kali mencret. 282 [ ]

2. [ ] Sebanyak mungkin/sebanyak anak bisa minum. 283 [ ]

3. [ ] Setengah gelas setiap kali mencret

7. [ ] Lain-lain, sebutkan _____

8. [ ] Tidak tahu

KESEHATAN IBU DAN ANAK

Sekarang kita akan berbicara tentang kesehatan Ibu dan anak.

Isi setiap kotak di bawah dengan nomor kode berikut:

0 = biasa 1 = berbahaya 8 = tidak tahu

33. Coba katakan manakah kehamilan yang biasa dan yang berbahaya ?

1. [ ] Kehamilan pertama 286 [ ]

2. [ ] Tidak ada kenaikan berat badan 288 [ ]

234

3. [ ] Usia ibu hamil kurang dari 20 tahun 290 [ ]

4. [ ] Usia ibu hamil lebih dari 30/35 tahun 300 [ ]

5. [ ] Kehamilan lebih dari 4 x 302 [ ]

6. [ ] Jarak antara kehamilan <2 tahun 304 [ ]

9. [ ] Tidak diperiksa bidan Puskesmas sedikitnya 4 kali 306 [ ]

10. [ ] Tidak melengkapi imunisasi 308 [ ]

11. [ ] Kehamilan sukar di masa lalu (bayi lahir tak bernyawa, letak bayi tak normal, persalinan lama = 12 jam +) 310 [ ]

12. [ ] Perdarahan 312 [ ]

13. [ ] Pergelangan kaki bengkak 314 [ ]

14. [ ] Muntah-muntah setiap hari dan lebih dari sekali sehari 316 [ ]

15. [ ] Pusing yang berkepanjangan 318 [ ]

34. Apakah kader dapat menjelaskan bagaimana seharusnya ibu hamil menjaga diri agar bayi dalam kandungannya tetap sehat? |

0. [ ] Biasa seperti waktu tidak hamil 323 [ ]

1. [ ] Makan lebih banyak daripada sewaktu tidak hamil. 324 [ ]

2. [ ] Makan makanan yang bergizi (ada nasi, sayur, tempe, telur, buah) 326 [ ]

3. [ ] Istirahat tiduran waktu siang 328 [ ]

4. [ ] Minum pil tambah darah sesuai anjuran bidan atau dokter 332 [ ]

5. [ ] Tidak minum obat sembarangan (bukan atas resep dokter) 334 [ ]

235

6. [ ] Memperoleh imunisasi TT lengkap 336 [ ]

9. [ ] Memeriksakan kehamilan sedikitnya 4x ke bidan atau dokter Puskesmas 338 [ ]

10. [ ] Timbang badan secara teratur 340 [ ]

7. [ ] Lain², sebutkan : _____ 342 [ ]

8. [ ] Tidak tahu 344 [ ]

KELUARGA BERENCANA

Kini kita akan berbincang-bincang tentang Keluarga Berencana.

Jika kader sudah menikah

40. Apakah kader mengikuti Program Keluarga Berencana?

1. [ ] Ya 0. [ ] Tidak 368 [ ]

kader harus memperlihatkan kartu KB

41. Apakah kader mempunyai KARTU KB?

1. [ ] Ya 0. [ ] Tidak 370 [ ]

42 Metode KB apa yang biasa kader pakai?

1. [ ] Kondom 372 [ ]
2. [ ] Pil
3. [ ] Suntik

236

4. [ ] Susuk

5. [ ] IUD (spiral)

6. [ ] Steril (MOW)

7. [ ] Lain : sebutkan _____

8. [ ] Tak tahu

INFEKSI SALURAN PERNAPASAN AKUT (ISPA)

43. Apakah kader pernah membawa balita binaan yang menderita flu/pilek berat ke Puskesmas dalam 12 bulan terakhir ini?

1. [ ] Ya 0. [ ] Tidak 374 [ ]

44. Kalau ada anak yang menderita batuk & pilek yang berat, kader akan menganjurkan ibu minta pertolongan siapa?

1. [ ] Dukun beranak 2. [ ] Puskesmas 376 [ ]

3. [ ] Perawat/Mantri 4. [ ] Dukun 378 [ ]

5. [ ] Dokter

7. [ ] Lain, sebutkan : _____

8. [ ] Tidak tahu

45. Bila anak menderita batuk dan pilek (demam), tanda-tanda apa yang mengkhawatirkan sehingga perlu mendapat pertolongan?

1. [ ] Demam 380 [ ]

2. [ ] Panas 382 [ ]

3. [ ] Gelisah 384 [ ]

4. [ ] Sesak napas 386 [ ]

5. [ ] Napas cepat 388 [ ]

6. [ ] Napas bersuara 390 [ ]

7. [ ] Lain², sebutkan _____ 392 [ ]

8. [ ] Tidak tahu 394 [ ]

9. [ ] Pernapasan cuping hidung

46. Bagaimana pendapat kader jika diberikan air minum lebih banyak dari biasanya kepada penderita batuk pilek yang berat?

1. [ ] Setuju 396 [ ]

2. [ ] Tak setuju

8. [ ] Tak tahu

47. DATA KESAKITAN

Apakah dalam 2 minggu terakhir ini, ada balita binaan yang sakit ?

0. [ ] Tidak 1. [ ] Ya 388 [ ]

Bila "ya", isilah kotak di halaman selanjutnya

738

A.

Usia Balita:.....	Lamanya sakit: ....
Gejala-gejala	Uraikan apa yang kader lakukan.
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

B.

Usia Balita:.....	Lamanya sakit: ....
Gejala-gejala	Uraikan apa yang kader lakukan.
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

JANGAN LUPA HALAMAN SELANJUTNYA

239

PESAN UNTUK PEWAWANCARA

Harap anda memeriksa kembali.

Apakah semua pertanyaan telah terjawab ?

Apakah tulisan anda terbaca dengan jelas ?

Sekiranya perlu diadakan perubahan kerjakan sekarang,

selagi anda masih berhadapan dengan responden.

Terima kasih untuk kerja samanya.

PEWAWANCARA KEPADA RESPONDEN

Ucapkan terima kasih atas jawaban yang diberikan.

Mohon maaf atas kerepotan yang disebabkan.

dsk. KADERSUR.WP

240

APPENDIX D

Mothers Control Sites Tables

APPENDIX D

CARE WEST JAVA
Sidangkerta Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: Sidangkerta, West Java. n = 205.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	0	0.0
2.	Under Grade Six	45	22.0
3.	Equal Grade Six	119	58.0
4.	Greater than Grade Six	41	20.0
	Total	205	100.0

Table 6A: Occupation of Respondent: Frequency distribution: Sidangkerta, West Java. n = 205.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	122	59.5
2.	Private Business (family)	30	14.6
3.	Merchant	9	4.4
4.	Seasonal Laborer	34	16.6
5.	Civil Servant or Domestic worker)	5	2.4
6.	Other (includes farmer)	5	2.4
	Total	205	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: Sidangkerta, West Java. n = 205.

	Category	Frequency	Percentage
1.	Could give proper reason	75	36.6
2.	Could not give proper reason	130	63.4
	Total	205	100.0

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: Sidangkerta, West Java. n = 57.

	Immunization Status:	Frequency	Percentage
1.	In the process or at least first series	39	68.4
2.	Never been immunized	18	31.6
	Total	57	100.0

Table 12C: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). Frequency distribution. Sidangkerta, West Java. n = 144.

	Immunization Status:	Frequency	Percentage
1.	Series complete	62	43.1
2.	Series not complete	82	56.9
	Total	144	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized. Frequency distribution. Sidangkerta, West Java. n = 82.

	Why Child Has Not Been Fully Immunized:	Frequency	Percentage
1.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go)	8	9.8
2.	Mother could not give a reason	14	17.1
3.	Mother or child was sick when the last immunization session was held	12	14.6
4.	The Immunizer was not present during the last immunization session	6	7.3
5.	Other	42	51.2
	Total number of statements	82	100.0

Table 14: Respondents' opinion on whether colostrum should be given to an infant. Frequency distribution. Sidangkerta, West Java. n = 205.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	139	67.8
2.	Colostrum should not be given to an infant	21	10.2
3.	Does not know	45	22.0
	Total	205	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: Sidangkerta, West Java. n = 11.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	8	72.7
2.	Respondent mentioned any other type of food	3	27.3
	Total	11	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: Sidangkerta, West Java. n = 10.

	Category	Frequency	Percentage
1.	Mother is giving proper food	6	60.0
2.	Weaning foods have not been started	1	10.0
3.	Proper food is not being given	3	30.0
	Total	10	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: Sidangkerta, West Java. n = 203.

	Category	Frequency	Percentage
1.	Respondents who stated either proper foods or Vitamin A	68	33.5
2.	Respondents who do not know	135	66.5
	Total	203	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: Sidangkerta, West Java. n = 205.

	Category	Frequency	Percentage
1.	Has been weighed at least once	173	84.4
2.	Has never been weighed	25	12.2
3.	Don't know	7	3.4
	Total	205	100.0

Table 25: Respondents with children that had diarrhea in the month prior to the survey. Frequency distribution: Sidangkerta, West Java. n = 203.

	Category	Frequency	Percentage
1.	Had diarrhea that month	29	14.3
2.	Did not have diarrhea	174	85.7
	Total	203	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: Sidangkerta, West Java. n = 205.

	One or More Correct Response	Frequency	Percentage
1.	Correct	160	78.0
2.	Incorrect	45	22.0
	Total	205	100.0

Table 27: Respondents who know one or more practices to help prevent diarrhea disease. Frequency distribution: Sidangkerta, West Java. n = 205.

	Response	Frequency	Percentage
1.	Respondent knew one method	42	20.5
2.	Respondent knew two methods	22	10.7
3.	Respondent knew three or more methods	20	9.8
4.	Respondent could not state a method	121	59.0
	Total	205	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: Sidangkerta, West Java. n = 205.

	Could repondent state one sign of severe dehydration:	Frequency	Percentage
1.	Yes	136	66.3
2.	No	69	33.7
	Total	205	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: Sidangkerta, West Java. n = 205.

	Category	Frequency	Percentage
1.	Mothers used the proper proportions of boiled water, salt, and sugar	27	13.2
2.	Mothers knew ORS ingredient but did not know proper proportions	40	19.5
3.	Mothers did not know ORS ingredients	138	67.3
	Total	205	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: Sidangkerta, West Java. n = 205.

	Amount Given	Frequency	Percentage
1.	Correct amount	109	53.2
2.	Correct amount for a baby under 12 months	19	9.3
3.	Incorrect amount	27	13.2
4.	Did not know	50	24.4
	Total	205	100.0

Table 32: Who assisted mother during last birthing. Frequency distribution: Sidangkerta, West Java. n = 203.

	Category	Frequency	Percentage
1.	Traditional birth attendant	156	76.8
2.	Family	17	8.4
3.	Puskesmas midwife or doctor	30	14.8
4.	Other	0	0.0
	Total	203	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy: Frequency distribution: Sidangkerta, West Java. n = 205.

	Number of Correct	Frequency	Percentage
1.	Stated two	49	23.9
2.	Stated three	22	10.7
3.	Stated four or more	9	4.4
4.	Could not state at least two	125	61.0
	Total	205	100.0

Table 35: Who examined mother during last pregnancy. Frequency distribution: Sidangkerta, West Java. n = 197.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	120	60.9
2.	Doctor	3	1.5
3.	Puskesmas staff	41	20.8
4.	Other	2	1.0
5.	No examination	31	15.7
	Total	197	100.0

Table 44: To whom a respondent would go for help if their child had a serious cough or cold (ARI symptoms). Frequency distribution: Sidangkerta, West Java. n = 202.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	2	0.9
2.	Go to Puskesmas health staff	164	76.7
3.	Go to Kader/Posyandu	0	0.0
4.	Do not know	18	8.4
5.	Other	30	14.0
	Total number of responses	214	100.0

Table 45: Respondents who could state at least one symptom they would worry about if their child already had a cough or cold. Frequency distribution: Sidangkerta, West Java. n = 205.

	Number correct	Frequency	Percentage
1.	One correct	53	25.9
2.	Two or more correct	45	22.0
3.	Could not offer at least one correct	107	52.2
	Total	205	100.0

Table: 46 Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Sidangkerta, West Java.** n = 205.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	26	12.7
2.	One correct answer	53	25.9
3.	Two correct answers	48	23.4
4.	Three correct answers	39	19.0
5.	Four correct answers	27	13.2
6.	Five correct answers	12	5.9
	Total	205	100.0

Average score = 2.12.

CARE EAST JAVA
Tegalombo Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: Tegalombo, East Java. n = 141.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	8	5.7
2.	Under Grade Six	34	24.1
3.	Equal Grade Six	85	60.3
4.	Greater than Grade Six	14	9.9
	Total	141	100.0

Table 6A: Occupation of Respondent: Frequency distribution: Tegalombo, East Java. n = 141.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	31	22.0
2.	Private Business (family)	58	41.1
3.	Merchant	7	5.0
4.	Seasonal Laborer	18	12.8
5.	Civil Servant or Domestic worker)	5	3.5
6.	Other (includes farmer)	22	15.6
	Total	141	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: Tegalombo, East Java. n = 141.

	Category	Frequency	Percentage
1.	Could give proper reason	20	14.2
2.	Could not give proper reason	121	85.8
	Total	141	100.0

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: Tegalombo, East Java. n = 25.

	Immunization Status:	Frequency	Percentage
1.	In the process or at least first series	24	96.0
2.	Never been immunized	1	4.0
	Total	25	100.0

Table 12C: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). Frequency distribution. Tegalombo, East Java. n = 116.

	Immunization Status:	Frequency	Percentage
1.	Series complete	73	62.9
2.	Series not complete	43	37.1
	Total	116	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized. Frequency distribution. Tegalombo, East Java. n = 41.

	Why Child Has Not Been Fully Immunized:	Frequency	Percentage
1.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go)	3	7.3
2.	Mother could not give a reason	8	19.5
3.	Mother or child was sick when the last immunization session was held	11	26.8
4.	The Immunizer was not present during the last immunization session	1	2.4
5.	Other	18	43.9
	Total number of statements	41	100.0

Table 14: Respondents' opinion on whether colostrum should be given to an infant. Frequency distribution. Tegalombo, East Java. n = 141.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	91	64.5
2.	Colostrum should not be given to an infant	47	33.3
3.	Does not know	3	2.1
	Total	141	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: Tegalombo, East Java. n = 3.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	3	100.0
2.	Respondent mentioned any other type of food	0	0.0
	Total	3	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: Tegalombo, East Java. n = 4.

	Category	Frequency	Percentage
1.	Mother is giving proper food	3	75.0
2.	Weaning foods have not been started	0	0.0
3.	Proper food is not being given	1	25.0
	Total	4	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: Tegalombo, East Java. n = 141.

	Category	Frequency	Percentage
1.	Respondents who stated either proper foods or Vitamin A	80	56.7
2.	Respondents who do not know	61	43.3
	Total	141	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: Tegalombo, East Java. n = 141.

	Category	Frequency	Percentage
1.	Has been weighed at least once	137	97.2
2.	Has never been weighed	3	2.1
3.	Don't know	1	0.7
	Total	141	100.0

Table 25: Respondents with children that had diarrhea in the month prior to the survey. Frequency distribution: Tegalombo, East Java. n = 140.

	Category	Frequency	Percentage
1.	Had diarrhea that month	16	11.4
2.	Did not have diarrhea	124	88.6
	Total	140	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: Tegalombo, East Java. n = 141.

	One or More Correct Response	Frequency	Percentage
1.	Correct	121	85.8
2.	Incorrect	20	14.2
	Total	141	100.0

Table 27: Respondents who know one or more practices to help prevent diarrhea disease. Frequency distribution: Tegalombo, East Java. n = 141.

	Response	Frequency	Percentage
1.	Respondent knew one method	37	26.2
2.	Respondent knew two methods	18	12.8
3.	Respondent knew three or more methods	6	4.3
4.	Respondent could not state a method	80	56.7
	Total	141	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: Tegalombo, East Java. n = 141.

	Could repondent state one sign of severe dehydration:	Frequency	Percentage
1.	Yes	75	53.2
2.	No	66	46.8
	Total	141	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: Tegalombo, East Java. n = 141.

	Category	Frequency	Percentage
1.	Mothers used the proper proportions of boiled water, salt, and sugar	5	3.5
2.	Mothers knew ORS ingredient but did not know proper proportions	9	6.4
3.	Mothers did not know ORS ingredients	127	90.1
	Total	141	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: Tegalombo, East Java. n = 141.

	Amount Given	Frequency	Percentage
1.	Correct amount	31	22.0
2.	Correct amount for a baby under 12 months	15	10.6
3.	Incorrect amount	63	44.7
4.	Did not know	32	22.7
	Total	141	100.0

Table 32: Who assisted mother during last birthing. Frequency distribution: Tegalombo, East Java. n = 140.

	Category	Frequency	Percentage
1.	Traditional birth attendant	126	90.0
2.	Family	0	0.0
3.	Puskesmas midwife or doctor	14	10.0
4.	Other	0	0.0
	Total	140	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy: Frequency distribution: Tegalombo, East Java. n = 141.

	Number of Correct	Frequency	Percentage
1.	Stated two	43	30.5
2.	Stated three	17	12.1
3.	Stated four or more	4	2.8
4.	Could not state at least two	77	54.6
	Total	141	100.0

Table 35: Who examined mother during last pregnancy. Frequency distribution: Tegalombo, East Java. n = 50.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	40	80.0
2.	Doctor	1	2.0
3.	Puskesmas staff	6	12.0
4.	Other	0	0.0
5.	No examination	3	6.0
	Total	50	100.0

Table 44: To whom a respondent would go for help if their child had a serious cough or cold (ARI symptoms). Frequency distributior Tegalombo, East Java. n = 139.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	9	5.6
2.	Go to Puskesmas health staff	123	76.9
3.	Go to Kader/Posyandu	3	1.9
4.	Do not know	0	0.0
5.	Other	25	15.6
	Total number of responses	160	100.0

Table 45: Respondents who could state at least one symptom they woulc worry about if their child already had a cough or cold. Frequency distribution: Tegalombo, East Java. n = 141.

	Number correct	Frequency	Percentage
1.	One correct	54	38.3
2.	Two or more correct	57	40.4
3.	Could not offer at least one correct	30	21.3
	Total	141	100.0

Table: 46 Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Tegalombo, East Java.** n = 141.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	6	4.3
2.	One correct answer	40	28.4
3.	Two correct answers	48	34.0
4.	Three correct answers	25	17.7
5.	Four correct answers	11	7.8
6.	Five correct answers	11	7.8
	Total	141	100.0

Average score = 2.20.

CARE NUSA TENGGARA BARAT
Labuapi Summary Tables - Mothers

Table 5A: Education level of Respondent: Frequency distribution: Labuapi, NTB. n = 161.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	67	41.6
2.	Under Grade Six	64	39.8
3.	Equal Grade Six	18	11.2
4.	Greater than Grade Six	12	7.5
	Total	161	100.0

Table 6A: Occupation of Respondent: Frequency distribution: Labuapi, NTB. n = 161.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	58	36.0
2.	Private Business (family)	14	8.7
3.	Merchant	24	14.9
4.	Seasonal Laborer	51	31.7
5.	Civil Servant or Domestic worker)	1	0.6
6.	Other (includes farmer)	13	8.1
	Total	161	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: Labuapi, NTB. n = 161.

	Category	Frequency	Percentage
1.	Could give proper reason	30	18.6
2.	Could not give proper reason	131	81.4
	Total	161	100.0

Table 11: Immunization status of children between 1 and 11 months of age (verbal confirmation from mother). Frequency distribution: Labuapi, NTB. n = 49.

	Immunization Status:	Frequency	Percentage
1.	In the process or at least first series	26	53.1
2.	Never been immunized	23	46.9
	Total	49	100.0

Table 12C: Immunization status of children between 12 and 48 months of age (verbal confirmation from mother). Frequency distribution. Labuapi, NTB. n = 112.

	Immunization Status:	Frequency	Percentage
1.	Series complete	40	35.7
2.	Series not complete	72	64.3
	Total	112	100.0

Table 12D: Answers to why respondents' children between the age of 12 to 48 months have not been fully immunized. Frequency distribution. Labuapi, NTB. n = 63.

	Why Child Has Not Been Fully Immunized:	Frequency	Percentage
1.	Lack of information: (Child is healthy, became ill after first immunization, child too old, or do not know why to go)	1	1.6
2.	Mother could not give a reason	19	30.2
3.	Mother or child was sick when the last immunization session was held	1	1.6
4.	The Immunizer was not present during the last immunization session	0	0.0
5.	Other	42	66.7
	Total number of statements	63	100.0

Table 14: Respondents' opinion on whether colostrum should be given to an infant. Frequency distribution. Labuapi, NTB. n = 161.

	Category	Frequency	Percentage
1.	Colostrum should be given to an infant	75	46.6
2.	Colostrum should not be given to an infant	78	48.4
3.	Does not know	8	5.0
	Total	161	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: Labuapi, NTB. n = 17.

	Category	Frequency	Percentage
1.	Give breast milk and boiled water only	16	94.1
2.	Respondent mentioned any other type of food	1	5.9
	Total	17	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution. Labuapi, NTB. n = 12.

	Category	Frequency	Percentage
1.	Mother is giving proper food	10	83.3
2.	Weaning foods have not been started	1	8.3
3.	Proper food is not being given	1	8.3
	Total	12	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: Labuapi, NTB. n = 158.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	83	52.5
2. Respondents who do not know	75	47.5
Total	158	100.0

Table 20: Respondents whose youngest child (under 48 months) has been weighed. Frequency distribution: Labuapi, NTB. n = 161.

Category	Frequency	Percentage
1. Has been weighed at least once	118	73.3
2. Has never been weighed	33	20.5
3. Don't know	10	6.2
Total	161	100.0

Table 25: Respondents with children that had diarrhea in the month prior to the survey. Frequency distribution: Labuapi, NTB. n = 159.

Category	Frequency	Percentage
1. Had diarrhea that month	42	26.4
2. Did not have diarrhea	117	73.6
Total	159	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: Labuapi, NTB. n = 161.

One or More Correct Response	Frequency	Percentage
1. Correct	139	86.3
2. Incorrect	22	13.7
Total	161	100.0

Table 27: Respondents who know one or more practices to help prevent diarrhea disease. Frequency distribution: Labuapi, NTB. n = 161.

	Response	Frequency	Percentage
1.	Respondent knew one method	23	14.3
2.	Respondent knew two methods	29	18.0
3.	Respondent knew three or more methods	18	11.2
4.	Respondent could not state a method	91	56.5
	Total	161	100.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: Labuapi, NTB. n = 161.

	Could repondent state one sign of severe dehydration:	Frequency	Percentage
1.	Yes	120	74.5
2.	No	41	25.5
	Total	161	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: Labuapi, NTB. n = 161.

	Category	Frequency	Percentage
1.	Mothers used the proper proportions of boiled water, salt, and sugar	7	4.3
2.	Mothers knew ORS ingredient but did not know proper proportions	20	12.4
3.	Mothers did not know ORS ingredients	134	83.2
	Total	161	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: Labuapi, NTB. n = 161.

	Amount Given	Frequency	Percentage
1.	Correct amount	58	36.0
2.	Correct amount for a baby under 12 months	19	11.8
3.	Incorrect amount	28	17.4
4.	Did not know	56	34.8
	Total	161	100.0

Table 32: Who assisted mother during last birthing. Frequency distribution: Labuapi, NTB. n = 158.

	Category	Frequency	Percentage
1.	Traditional birth attendant	125	79.1
2.	Family	3	1.9
3.	Puskesmas midwife or doctor	15	9.5
4.	Other	15	9.5
	Total	158	100.0

Table 34: Respondents who were able to state two or more ways to increase chances of maintaining a healthy pregnancy: Frequency distribution: Labuapi, NTB. n = 161.

	Number of Correct	Frequency	Percentage
1.	Stated two	22	13.7
2.	Stated three	9	5.6
3.	Stated four or more	6	3.7
4.	Could not state at least two	124	77.0
	Total	161	100.0

Table 35: Who examined mother during last pregnancy. Frequency distribution: Labuapi, NTB. n = 133.

	Category	Frequency	Percentage
1.	Traditional caretaker (dukun beranak)	42	31.6
2.	Doctor	2	1.5
3.	Puskesmas staff	41	30.8
4.	Other	1	0.8
5.	No examination	47	35.3
	Total	133	100.0

Table 44: To whom a respondent would go for help if their child had a serious cough or cold (ARI symptoms). Frequency distribution: Labuapi, NTB. n = 161.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	29	15.6
2.	Go to Puskesmas health staff	126	67.7
3.	Go to Kader/Posyandu	1	0.5
4.	Do not know	2	1.1
5.	Other	28	15.1
	Total number of responses	186	100.0

Table 45: Respondents who could state at least one symptom they would worry about if their child already had a cough or cold. Frequency distribution: Labuapi, NTB. n = 161.

	Number correct	Frequency	Percentage
1.	One correct	77	47.8
2.	Two or more correct	65	40.4
3.	Could not offer at least one correct	19	11.8
	Total	161	100.0

Table: 46 Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Labuapi, NTB.** n = 161.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	9	5.6
2.	One correct answer	46	28.6
3.	Two correct answers	58	36.0
4.	Three correct answers	28	17.4
5.	Four correct answers	15	9.3
6.	Five correct answers	5	3.1
	Total	161	100.0

Average score = 2.06.

APPENDIX E

Kader Tables

APPENDIX E

CARE WEST JAVA
Gununghalu Kader Summary Tables

Table 5A: Education level of Respondent: Frequency distribution: **Gununghalu, West Java.** n = 40.

	Education Level	**Frequency**	**Percentage**
1.	None (does not have to equal illiteracy)	0	0.0
2.	Under Grade Six	4	10.0
3.	Equal Grade Six	21	52.5
4.	Greater than Grade Six	15	37.5
	Total	40	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Gununghalu, West Java.** n = 40.

	Occupation	**Frequency**	**Percentage**
1.	No Wage Labor Reported	22	55.0
2.	Private Business (family)	6	15.0
3.	Merchant	3	7.5
4.	Seasonal Laborer	3	7.5
5.	Civil Servant or Domestic worker)	1	2.5
6.	Farmer	5	12.5
7.	Other	0	0.0
	Total	40	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Category	**Frequency**	**Percentage**
1.	Could give proper reason	27	67.5
2.	Could not give proper reason	13	32.5
	Total	40	100.0

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution: **Gununghalu, West Java.** n = 40.

Category	Frequency	Percentage
1. Colostrum should be given to an infant	23	57.5
2. Colostrum should not be given to an infant/Does not know	17	42.5
Total	40	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Gununghalu, West Java.** n = 40.

Category	Frequency	Percentage
1. Give breast milk and boiled water only	27	67.5
2. Respondent mentioned any other type of food	13	32.5
Total	40	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: **Gununghalu, West Java.** n = 40.

Category	Frequency	Percentage
1. Mother is giving proper food	36	90.0
2. Weaning foods have not been started/ Proper food is not being given	4	10.0
Total	40	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Gununghalu, West Java.** n = 40.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	28	70.0
2. Respondents who do not know	12	30.0
Total	40	100.0

Table 20: Respondents knwing the age at which a child should be first weighed. Frequency distribut. n: **Gununghalu, West Java.** n = 40.

Category	Frequency	Percentage
1. Knows age at which a child should be first weighed	28	70.0
2. Does not know age at which a child should be first weighed	12	30.0
Total	40	100.0

Table 25: Respondents supervising children who had diarrhea in the month prior to the survey. Frequency distribution: **Gununghalu, West Java.** n = 40.

Category	Frequency	Percentage
1. Supervises children who had diarrhea that month	15	37.5
2. Does not supervise children who had diarrhea that month	25	62.5
Total	40	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Gununghalu, West Java.** n = 40.

One or More Correct Response	Frequency	Percentage
1. Correct	38	95.0
2. Incorrect	2	5.0
Total	40	100.0

Table 27: Respondents who know two or more practices to help prevent diarrhea disease. Frequency distribution: **Gununghalu, West Java.** n = 40.

Response	Frequency	Percentage
1. Respondent knew one method	10	25.0
2. Respondent knew two methods	6	15.0
3. Respondent knew three or more methods	12	30.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Response:	**Frequency**	**Percentage**
1.	Knew one sign	7	17.5
2.	Knew two signs	10	25.0
3.	Knew three or more signs	16	40.0
4.	Could not state a sign	7	17.5
	Total	40	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Category	**Frequency**	**Percentage**
1.	Kaders used the proper proportions of boiled water, salt, and sugar	9	22.5
2.	Kaders did not know proper amounts of ORS ingredients	31	77.5
	Total	40	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Amount Given	**Frequency**	**Percentage**
1.	Correct amount	29	72.5
2.	Incorrect amount	7	17.5
3.	Did not know	4	10.0
	Total	40	100.0

Table 34: Respondents that were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	29	72.5
2.	Could not state at least two	11	27.5
	Total	40	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Gununghalu, West Java.** n = 40.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	2	5.0
2.	Go to Puskesmas health staff	32	80.0
3.	Go to Kader/Posyandu	0	0.0
4.	Do not know	0	0.0
5.	Other	6	15.0
	Total number of responses	40	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Number correct	Frequency	Percentage
1.	One correct	18	45.0
2.	Two correct	3	7.5
3.	More than two correct	4	10.0
4.	Could not offer at least one correct	15	37.5
	Total	40	100.0

CARE WEST JAVA
Sidangkerta Kader Summary Tables

Table 5A: Education level of Respondent: Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	1	2.5
2.	Under Grade Six	5	12.5
3.	Equal Grade Six	22	55.0
4.	Greater than Grade Six	12	30.0
	Total	40	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	21	52.5
2.	Private Business (family)	13	32.5
3.	Merchant	0	0.0
4.	Seasonal Laborer	2	5.0
5.	Civil Servant or Domestic worker)	0	0.0
6.	Farmer	4	10.0
7.	Other	0	0.0
	Total	40	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Category	Frequency	Percentage
1.	Could give proper reason	28	70.0
2.	Could not give proper reason	12	30.0
	Total	40	100.0

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Category	Frequency	Percentage
1. Colostrum should be given to an infant	33	82.5
2. Colostrum should not be given to an infant/Does not know	7	17.5
Total	40	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Category	Frequency	Percentage
1. Give breast milk and boiled water only	28	70.0
2. Respondent mentioned any other type of food	12	30.0
Total	40	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Category	Frequency	Percentage
1. Mother is giving proper food	35	87.5
2. Weaning foods have not been started/ Proper food is not being given	5	12.5
Total	40	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	21	52.5
2. Respondents who do not know	19	47.5
Total	40	100.0

Table 20: Respondents knowing the age at which a child should be first weighed. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Category	Frequency	Percentage
1. Knows age at which a child should be first weighed	12	30.0
2. Does not know age at which child should be first weighed	28	70.0
Total	40	100.0

Table 25: Respondents supervising children who had diarrhea in the month prior to the survey. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Category	Frequency	Percentage
1. Had diarrhea that month	6	15.0
2. Did not have diarrhea	34	85.0
Total	40	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Sidangkerta, West Java.** n = 40.

One or More Correct Response	Frequency	Percentage
1. Correct	37	92.5
2. Incorrect	3	7.5
Total	40	100.0

Table 27: Respondents who know two or more practices to help prevent diarrhea disease. Frequency distribution: **Sidangkerta, West Java.** n = 40.

Response	Frequency	Percentage
1. Respondent knew one method	10	25.0
2. Respondent knew two methods	10	25.0
3. Respondent knew three or more methods	8	20.0
4. Respondent could not state a method	12	30.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Response:	**Frequency**	**Percentage**
1.	Knew one sign	11	27.5
2.	Knew two signs	6	15.0
3.	Knew three or more signs	10	25.0
4.	Could not state a sign	13	32.5
	Total	40	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Category	**Frequency**	**Percentage**
1.	Kaders used the proper proportions of boiled water, salt, and sugar	14	35.0
2.	Kaders did not know proper amounts of ORS ingredients	26	65.0
	Total	40	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Amount Given	**Frequency**	**Percentage**
1.	Correct amount	29	72.5
2.	Incorrect amount	6	15.0
3.	Did not know	5	12.5
	Total	40	100.0

Table 34: Respondents that were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	27	67.5
2.	Could not state at least two	13	32.5
	Total	40	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	0	0.0
2.	Go to Puskesmas health staff	32	80.0
3.	Go to Kader/Posyandu	4	10.0
4.	Do not know	0	0.0
5.	Other	4	10.0
	Total number of responses	40	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Number correct	Frequency	Percentage
1.	One correct	16	40.0
2.	Two correct	7	17.5
3.	More than two correct	6	15.0
4.	Could not offer at least one correct	11	27.5
	Total	40	100.0

CARE EAST JAVA
Tulakan Kader Summary Tables

Table 5A: Education level of Respondent: Frequency distribution: **Tulakan, East Java.** n = 38.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	0	0.0
2.	Under Grade Six	5	13.2
3.	Equal Grade Six	26	68.4
4.	Greater than Grade Six	7	18.4
	Total	38	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Tulakan, East Java.** n = 38.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	14	36.8
2.	Private Business (family)	10	26.3
3.	Merchant	3	7.9
4.	Seasonal Laborer	0	0.0
5.	Civil Servant or Domestic worker)	0	0.0
6.	Farmer	11	28.9
7.	Other	0	0.0
	Total	38	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Tulakan, East Java.** n = 38.

	Category	Frequency	Percentage
1.	Could give proper reason	26	68.4
2.	Could not give proper reason	12	31.6
	Total	38	100.0

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution: **Tulakan, East Java.** n = 38.

Category	Frequency	Percentage
1. Colostrum should be given to an infant	29	76.3
2. Colostrum should not be given to an infant/Does not know	9	23.7
Total	38	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Tulakan, East Java.** n = 38.

Category	Frequency	Percentage
1. Give breast milk and boiled water only	38	100.0
2. Respondent mentioned any other type of food	0	0.0
Total	38	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: **Tulakan, East Java.** n = 38.

Category	Frequency	Percentage
1. Mother is giving proper food	37	97.4
2. Weaning foods have not been started/ Proper food is not being given	1	2.6
Total	38	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Tulakan, East Java.** n = 38.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	32	84.2
2. Respondents who do not know	6	15.8
Total	38	100.0

Table 20: Respondents knowing the age at which a child should be first weighed. Frequency distribution: **Tulakan, East Java.**
n = 38

Category	Frequency	Percentage
1. Knows age at which a child should be first weighed	26	68.4
2. Does not know all at which a child should be first weighed	12	31.6
Total	38	100.0

Table 25: Respondents supervising children who had diarrhea in the month prior to the survey. Frequency distribution: **Tulakan, East Java.** n = 38.

Category	Frequency	Percentage
1. Supervises children who had diarrhea that month	4	10.5
2. Does not supervise children who had that month	34	89.5
Total	38	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Tulakan, East Java.** n = 38.

One or More Correct Response	Frequency	Percentage
1. Correct	37	97.4
2. Incorrect	1	2.6
Total	38	100.0

Table 27: Respondents who know two or more practices to help prevent diarrhea disease. Frequency distribution: **Tulakan, East Java.** n = 38.

Response	Frequency	Percentage
1. Respondent knew one method	7	18.4
2. Respondent knew two methods	10	26.3

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Tulakan, East Java.** n = 38.

	Response:	Frequency	Percentage
1.	Knew one sign	12	31.6
2.	Knew two signs	11	28.9
3.	Knew three or more signs	9	23.7
4.	Could not state a sign	6	15.8
	Total	38	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: **Tulakan, East Java.** n = 38.

	Category	Frequency	Percentage
1.	Kaders used the proper proportions of boiled water, salt, and sugar	10	26.3
2.	Kaders did not know proper amounts of ORS ingredients	28	73.7
	Total	38	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Tulakan, East Java.** n = 38.

	Amount Given	Frequency	Percentage
1.	Correct amount	25	65.8
2.	Incorrect amount	7	18.4
3.	Did not know	6	15.8
	Total	38	100.0

Table 34: Respondents that were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Tulakan, East Java.** n = 38.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	30	78.9
2.	Could not state at least two	8	21.1
	Total	38	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Tulakan, East Java.** n = 38.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	0	0.0
2.	Go to Puskesmas health staff	34	89.5
3.	Go to Kader/Posyandu	2	5.3
4.	Do not know	0	0.0
5.	Other	2	5.3
	Total number of responses	38	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Tulakan, East Java.** n = 38.

	Number correct	Frequency	Percentage
1.	One correct	12	31.6
2.	Two correct	22	57.9
3.	More than two correct	3	7.9
4.	Could not offer at least one correct	1	2.6
	Total	38	100.0

Care East Java
Tegalombo Kader Summary Tables

Table 5A: Education level of Respondent: Frequency distribution: **Tegalombo, East Java.** n = 40.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	0	0.0
2.	Under Grade Six	2	5.0
3.	Equal Grade Six	29	72.5
4.	Greater than Grade Six	9	22.5
	Total	40	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Tegalombo, East Java.** n = 40.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	5	12.5
2.	Private Business (family)	17	42.5
3.	Merchant	5	12.5
4.	Seasonal Laborer	7	17.5
5.	Civil Servant or Domestic worker)	0	0.0
6.	Farmer	6	15.0
7.	Other	0	0.0
	Total	40	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Category	Frequency	Percentage
1.	Could give proper reason	21	52.5
2.	Could not give proper reason	19	47.5
	Total	40	100.0

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution: **Tegalombo, East Java.** n = 40.

Category	Frequency	Percentage
1. Colostrum should be given to an infant	23	57.5
2. Colostrum should not be given to an infant/Does not know	17	42.5
Total	40	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Tegalombo, East Java.** n = 40.

Category	Frequency	Percentage
1. Give breast milk and boiled water only	34	85.0
2. Respondent mentioned any other type of food	6	15.0
Total	40	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: **Tegalombo, East Java.** n = 40.

Category	Frequency	Percentage
1. Mother is giving proper food	35	87.5
2. Weaning foods have not been started/ Proper food is not being given	5	12.5
Total	40	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Tegalombo, East Java.** n = 40.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	34	85.0
2. Respondents who do not know	6	15.0
Total	40	100.0

Table 20: Respondents knowing the age at which a child should be first weighed. Frequency distribution: **Tegalombo, East Java.** n = 40.

Category	Frequency	Percentage
1. Knows age at which a child should be first weighed	31	77.5
2. Does not know age of which a child should be first weighed	9	22.5
Total	40	100.0

Table 25: Respondents supervising children who had diarrhea in the month prior to the survey. Frequency distribution: **Tegalombo, East Java.** n = 40.

Category	Frequency	Percentage
1. Supervises children who had diarrhea that month	5	12.5
2. Does not supervise children who had that month	35	87.5
Total	40	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Tegalombo, East Java.** n = 40.

One or More Correct Response	Frequency	Percentage
1. Correct	39	97.5
2. Incorrect	1	2.5
Total	40	100.0

Table 27: Respondents who know two or more practices to help prevent diarrhea disease. Frequency distribution: **Tegalombo, East Java.** n = 40.

Response	Frequency	Percentage
1. Respondent knew one method	2	5.0
2. Respondent knew two methods	12	30.0
3. Respondent knew three or more methods	9	22.5

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Response:	**Frequency**	**Percentage**
1.	Knew one sign	11	27.5
2.	Knew two signs	13	32.5
3.	Knew three or more signs	5	12.5
4.	Could not state a sign	11	27.5
	Total	40	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Category	**Frequency**	**Percentage**
1.	Kaders used the proper proportions of boiled water, salt, and sugar	5	12.5
2.	Kaders did not know proper amounts of ORS ingredients	35	87.5
	Total	40	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Amount Given	**Frequency**	**Percentage**
1.	Correct amount	22	55.0
2.	Incorrect amount	3	7.5
3.	Did not know	15	37.5
	Total	40	100.0

Table 34: Respondents that were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	36	90.0
2.	Could not state at least two	4	10.0
	Total	40	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Tegalombo, East Java.** n = 40.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	0	0.0
2.	Go to Puskesmas health staff	32	80.0
3.	Go to Kader/Posyandu	2	5.0
4.	Do not know	0	0.0
5.	Other	6	15.0
	Total number of responses	40	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Number correct	Frequency	Percentage
1.	One correct	15	37.5
2.	Two correct	15	37.5
3.	More than two correct	2	5.0
4.	Could not offer at least one correct	8	20.0
	Total	40	100.0

CARE NUSA TENGGARA BARAT
Gunung Sari Kader Summary Tables

Table 5A: Education level of Respondent: Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Education Level	**Frequency**	**Percentage**
1.	None (does not have to equal illiteracy)	1	2.0
2.	Under Grade Six	7	14.0
3.	Equal Grade Six	12	24.0
4.	Greater than Grade Six	30	60.0
	Total	50	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Occupation	**Frequency**	**Percentage**
1.	No Wage Labor Reported	13	26.0
2.	Private Business (family)	5	10.0
3.	Merchant	12	24.0
4.	Seasonal Laborer	2	4.0
5.	Civil Servant or Domestic worker)	2	4.0
6.	Farmer	16	32.0
7.	Other	0	0.0
	Total	50	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Category	**Frequency**	**Percentage**
1.	Could give proper reason	32	64.0
2.	Could not give proper reason	18	36.0
	Total	50	100.0

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution: **Gunung Sari, NTB.** n = 50.

Category	Frequency	Percentage
1. Colostrum should be given to an infant	32	64.0
2. Colostrum should not be given to an infant/Does not know	18	36.0
Total	50	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Gunung Sari, NTB.** n = 50.

Category	Frequency	Percentage
1. Give breast milk and boiled water only	45	90.0
2. Respondent mentioned any other type of food	5	10.0
Total	50	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: **Gunung Sari, NTB.** n = 50.

Category	Frequency	Percentage
1. Mother is giving proper food	46	92.0
2. Weaning foods have not been started/ Proper food is not being given	4	8.0
Total	50	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Gunung Sari, NTB.** n = 50.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	39	78.0
2. Respondents who do not know	11	22.0
Total	50	100.0

Table 20: Respondents knowing the age at which a child should be first weighed. Frequency distribution: **Gunung Sari, NTB.**

n = 50.

	Category	Frequency	Percentage
1.	Knows age at which a child should be first weighed	37	74.0
2.	Does not know age at which a child should be first weighed	13	26.0
	Total	50	100.0

Table 25: Respondents supervising children who had diarrhea in the month prior to the survey. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Category	Frequency	Percentage
1.	Supervises children who had diarrhea that month	12	24.0
2.	Does not supervise children who had that month	38	76.0
	Total	50	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	One or More Correct Response	Frequency	Percentage
1.	Correct	49	98.0
2.	Incorrect	1	2.0
	Total	50	100.0

Table 27: Respondents who know two or more practices to help prevent diarrhea disease. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Response	Frequency	Percentage
1.	Respondent knew one method	10	20.0
2.	Respondent knew two methods	7	14.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Response:	Frequency	Percentage
1.	Knew one sign	15	30.0
2.	Knew two signs	11	22.0
3.	Knew three or more signs	14	28.0
4.	Could not state a sign	10	20.0
	Total	50	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Category	Frequency	Percentage
1.	Kaders used the proper proportions of boiled water, salt, and sugar	8	16.0
2.	Kaders did not know proper amounts of ORS ingredients	42	84.0
	Total	50	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Amount Given	Frequency	Percentage
1.	Correct amount	24	48.0
2.	Incorrect amount	10	20.0
3.	Did not know	16	32.0
	Total	50	100.0

Table 34: Respondents that were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	34	68.0
2.	Could not state at least two	16	32.0
	Total	50	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	1	2.0
2.	Go to Puskesmas health staff	41	82.0
3.	Go to Kader/Posyandu	5	10.0
4.	Do not know	1	2.0
5.	Other	2	4.0
	Total number of responses	50	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Number correct	Frequency	Percentage
1.	One correct	19	38.0
2.	Two correct	14	28.0
3.	More than two correct	8	16.0
4.	Could not offer at least one correct	9	18.0
	Total	50	100.0

CARE NUSA TENGGARA BARAT
Labuapi Kader Summary Tables

Table 5A: Education level of Respondent: Frequency distribution: **Labuapi, NTB.** n = 20.

	Education Level	Frequency	Percentage
1.	None (does not have to equal illiteracy)	0	0.0
2.	Under Grade Six	4	20.0
3.	Equal Grade Six	4	20.0
4.	Greater than Grade Six	12	60.0
	Total	20	100.0

Table 6A: Occupation of Respondent: Frequency distribution: **Labuapi, NTB.** n = 20.

	Occupation	Frequency	Percentage
1.	No Wage Labor Reported	1	5.0
2.	Private Business (family)	5	25.0
3.	Merchant	3	15.0
4.	Seasonal Laborer	2	10.0
5.	Civil Servant or Domestic worker)	1	5.0
6.	Farmer	8	40.0
7.	Other	0	0.0
	Total	20	100.0

Table 9: Can the respondent state the reason why immunization is important for children under five. Frequency distribution: **Labuapi, NTB.** n = 20.

	Category	Frequency	Percentage
1.	Could give proper reason	9	45.0
2.	Could not give proper reason	11	55.0
	Total	20	100.0

Table 14: Respondents' opinion or whether colostrum should be given to an infant. Frequency distribution: **Labuapi, NTB.** n = 20.

Category	Frequency	Percentage
1. Colostrum should be given to an infant	8	40.0
2. Colostrum should not be given to an infant/Does not know	12	60.0
Total	17	100.0

Table 17A: Feeding practice of mother with child between 1 to 3 months of age. Frequency distribution: **Labuapi, NTB.** n = 20.

Category	Frequency	Percentage
1. Give breast milk and boiled water only	20	100.0
2. Respondent mentioned any other type of food	0	0.0
Total	20	100.0

Table 17B: Feeding practice of mother with child between 4 to 7 months of age. Frequency distribution: **Labuapi, NTB.** n = 20.

Category	Frequency	Percentage
1. Mother is giving proper food	20	100.0
2. Weaning foods have not been started/ Proper food is not being given	0	0.0
Total	20	100.0

Table 19: Respondents who know how to prevent night blindness. Frequency distribution: **Labuapi, NTB.** n = 20.

Category	Frequency	Percentage
1. Respondents who stated either proper foods or Vitamin A	17	85.0
2. Respondents who do not know	3	15.0
Total	20	100.0

Table 20: Respondents knowing the age at which a child should be first weighed. Frequency discribution: **Labuapi, NTB.** n = 20.

Category	Frequency	Percentage
1. Knows age it which a child should be weighed	17	85.0
2. Does not know age at which at child should be first weighed	3	15.0
Total	20	100.0

Table 25: Respondents supervising children who had diarrhea in the month prior to the survey. Frequency distribution: **Labuapi, NTB.** n = 20.

Category	Frequency	Percentage
1. Supevises children who had diarrhea that month	8	40.0
2. Does not supervise children who had that month	12	60.0
Total	20	100.0

Table 26: Respondents who can state at least one correct action to be taken when a child has diarrhea. Frequency distribution: **Labuapi, NTB.** n = 20.

One or More Correct Response	Frequency	Percentage
1. Correct	19	95.0
2. Incorrect	1	5.0
Total	20	100.0

Table 27: Respondents who know two or more practices to help prevent diarrhea disease. Frequency distribution: **Labuapi, NTB.** n = 20.

Response	Frequency	Percentage
1. Respondent knew one method	2	10.0
2. Respondent knew two methods	6	30.0
3. Respondent knew three or more methods	7	35.0

Table 28: Respondent asked to state at least one sign of severe dehydration. Frequency distribution: **Labuapi, NTB.** n = 20.

	Response:	**Frequency**	**Percentage**
1.	Knew one sign	4	20.0
2.	Knew two signs	7	35.0
3.	Knew three or more signs	7	35.0
4.	Could not state a sign	2	10.0
	Total	20	100.0

Table 30B: Preparation of salt and sugar oral rehydration solution. Frequency distribution: **Labuapi, NTB.** n = 20.

	Category	**Frequency**	**Percentage**
1.	Kaders used the proper proportions of boiled water, salt, and sugar	3	15.0
2.	Kaders did not know proper amounts of ORS ingredients	17	85.0
	Total	20	100.0

Table 31: Amount of ORS to give an under five child with diarrhea. Frequency distribution: **Labuapi, NTB.** n = 20.

	Amount Given	**Frequency**	**Percentage**
1.	Correct amount	15	75.0
2.	Incorrect amount	1	5.0
3.	Did not know	4	20.0
	Total	20	100.0

Table 34: Respondents that were able to state two or more ways to increase chances of maintaining a healthy pregnancy. Frequency distribution: **Labuapi, NTB.** n = 20.

	Number of Correct	Frequency	Percentage
1.	Stated two or more	11	55.0
2.	Could not state at least two	9	45.0
	Total	20	100.0

Table 44: To whom a respondent would go if worried about a child's cough or cold (ARI symptoms). Frequency distribution: **Labuapi, NTB.** n = 20.

	Category	Frequency	Percentage
1.	Go to Traditional healer (TBA/Dukun)	0	0.0
2.	Go to Puskesmas health staff	14	70.0
3.	Go to Kader/Posyandu	3	15.0
4.	Do not know	1	5.0
5.	Other	2	10.0
	Total number of responses	20	100.0

Table 45: Respondents who could state at least one symptom they would worry about it their child already had a cough or cold. Frequency distribution: **Labuapi, NTB.** n = 20.

	Number correct	Frequency	Percentage
1.	One correct	8	40.0
2.	Two correct	9	45.0
3.	More than two correct	3	15.0
4.	Could not offer at least one correct	0	0.0
	Total	20	100.0

Table: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Gununghalu, West Java.** n = 40.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	0	0.0
2.	One correct answer	6	15.0
3.	Two correct answers	10	25.0
4.	Three correct answers	8	20.0
5.	Four correct answers	8	20.0
6.	Five correct answers	8	20.0
	Total	40	100.0

Average score = 3.05.

Table: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Sidangkerta, West Java.** n = 40.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	0	0.0
2.	One correct answer	4	10.0
3.	Two correct answers	6	15.0
4.	Three correct answers	10	25.0
5.	Four correct answers	11	27.5
6.	Five correct answers	9	22.5
	Total	40	100.0

Average score = 3.33.

Table: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Tulakan, East Java.** n = 38.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	0	0.0
2.	One correct answer	1	2.6
3.	Two correct answers	3	7.9
4.	Three correct answers	10	26.3
5.	Four correct answers	10	26.3
6.	Five correct answers	14	36.8
	Total	38	100.0

Average score = 3.87.

Table: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Tegalombo, East Java.** n = 40.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	0	0.0
2.	One correct answer	1	2.5
3.	Two correct answers	9	22.5
4.	Three correct answers	11	27.5
5.	Four correct answers	14	35.0
6.	Five correct answers	5	12.5
	Total	40	100.0

Average score = 3.33.

Table: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Gunung Sari, NTB.** n = 50.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	1	2.0
2.	One correct answer	7	14.0
3.	Two correct answers	8	16.0
4.	Three correct answers	10	20.0
5.	Four correct answers	8	16.0
6.	Five correct answers	16	32.0
	Total	50	100.0

Average score = 3.30.

Table: Health Knowledge score, based on correct answers to questions 9, 14, 27, 34, and 45. Frequency distribution: **Labuapi, NTB.** n = 20.

	Number of Correct Responses	**Frequency**	**Percentage**
1.	No correct answers	0	0.0
2.	One correct answer	4	20.0
3.	Two correct answers	2	10.0
4.	Three correct answers	7	35.0
5.	Four correct answers	3	15.0
6.	Five correct answers	4	20.0
	Total	20	100.0

Average score = 3.05.

DIARE

YANG PENTING DARI DIARE

1. Diare atau mencret yaitu berak cair/air.
2. Diare ringan mudah menjadi diare berat dan dapat menyebabkan kematian karena terlalu banyak cairan yang hilang dari tubuh.
3. Beberapa cara menanggulangi mencret di rumah: dengan cairan yang ada di rumah, Larutan Gula Garam (LGG) dan Oralit.
4. Obat-obatan tidak boleh digunakan untuk diare kecuali de
5. Bil ma an s
6. Bil me
7. Ta Pu be cai da

7

BATUK DAN PILEK

ANAK YANG MENDERITA BATUK DAN PILEK HARUS DIBAWA KE PUSKESMAS DENGAN SEGERA JIKA :

1. Bernafas lebih cepat dari biasanya, maka anak ini menghadapi bahaya.
2. Bagian bawah dari dada anak cekung ke dalam pada saat anak bernafas dan bukan cembung sebagaimana biasanya.
3. Anak sama sekali tidak bisa minum apapun.

ANAK YANG MENDERITA BATUK DAN PILEK DAPAT DIRAWAT DI RUMAH, JIKA BERNAFAS NORMAL, DAN DIUSAHAKAN :

1. Makan seperti biasa dan minum banyak.
   dan tidak menyebabkan

5

FRONT

MENCEGAH DIARE

Penyebab utama dari diare adalah kuman dari kotoran manusia yang masuk ke dalam mulut. Cara terbaik untuk mencegah diare ialah :

1. Minum air yang dimasak.
2. Makanan harus dimasak dengan baik dan tidak boleh dibiarkan lama, agar tidak tercemar kuman atau basi.
3. Makanan dan air minum harus ditutup.
4. Alat-alat makan harus dicuci bersih.
5. Lalapan dan buah-buahan harus dicuci sebelum dimakan.
6. Gunakan selalu jamban untuk buang air besar atau membuang kotoran anak.
7. Cucilah tangan dengan sabun dan air setelah buang air besar atau membuang kotoran anak, sebelum makan.

8

MENCEGAH BATUK, PILEK DAN RADANG PARU-PARU

1. Berikan Air Susu Ibu (ASI) saja selama masa 4 - 6 bulan pertama dari kehidupan bayi, karena ASI membantu melindungi anak terhadap penyakit.
2. Berikan makanan yang cukup dan baik sesuai dengan usianya sehingga lebih kecil kemungkinan anak menderita sakit berat dan meninggal dunia karena radang paru-paru.
3. Vitamin A dari buah-buahan berwarna kemerahan
4.

6

REVERSE

300

FRONT

TANDA SELAMA KEHAMILAN YANG HARUS SEGERA DIRUJUK

1. Pendarahan dari kemaluan/jalan lahir.
2. Sakit kepala yang hebat.

KESEHATAN IBU DAN ANAK

HAL PENTING DARI KEHAMILAN

1. Periksakan kehamilan ibu paling sedikit 4 kali selama kehamilan, dan timbang badan setiap bulan ke Posyandu atau Puskesmas.
2. Kehamilan yang tepat adalah pada umur 20 - 35 tahun dan berbadan sehat.
3. Usahakan untuk melahirkan dengan bantuan dokter, bidan atau dukun bayi yang sudah dilatih Puskesmas.
4. Berikan imunisasi TT 2 kali selama kehamilan.

dari

lauk

ngan

berat

PEMBERIAN MAKANAN BALITA

UMUR ANAK	ASI	MAKANAN LUMAT	MAKANAN LEMBIK	MAKANAN ORANG DEWASA
0 - 3 bulan				
4 - 6 bulan				

: Bubur tepung atau bubur beras encer yang dicampur dengan lauk (misalnya tahu atau telur) serta sayuran (misalnya bayam) yang dihaluskan, pisang atau pepaya yang dikeruk dengan sendok.

: Bubur beras, nasi tim, nasi lembik yang dimasak dengan lauk (misalnya tahu atau telur) dan sayuran (misalnya bayam) yang dihaluskan.

DEWASA : Nasi, ikan asin, kangkung dan buah.

GIZI

YANG PENTING DARI GIZI

1. Gizi adalah zat makanan yang berguna untuk memberikan tenaga, mengatur dan membangun tubuh.
2. Berikan anak makanan yang bergizi. Anak yang kurang gizi bisa menyebabkan pertumbuhannya terlambat dan mudah terserang penyakit.
3. Timbang anak setiap bulan di Posyandu. Anak yang sehat bertambah umur bertambah pula berat badannya.
4. Air Susu Ibu (ASI) adalah makanan bayi yang terbaik. Untuk 4 - 6 bulan pertama hidupnya, bayi tidak perlu diberi makanan tambahan apapun selain ASI. Mulai umur 4 - 6 bulan, bayi memerlukan makanan tambahan, tetapi ASI terus diberikan, sekurang-kurangnya sampai anak umur 2 tahun.
5. Anak balita membutuhkan lima atau enam kali makan dalam sehari dengan makanan yang bergizi, termasuk makanan kecil dan buah.

-301-

REVERSE

HAL PENTING BAGI IBU MENYUSUI

1. Menjaga dan memelihara kesehatan sesudah masa persalinan.
2. Sejak usia kehamilan 4 bulan rawatlah payudara 2 kali sehari dengan mengurutnya dari pangkal kearah puting susu, tarik puting susu keluar dan putar-putar.
3.
4.
5.
6.
7.
8.
9.
10.

KEHAMILAN YANG PERLU DIPERHATIKAN

1. Ibu hamil yang berumur kurang dari 20 tahun, atau lebih dari 35 tahun.
2. Ibu yang masih punya anak berumur kurang dari 2 tahun
3. Riwayat kehamilan atau persalinan yang buruk.

hamil.
mil.
a.

PERHATIAN

1. Susu pertama (kolostrum) yang berwarna kuning harus diberikan pada bayi, karena melindungi bayi dari serangan penyakit.
2. Berikan makanan lebih sering dari biasanya untuk anak yang berat badannya berada di bawah garis titik-titik (BGT).
3. Anak yang berat badannya tiga kali tidak naik berturut-rada di bawah garis merah (BGM), segera e Puskesmas.

ak yang tidak mau makan, dan ganti-ganti

banyak makan buah-buahan yang ber-ahan dan sayuran yang berwarna kehijauan ar dari penyakit buta senja dan penyakit-

uk anak balita dapat diperoleh di Posyandu 1 sekali.

am beryodium setiap kali masak untuk penyakit gondok.

TIGA UNSUR ZAT MAKANAN

3 ZAT MAKANAN	ARTI	3 MACAM MAKANAN
Zat tenaga	Zat yang diperlukan tubuh, untuk dapat menggerakkan tubuh	Beras, jagung, singkong, ubi, roti, mie, terigu, sagu
Zat pengatur	Zat yang diperlukan tubuh untuk mengatur keseimbangan dalam tubuh	Mangga, pepaya, jeruk, pisang, nangka, sawo, kangkung, bayam, daun ubi, tomat, wortel
Zat pembangun	Zat yang diperlukan tubuh, agar tubuh dapat tumbuh berkembang terus	Daging, ikan laut, telur, hati, daging ayam, tahu, tempe, kacang hijau, kedelai, kacang merah

Setiap kali makan, harus mengandung 3 unsur zat makanan yang disebut diatas.

302

APPENDIX G

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

Fiscal Year: 1992

PN: 30

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
INPUTS										
PERSONNEL INPUTS:										
Management staff: 43.05 mos.(Int'l:13.32, Nat'l:30.20)	20.44			20.04			55.05			
Adm.:130.05 mos.(WJ:32.40, EJ:22,08,NTB:38.88,JET:42.12)	67.65			67.65			135.30			
Field staff:152.0 mos.(PO:20.0, FO:156.0)	132.00			132.00			274.00			
OUTPUTS										
GOALS, INDICATORS, PROJECT ACTIVITY TARGETS (PATs) AND OUTPUTS:										
INTERMEDIATE GOAL #1										
Village Supervision Team (Tim Pembina Desa) operates independently to improve and maintain village health system.										
INDICATORS:										
- 70% of villages have VST established	-			70%			70%			
- 70% of VSTs meet regularly in accordance with agreed schedule.	70%			70%			70%			
- 70 % of VSTs implement workplans for priority health problems	70%			70%			70%			
- 70% of Posyandu sessions held are supervised by VSTs.	70%			70%			70%			
- 70% of VSTs conduct training for kader.	70%			70%			70%			
- 70% of TBAs trained by the project are active in promoting the Posyandu and relaying health messages and referring high risk pregnancies.	-			70%			70%			
- 70% of informal community leaders (religious leaders and or teachers) trained by the project are actively involved in promoting the Posyandu and relaying health messages.	-			70%			70%			
- 70% of villages have at least 2 health posts distributing and receiving their supplies.	70%			70%			70%			
- Support System for kader established in 50 % of villages	50%			50%			50%			

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Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 30

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
PROJECT ACTIVITY TARGETS:										
- Refresher training for VST on How to Manage Posyandu and PHC activities										
- West Java (# villages)	10			7			17			
- East Java (")	5			5			10			
- NTB (")	5			5			10			
- Training for informal leader (teacher and/or religious leader) on promoting Posyandu										
- West Java (# inf. leader)	30 + 55			30 + 55			155			
- NTB (")	0			50			50			
- Refresher training for TBAs on promoting Posyandu and referral system for pregnant women.										
- West Java (# TBAs)	25			25			50			
- NTB (# TBAs)	29			0			29			
- Training for oralit Post Manager/Supervisor on the distributing and restocking of oralit										
- West Java (# villages)	10			7			17			
- NTB (")	5			5			10			
- Training for VST on the development of Leader Support system										
- West Java (# villages)	10			7			17			
- East Java (")	0			5			5			
- NTB (")	0			5			5			
Bandar Subdistrict, East Java only:										
- Training for VST on Posyandu management (# villages)	5			-			5			
- VST develop workplan for first intervention (# villages)	5			-			5			
- Training for VST on the development of Posyandu feedback session (# villages)	4			4			8			
- Training for VST on the establishment and administration of oralit post (# villages.	4			4			8			
- LSS Training for VST on the development of Leader Support System				4			4			

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304

Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 30

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
- Training for VST on the development of immunization target list (# villages)	4			4			8			
- Training for VST on the establishment of nutrition feeding/education program (# villages)	2			6			8			
- Training for TBAs on Promoting Posyandu and Referal system for Pregnant Women (# TBAs)	23			23			46			
INTERMEDIATE GOAL # 2										
Comprehensive and convenient posyandu services are regularly functioning in all villages.										
INDICATORS:										
- 90% of posyandus hold sessions monthly.	80%			90%			90%			
- 70% of Posyandu operate with "Four Table" system	50%			70%			70%			
- 80% of children under 5 weighed at Posyandu.	45%			80%			80%			
- 80% of pregnant women are examined during their pregnancy	-			80%			80%			
- 70% of mothers report they would provide appropriate treatment if their child has diarrhea	-			70%			70%			
- 70% of mothers demonstrate improved health knowledge and attitudes	-			70%			70%			
- Kader at 70% of Posyandu are making home visits.	70%			70%			70%			
- 70% of Posyandu complete P1 form monthly.	60%			70%			70%			
- 70% of Posyandu have referal system to Puskesmas operating.	51%			70%			70%			
- 70% of Posyandu have feedback sessions.	60%			70%			70%			
- Children 0 to 12 months receive immunizations as follows:										
BCG 90%	-			90%			90%			
DPT 1 90%	-			90%			90%			
Polio 80%	-			80%			80%			
Measles 80%	-			80%			80%			
- 80% of pregnant women receive 2 TT immunizations	-			80%			80%			
- 40% of malnourished children are enrolled in a feeding/nutrition education group	20%			40%			40%			

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Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 30

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
PROJECT ACTIVITY TARGETS:										Note: PATs under Intermediate Goal for East Java include first the Tulakan data and then the Bangar data.
- Provision of health services for pregnant women at Posyandu operating										
- West Java (# Posyandu)	58			42			100			
- East Java (")	29+20			29+21			58+41			
- NTB (")	29			29			58			
- Application of instrument (books, forms) for the referral system from Posyandu to Puskesmas										
- West Java (# Posyandu)	2			0			2			
- East Java (")	5+0			5+8			10+8			
- NTB (")	2			0			2			
- Nutrition feeding/education groups has their children enrolled and schedule of sessions										
- West Java (# groups)	10			7			17			
- East Java (")	2+0			2+6			4+6			
- NTB (")	2			0			2			
- Community based Posyandu model operating										
- West Java (# Posyandu)	2			0			2			
- East Java (")	10+0			6+5			16+5			
- NTB (")	2			0			2			
NTB only:										
- Training for new kader on Posyandu activities (# villages)	7			-			7			
- Training for PKK on Posyandu supervision (# villages)	7			-			7			
- Posyandu development in isolated area.hamlet (# hamlet)	4			1			5			
Bangar Subdistrict, East Java only:										
- Refresher training for kader (Posyandu management (# kader)	0			111			111			

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Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 36

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
INTERMEDIATE GOAL # 3										
Subdistrict Team and Puskesmas staff adopt a community participatory approach to village primary health care services.										
INDICATORS:										
- 100% of SDTs develop written plans and monitor Posyandu activities.	100%			100%			100%			
- 100% of SDTs conduct quarterly supervision visits to VST.	100%			100%			100%			
- 100% of SDTs implement participatory training events which have as outputs action plans which are followed.	100%			100%			100%			
- SDT/Puskesmas staff provide immunization services to 50% of Posyandu, as required.	70%			70%			70%			
PROJECT ACTIVITY TARGETS:										Note: PATs under Intermediate Goals # 3 for East Java include both Tulakan and Sendar Subdistricts.
- Joint quarterly visits CARE - GOI subdistrict to VST and/or Posyandu (2 x 45 villages per semester).										
- West Java (# visits)	34			34			68			
- East Java (# visits)	36			36			72			
- NTE (# visits)	20			20			40			
- Joint quarterly visits CARE - GOI Provincial, District to Subdistrict / VST / Posyandu (2 x per semester)										
- West Java	2			2			4			
- East Java	2			2			4			
- NTE	2			2			4			
- Subdistrict planning and evaluation workshop on Posyandu activities										
- West Java (# workshop)	1			1			2			
- East Java (")	2			2			4			
- NTE (")	1			1			2			
- CARE-GOI workshop for informal leaders (teachers and/or religious leaders) at subdistrict and or village level										
- West Java (# workshop)	1			1			2			
- East Java (")	1			1			1			
- Phase out survey conducted										
- West Java (# survey)	1						1			
- East Java (")										
- NTE (")				1			1			
NTB only:										
- CARE-GOI workshop for teacher at village level.										
- Training for Trainer at subdistrict level										

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Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

FN: 20

EXPLANATION	FIRST SEMESTER			SECOND SEMESTER			ANNUAL TOTAL			REMARKS
	Plan	Actual	Deviation	Plan	Actual	Deviation	Plan	Actual	Deviation	
INTERMEDIATE GOAL # 4										
Information, materials and media to support the PHC program developed and utilized.										
INDICATORS:										
- Nilai System to assist mothers monitor their children's growth utilized in at least one subdistrict	0			1			1			
- At least two materials developed and promoted by the project are utilized in subdistrict	0			2			2			
PROJECT ACTIVITY TARGETS:										
- Discussion with SDT and Puskesmas staff on monitoring the use of Nilai System at East Java	1			0			1			
- Meetings on monitoring the use of materials developed										
- West Java	0			1			1			
- East Java	-			1			1			
- NTB	1			0			1			
PROJECT ACTIVITY TARGETS for Staff Development:										
- External training										
- West Java	1			1			2			Note: Number refers to the number of staff involved
- East Java	1			1			2			
- NTB	1			1			2			
- CIBQ	1			0			1			
- In-service training										
- West Java	7			0			7			
- East Java	5			0			5			
- NTB	7			0			7			
- Cross Visit										
- West Java	0			2			2			
- East Java	2			2			4			
- NTB	2			0			2			

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Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 30

TOTAL OUTPUTS PLAN * (Project Duration: Sept.88 - mid 92)				FIRST SEMESTER ACTUAL			SECOND SEMESTER ACTUAL			TOTAL OUTPUTS TO DATE				REMARKS
	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	TOTAL	
1. 700 VST members representing 51 villages participate in an average of 30 hours training.														* The TOTAL OUTPUTS PLAN is not the sum of the three Field Offices. It is the overall estimated project achievement which is listed in the Detailed Implementation Plan (DIP).
- VST members	241	229 + 98	165							241	165+84	212	513	
- Villages	17	16 + 8	10							17	10+ 8	16	51	
- Hours of training	40	16 + 24	50							32	27+24	17	30	
2. 51 VST are provided assistance in developing 190 workplans														
- VST	17	16 + 8	10							13	16+8	9	46	
- Workplans	34	85 + 41	30							37	101+0	22	220	
3. 500 Kader Supervisors from 51 villages participate in an average of 30 hours of training														
- Kader Supervisors	233	117 + 40	150							233	148+27	141	549	
- Villages	17	16 + 8	10							17	10+ 2	8	43	
- Hours of training	40	24 + 16	37							32	22+23	27	26	
4. 1000 Kaders from 51 villages are trained														
- Kaders	400	288 +157	300							140	311+0	145	596	
- Villages	17	10 + 8	10							13	10+0	10	33	
5. 10 Villages have developed and operate Kader Support System														
- Villages	17	1 + 5	5							5	1+0	5	11	
6. 500 Informal Leaders (religious leaders and/or teachers) representing 51 villages participate in a minimum average of 25 hours of training														
- Religious Leaders/ Teachers	200	412 + 50	55							72	354+114	35	590	
- Villages	17	16 + 5	10							17	10+5	10	51	
- Hours of training	10	20 + 18	12							17	15+20	2	16	
7. 150 TBAs representing 51 villages participate in a minimum average of 30 hours of training														
- TBAs	51	47 + 22	41							40	47+4	15	102	Note: Mistake corrected in DIP's data. Previously 42 TBA's had been reported in error. Correct number is 47.
- Villages	17	15 + 5	11							17	15+0	9	41	
- Hours of training	51	60 + 45	21							17	17+4	13	11	

Note: CIEJ = Tulaken + Kandar

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Fiscal Year: 1992

PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

PN: 30

No.	TOTAL OUTPUTS PLAN (Project Duration: Sept.88 - Mid 92)				FIRST SEMESTER ACTUAL			SECOND SEMESTER ACTUAL			TOTAL OUTPUTS TO DATE				REMARKS
		CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	TOTAL	
8.	250 Oralit Post/Diarrhea Treatment Centers are established and actively functioning in 51 villages														
		CIWJ	CIEJ	CINTB											
	- Oralit Post	100	391 + 49	20							90	491+0	26	607	
	- Villages	17	16 + 8	10							17	16+0	10	43	
9.	40 Nutrition Education and Feeding Program established in 40 villages.														
		CIWJ	CIEJ	CINTB											
	- Nutrition/Feed. Pro	17	16 + 8	2							1	12+0	0	12	Note: Mistake corrected in EJ's data. Previously 11 programmes had been reported in error. Correct number is 12.
	- Villages	17	16 + 8	2							1	12+0	0	12	
10a.	291 Posyandus are operating and weighing at least 60 % of the total 23,000 children under 5.														
		CIWJ	CIEJ	CINTB											
	- Posyandu operating	100	85 + 41	65							87	86+46	55	200	
	- Total children -5	6000	6000+1079	5525							5701	5921-2088	5525	13549	
	- Total child.weighed	50 %	50 %	35 %							45%	51%+36%	50%	41%	
10b.	100 Posyandus are operating which are individually weighing at least 80 % of their children under 5.														
		CIWJ	CIEJ	CINTB											
	- Posyandus with D/S at least 80 %	69	65 + 25	0							65	78+2	0	143	
11a.	251 Posyandus are operating and weighing at least 30 % of the total 5,000 pregnant women.														
		CIWJ	CIEJ	CINTB											
	- Posyandus operating	100	85 + 41	65							6	2 + 1	1	7	
	- Total preg.women	2525	1210 + 240	2615							6	1170+164	2620	3790	
	- Preg. women weighed	30 %	30% + 30%	35 %							3	21%+72%	3%	9%	
11b.	85 Posyandus are operating which are individually weighing at least 50 % of their pregnant women.														
		CIWJ	CIEJ	CINTB											
	- Posyandus covering at least 50 % of pregnant women	35	30 + 35	0							0	0	0	0	
12.	340 Subdistrict Team members participate in a minimum average of 35 hours of training.														
		CIWJ	CIEJ	CINTB											
	- SDT members	67	7 + 2	25							67	14+35	25	126	
	- Hours of training	35	107 + 52	35							35	37+35	35	37	

Note: CIWJ = Tulakan + Pancar

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PROJECT IMPLEMENTATION REPORT (PIR)
Country : Indonesia
Title: VILLAGE PRIMARY HEALTH CARE II

Form AIP 1.2

Fiscal Year: 1992

PN: 30

No.	TOTAL OUTPUTS PLAN (Project Duration: Sept.88 - Mid 92)				FIRST SEMESTER ACTUAL			SECOND SEMESTER ACTUAL			TOTAL OUTPUTS TO DATE				REMARKS
		CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	CIWJ	CIEJ	CINTB	TOTAL	
13.	Model for Posyandu tested in 22 villages														
		CIWJ	CIEJ	CINTB											
	- Villages	2	10 + 8	2							2	8+0	0	10	
14.	Nilai System functioning in 3 subdistricts														
		CIWJ	CIEJ	CINTB											
	- Subdistrict	1	1 + 1	0							0	1+0	0	1	
15.	2 Materials developed by the project utilized in 3 subdistrict.														
		CIWJ	CIEJ	CINTB											
	- Material	1	2 + 1	0							1	2+0	3	3	Note: Same materials are utilized in more than one subdistrict.
	- Subdistrict	1	1 + 1	0							1	1	1	3	

Note: CIEJ = Tulakan + Bander

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS, CSIV
CARE INDONESIA

	Expenditures to Date 10/1/88 - 6/30/91			Remaining Obligated Funds 7/1/91 - 9/30/92			Total Agreement Budget 10/1/88 - 9/30/92		
	AID	CARE	TOTAL	AID	CARE	TOTAL	AID	CARE	TOTAL
I. PROCUREMENT									
A. Supplies	48,853	20,412	69,265*	(37,438)	(12,134)	(49,572)	11,415	8,278	19,693
B. Equipment	16,095	18,702	34,797	45,576	9,521	55,097	61,671	28,223	89,894
C. Services/Consultants	20,145	7,393	27,538	(2,305)	33,897	31,592	17,840	41,290	59,130
SUBTOTAL I	85,093	46,507	131,600	5,833	31,284	37,117	90,926	77,791	168,717
II. EVALUATION/SUBTOTAL II	8,752	3,406	12,158	3,548	8,894	12,442	12,300	12,300	24,600
III. INDIRECT COSTS/SUBTOT.III	55,541	21,997	77,538	20,899	15,726	36,625	76,440	37,723	114,163
IV. OTHER PROGRAM COSTS									
A. Personnel	455,544	171,750	627,294	104,276	88,957	193,233	559,820	260,707	820,527
B. Travel/Per Diem	50,724	20,566	71,290	5,812	51,314	57,126	56,536	71,880	128,416
C. Other Direct Costs	64,319	20,915	85,234	43,316	15,040	58,356	107,635	35,955	143,590
SUB-TOTAL IV	570,587	213,231	783,818	153,404	155,311	308,715	723,991	368,542	1,092,533
TOTAL FIELD	719,973	285,141	983,117	183,684	211,215	394,899	903,657	496,356	1,400,013

This document should replace the estimate included in CARE Headquarters' 1991 Child Survival Annual Report, cover letter dated November 4, 1991.

* Includes $29,574 reported in 1990 as 'Other Direct Costs.' 'Other Direct Costs' has been reduced accordingly.

1991 ANNUAL REPORT FORM A: CARE INDONESIA/HQ PIPELINE SUMMARY

	Expenditures to Date 10/1/88 - 6/30/91			Remaining Obligated Funds 7/1/91 - 9/30/92			Total Agreement Budget 10/1/88 - 9/30/92		
FIELD AND HQ COSTS	AID	CARE	TOTAL	AID	CARE	TOTAL	AID	CARE	TOTAL
HQ	117,610	0	117,610	156,332	0	156,932	274,542	0	274,542
TOTAL INDONESIA	719,971	285,142	1,005,113	183,686	211,214	394,900	903,657	496,356	1,400,013
TOTAL PROJECT COSTS	837,581	285,142	1,122,723	340,618	211,214	551,832	1,178,199	496,356	1,674,555