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CARE INDONESIA
VILLAGE PRIMARY HEALTH CARE
FINAL EVALUATION
CHILD SURVIVAL I GRANT 1985 - 1988

October 1988

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
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

EXECUTIVE SUMMARY

In October 1988 a team of three external evaluators were commissioned by CARE to evaluate its Village Primary Health Care (VPHC) project. The selection of the team members was based on familiarity with the Child Survival program and Primary Health Care services in Indonesia. The terms of reference for this evaluation were provided by USAID/W. The entire evaluation process lasted 16 days. The evaluation team visited each of CARE's Field Offices and selected project sites in West Java, East Java and West Nusa Tenggara (NTB). The evaluation team in each province was accompanied by local government counterparts and CARE staff members. The team interviewed government officials, Puskesmas doctors, community volunteer health workers (kader), community leaders, mothers and CARE staff. Based on these interviews, a review of CARE reports and government health data, the team judged the effectiveness of the interventions, the level of cooperation of the government and estimated the sustainability of the project. In addition, specific recommendations for the 1988-1992 VPHC II project were provided.

CARE's original three year, 1985-1988 VPHC project was designed to upgrade community health activities. Kaders were trained to promote immunization services, educate mothers on how to prevent diarrhea and reduce severity of dehydration and facilitate Posyandu or integrated community health post services. The original project strategy was modified in 1987 in West Java and East Java in an effort to increase coverage and improve the sustainability of the project activities.

The modified strategy required CARE staff to adopt a facilitator's role rather than serve as direct community workers at the village level. As facilitators the CARE staff worked in close collaboration with the Subdistrict Management Teams. The objective was to promote positive improvements in the training and support services provided to village Posyandu and kader. CARE implemented workshops for the subdistrict Management Teams that focussed on upgrading training, creation of revised work plans and local monitoring procedures. In NTB, the VPHC staff made efforts to change operational roles but found that the lack of village infrastructure and past strained relationships with local government counterparts made it impossible to optimally function as effective facilitators. Therefore CARE NTB has continued to assign Field Officers to key villages. In all three provinces CARE established model sites that are designed to serve as training centers for three to four adjacent villages. The goal of these model sites is to expand coverage from an average of 16 villages per year to 32.

The evaluation team found the VPHC project to be effective in promoting community participation. This was particularly evident in West Java. Though CARE's activities had been completed for at least four months, it was found that kader were still active. Kader in these sites demonstrated basic working knowledge and skills in ORT, growth monitoring and immunization. However, the kader's knowledge and work performance was found to be weak in the areas of nutrition counselling, and follow up services for "at risk" children and mothers were not conducted regularly. The VPHC project's impact on the surrounding communities was found to be less than in the model sites. However, the pilot - satellite system of promoting community interest in the development of their own Posyandu was regarded as positive. [Four satellite villages were identified for each (one) pilot site. The pilot villages served as example - training centers to the neighboring villages.] This approach was most effective in West Java and NTB. In East Java CARE VPHC staff had spent the

majority of their efforts working directly through the subdistrict Management Teams. As a result the model sites were found to be well established and functioning, but the satellite expansion activities was not fully implemented.

The evaluators found in all three provinces that CARE's VPHC project was understood and appreciated by the government counterparts. The official reaction was that CARE had made substantial improvements in communicating with local government officials. Relations from the provincial level, district to subdistrict were considered good. This was a sharp contrast to the findings of the mid-term evaluation conducted in 1987.¹

The evaluation team concluded that the VPHC project's modified strategy -- to work more closely with the subdistrict Management Teams -- was appropriate and enhanced the chances of project long term success. However, there has not been sufficient time to determine the degree to which the government counterparts will adopt the new management approaches. There was ample evidence that the village to village training is a potent means of motivation and effectively stimulates kader services. How long kader will remain active is yet to be determined.

The VPHC project has developed a solid foundation in all three provinces. This base should make it possible for the program to become more efficient and to expand its coverage during the next four years.

The evaluation team strongly recommended that the VPHC project continue to work in cooperation with the subdistrict Management Teams. At the same time, CARE must ensure that village leaders and kaders are provided with the needed support and follow-up services required to enhance the quality of the village level Primary Health Care services. An objective of the VPHC II project should be to develop a subdistrict-wide system that strengthens village leadership capacity to conduct independently their own Posyandu programs with only technical medical support provided from the Puskesmas (Health Center). To enhance the quality and independent operation of the Posyandu programs CARE will need to explore and identify feasible, cost effective incentives that communities can provide the kader to encourage them to remain active.

A second major recommendation made by the evaluators is that the VPHC project in the future must concentrate activities on development of quality Posyandu services. Emphasis should be placed on the creation of systems that make it possible for kader to more easily identify and follow-up "at risk" children and pregnant women.

¹ Village Primary Health Care Project Mid-Term Evaluation Report, September 2-14, 1987, CARE Indonesia.

EVALUATION METHODOLOGY

The primary purpose of this evaluation was to assess the strategy and progress of implementation of CARE Indonesia's Village Primary Health Care project. A second and equally important objective of the evaluation was to formulate specific recommendations that would serve to improve the implementation of the second phase of the VPHC project. The guidelines used for this evaluation were provided by USAID/W in June 1988.

A team of three external evaluators and representatives from each province as well as selected members of the CARE staff participated in the evaluation. (Evaluation team members are listed on the following page). The evaluation team visited project sites in West Java, East Java and West Nusa Tenggara (NTB) from October 6 to 21, 1988. CARE staff as well as government officials related to the Primary Health Care sector were interviewed. CARE Field Office staff provided documentation, as requested and assisted with the arrangements of all meetings. The evaluation schedule in Attachment #3 lists the government officials contacted and the project sites visited.

The external evaluation findings were shared with the CARE project staff. The final report to be submitted to CARE's government counterparts in December 1988.

Survey Results

Included with this external evaluation summary is a report documenting the change in knowledge, attitude and practice (KAP) between a 1987 baseline survey and the one year follow up survey results in all target sites in West Java, East Java and NTB. This formative survey was conducted in NTB in July 1988, and in West Java and East Java in September 1988. (Refer to Attachment #1).

EVALUATION TEAM MEMBERS

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- Syoehada Kartawinata, BS - Staff of Nutritional Community
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- Nurlaita Hartono, MD, MS - Head of Community Participation
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The evaluation participants in NTB

- Said, BS - Head of Environment and Community
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CARE evaluation participants

- * Frederick Henning, Ed.D. - CARE Village Primary Health Care
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- * Core Evaluation Team Members

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PRIMARY FOCUS AND USE OF FUNDING

Original Proposed Strategy

The strong traditional Indonesian ideal of gotong-royong (mutual help) forms a solid foundation for developing the kader services. The health kader concept has been well implemented over the past 15 years and the kaders' potential value and the role of women kader at the village level is generally effective. The strong government interest and a commitment by Puskesmas staff (Community health clinic) to promote community based PHC (Primary Health Care) services is of vital importance and opens the door for continued development of the Posyandu services.

The wide proliferation of the Posyandu at the village or neighborhood level coupled with the sophisticated village leadership structure makes it possible to quickly implement primary health care intervention in the rural villages. Where the Posyandu are not in operation or village leadership is weak it is frequently necessary to strengthen the village infrastructure before primary health care programs can be effectively introduced. The VPHC project was designed to fit within the existing PHC national primary health care strategy.

The major focus of the VPHC/Child Survival (CS) I project has been to support subdistrict government development of community PHC services, increase community awareness of health needs, and positively influence health related practices. The aim of the project has been to supplement and increase utilization of existing government and community PHC services. The VPHC project has focused on management and training of village kader rather than providing supplies or equipment. The VPHC/CS I funds have been used primarily to improve existing primary health services. The Child Survival I funds helped CARE to both expand coverage and services to new communities.

The original VPHC project design, which was implemented for one year, stressed immediate short term results requiring field staff to be highly operational. Records indicate that CARE staff organized and trained village voluntary health workers (kader) to promote and conduct a wide range of Primary Health Care activities. The underlining assumption of this project was that after one year of intensive support, the village kader would remain active, serving as effective adjuncts to the public health program, requiring only periodic support from the local health centers. After the initial year, the program would sustain itself and CARE field personnel could move on to other villages.

Modified Strategy

It became evident to CARE that kader required substantially more follow-up support than originally anticipated. Local health centers are not sufficiently staffed to provide the necessary support. In addition, because of CARE's operational role, village leaders tend to depend on the CARE field staff, with the expectation that CARE would independently implement and maintain the project. Consequently, it was unlikely

improvements at the village level achieved through the present model could be sustained after CARE's withdrawal. Further, CARE's involvement in 48 villages, as originally planned, would have a beneficial effect in these communities, but on the whole, it would be inconsequential to the national need.

In an effort to establish a VPHC project that was more effective, sustainable and eventually replicable, CARE Indonesia modified the original project strategy in January 1987. Though the first year of the Child Survival project was reported to be successful it was determined by CARE that even a greater impact might be possible over a long term if the VPHC project staff adopted a facilitative role rather than concentrating on the direct implementation of health care activities. During the second and throughout the third year of the project period (FY 1987 - FY 1988) CARE and its government counterparts developed a prototype suitable for expansion to other villages by other government district and subdistrict Management Teams. CARE VPHC staff began by identifying Kecamatan (Subdistrict): two in West Java, three in East Java and four in West Nusa Tenggara (NTB), where officials had a strong interest in collaborating on the development of a comprehensive community health system. Following the establishment of a working agreement with the district representatives, specific villages were selected and child survival programs introduced and developed to a point where they later served as functioning training samples for surrounding communities.

Pilot Sites

In the pilot areas in West and East Java the VPHC staff limited direct involvement at the village level, working instead to mobilize village leaders and government subdistrict personnel to provide sustained support after CARE's departure. CARE's plan was to focus on identifying and implementing PHC activities that the individual villages could conduct independently. The results of this revised strategy are:

- * VPHC project established a total of 14 model sites: [four in West Java, three in East Java and seven in NTB] that served as the nucleus for expansion of the project's health promotion services into surrounding villages. Each pilot site assisted a minimum of four neighboring villages. Increasing local government and village leader involvement in the project made it possible to expand the project activities to more villages than the 48 planned in the original proposal. In total the VPHC project involved a total of 32 villages in one year.
- * The number of health activities introduced and the pace of implementation was designed to be based on the communities' willingness and ability to manage independently the project activities. CARE conducted health service training sessions with government counterparts but only facilitated and guided actual implementation of project activities in the villages in West Java and East Java. In NTB, because of the lack of a village infrastructure, it was necessary for CARE staff to continue to directly promote the implementation of the basic PHC services at the village level.

- * VPHC project focused on three specific health education interventions in West Java and East Java: ORT, immunization and nutrition. In NTB, due to the local emphasis on immunization campaigns and sporadic availability of vaccines, CARE did not include immunizations. This strategy was described in the VPHC work plans prepared in September 1987. CARE in West Java and East Java collaborated with the Subdistrict Management Teams and Trainer Teams to assist their work with community groups to conduct ORT training for mothers, promote immunization and improve basic nutrition practices for children.
- * Monitoring focused, in part, on improving the kaders' ability to use existing systems. Emphasis was placed on utilizing simple monitoring systems already used in the village.

In summary, CARE Indonesia modified its VPHC project in 1987 in an effort to develop a sustainable project that subdistrict government officials could replicate. The strategy was designed to encourage subdistrict government Management Teams to use core villages as training sites for surrounding communities and in the process identify alternative management approaches that could be utilized to increase the subdistrict Management Teams effectiveness.

ORGANIZATIONAL DEVELOPMENT

Technical Ability of Field Staff

To determine technical competence the field staff the evaluation team reviewed the staff field trip reports and interviewed the VPHC staff members. It was concluded that during the past three years CARE's managerial and field staff have clearly gained a wealth of practical experience. Though CARE's village level field staff had little background or skills when they were hired it is evident that inservice training and experience has taught the majority to be effective community organizers, adequate trainers of community health workers (kaders) and effective project monitors. In managing the VPHC project, the staff stated that they encountered a myriad of difficulties that they had to solve in order to meet the project's goals. Important lessons learned by the project staff include 1) how to collaborate and coordinate effectively with the local provincial and district governments departments, 2) the importance of identifying community health priorities and utilizing existing community resources, and 3) the use of nonformal education methods that are effective at both the community and government level.

The CARE field staff demonstrated a good understanding of the project's objectives, and possessed the skills required to implement the project activities. However, CARE senior staff reported that approximately one third of field personnel had difficulty making the transition from direct project implementors to facilitators. Despite extensive participatory planning sessions coupled with additional inservice training and increased supervision, many of the field staff were apparently not able to cope with the demands of the new job responsibilities. Interacting with subdistrict government officials was a threatening experience for the field officers.

Their problem solving skills were too limited for effective work. At times, the more complex bureaucratic procedures were confusing and frustrating. Previously, the staff worked at a more basic, speedier, less sophisticated village level.

Before continuing with VPHC project implementation extensive inservice training will be required to ensure that all the field staff can meet the job responsibilities required. CARE will also be required to hire personnel that have the ability to work effectively with government officials. CARE senior management staff are aware of the personnel needs and requirements and are in the process of making appropriate adjustments.

CARE's staff is primarily composed of the host country nationals. The national staff is performing the majority of the administrative, training and project monitoring services. The project coordinator is an American with a doctoral degree in Health Education and seven years experience managing primary health care projects in developing countries. He is responsible for overall project management. Currently the only other non-Indonesian staff member is the Chief Representative in Bandung. He has nine years of senior management experience and has served in two developing countries. He is responsible for all project implementation in the province of West Java. Up until April 1988, the Chief Representative in NTB was also an expatriate with an MPH degree and two years of related work experience. The vacant Chief Representative position has been filled by the former Assistant Chief Representative (an Indonesian) who has eighteen years experience with CARE.

CARE management staff stated that they have used a variety of approaches to enhance staff management and technical skills. Four times a year, CARE's entire management staff met together to review all of CARE projects and solve related administrative concerns. Regular in-house staff technical training has been established by each field office. In addition monthly project supervisory meetings are conducted at the field offices. CARE East Java staff also participated in Yayasan Indonesia Sejahtera's (YIS; Local PHC Non-Government Organization) four week Primary Health Care management and training course. CARE NTB field staff participated in a two week NTB - Department of Health sponsored field training session focussing on operation of Posyandus and use of appropriate health messages.

Technical Resources and Headquarters Support

Substantial support has been provided to CARE Indonesia by the CARE Regional Technical Advisor (RTA) for Primary Health Care based in Bangkok, Thailand. The RTA has visited Indonesia five times during the past three years for a total of 64 days (33 days during the past year [1987-1988]). The evaluation teams review of the RTA's trip reports indicates that the RTA travelled extensively, participated in project planning, monitored VPHC interventions, assisted with the preparation of the midterm evaluation and provided recommendations for improved field operations.

As described by the CARE Indonesian staff there is a Regional Management Unit (RMU) in New York, USA that reviews the Planning, Implementation and Evaluation (PIE) documents. This report serves as CARE's major monitoring

instrument and is submitted to their Headquarters every four months. Feedback from the RMU is then sent to missions with comments and recommendations pertaining to the information outlined in the PIE report. The CARE Headquarters PHC Unit also receives all Child Survival related information and has access to the PIEs. A CARE Headquarters Child Survival Coordinator collaborates with the RMUs and RTAs to ensure that all Child Survival Documents are discussed and acted upon via telex, letter, telephone conversation or site visit.

The following chart lists personnel, title and the amount of time each staff member from headquarters actually assisted with in-country implementation of the Child Survival I project.

<u>Title/Name</u>	<u>Year</u>	<u>Purpose of Trip</u>	<u>Total # of Days</u>
Mary Ruth Horner Ph.D Director of the PHC Unit, CARE New York	Nov. 86	Conducted in-country review and provided technical guidance on project activities.	7 days
Patricia Monahan, MPH Coordinator of PHC Services, CARE New York	Nov. 86	Reviewed VPHC field project activities	7 days
Susan Toole, MPH Deputy Director of the PHC Unit, CARE NY	Sep. 87	Conducted in-country review of VPHC progress and assist in the preparation of the CARE Indonesia Child Survival Annual Report.	14 days

Technical USAID funded assistance was also provided by the following personnel:

David Pyle, Ph.D USAID/W	Sep. 85	Assisted with preparation of Child Survival I DIP	7 days
Doris Storms, Ph.D USAID/W	Feb. 87	Reviewed CARE's Child Survival project in NTB	7 days
Richard Arnold, MD USAID/W	Aug. 87	Reviewed the implemen- tation, strategy, moni- toring and evaluation procedures and project activities being implemen- ted in target sites in West Java and NTB.	7 days

In general the technical assistance provided was reported by the CARE staff to be supportive and useful. According to the management personnel interviewed the major difficulties were associated with the time required from management to set up appropriate travel schedules. Frequently travel schedules were changed causing delays and confusion. In addition, CARE staff stated that in the future, it would be helpful if USAID/W technical consultants made more of an effort to carefully review project documents

before their arrival and focus on identifying major project weakness and designing approaches for implementing possible solutions.

Written technical comments provided by USAID/W proved to be of little help to the CARE staff. The technical advice was vague and failed to provide relevant suggestions. After the first year of the project's implementation CARE modified its working strategy and monitoring procedures. No feedback from USAID/W was received on the revised VPHC work plan or on the second annual report 1987.

CARE also received financial support for technical assistance from PRITECH. CARE and PRITECH arranged with Yayasan Indonesia Sejahtera (YIS), a local NGO with extensive Primary Health Care activities, to assist CARE to prepare East Java VPHC strategy for the period of 1987 - 1988. The revised work plan was submitted to USAID/W May 1987.

To further enhance VPHC staff performance CARE New York conducted an Asia region seminar. The CARE Indonesia Project Coordinator and one project manager attended this conference in Calcutta, India (November 7-20, 1986). The conference provided the opportunity for CARE staff to discuss different primary health care programs being implemented throughout the world. The conference was considered by the Indonesian staff participants to be too "basic" and frequently not relevant to specific country concerns. In an effort to continue to upgrade CARE staff PHC skills, CARE's RTA is in the process of organizing a "cross visit" training opportunity in Bangladesh to give staffs from other countries the opportunity to study in-depth primary health care activities as they are being implemented. Two project managers from CARE Indonesia's VPHC project will be attending this "cross visit" training program. (Due to recent extensive flooding in Bangladesh this training program, planned for October, has been delayed until conditions in Bangladesh are stabilized).

Health Information System

During the third year VPHC project staff focused on improving monitoring and evaluation methods. Local technical assistance is now being used to revise and field test data collection procedures. Close project monitoring and utilization of CARE's extensive computer system will help to make the VPHC project more effective.

A baseline study was conducted in all three provinces where CARE established the VPHC project. A formal midterm evaluation was conducted in September 1987. (Refer to Attachment #5) A summary of the latest survey conducted in September 1988 is also included with this report (Refer to Attachment #1).

The CARE VPHC staff found that preparing survey materials was a complex chore and survey implementations proved to be a difficult task for many of the CARE national staff. From interviews with CARE staff it was noted that they had never been exposed to the sophisticated procedures inherent in conducting social research. As a result many mistakes were made. Frequently research methodologies were not understood or ignored and sampling procedures were considered confusing or not necessary. When data

was collected establishing systems for tabulating and analyzing the results seemed to be overwhelming. Over the past three years CARE VPHC staff have worked hard to find appropriate solutions and have used outside technical assistance to overcome the difficulties.

During the past year CARE Indonesia hired a full time evaluation officer to assist the VPHC project staff, and upgrade monitoring and evaluation instruments. The American evaluation officer was a former Volunteer in Asia. He revised existing survey instruments, prepared standard evaluation guidelines and trained staff in monitoring and evaluation procedures. CARE also employed, on a part-time basis, an experienced Primary Health Care physician to periodically review project activities and provide direct feedback to the staff on how to improve project interventions at the village level.

Both the evaluation officer and physician helped to upgrade staff performance and project implementation. However, the short term assistance of less than one year, does not allow for sufficient interaction and understanding between staff or government officials.

The process of streamlining and improving CARE's VPHC projects management information system is being conducted and the lessons learned are being incorporated into the new Child Survival IV Detailed Implementation Plan. It was apparent to the evaluators that the VPHC staff have made a valiant effort to monitor project activities. The VPHC projects monitoring system was found to be extensive but in some areas are cumbersome.

PROJECT DESIGN AND IMPLEMENTATION

During the past year, CARE staff functioned as facilitators working with GOI at the subdistrict level to implement selected interventions. The type of activities implemented by CARE were: 1) Work with Management Teams consisting of subdistrict level officials to manage Posyandu and kaders activities in the target villages [included record keeping, establishment of health posts, mobilization and organization of formal and informal leaders]; 2) With Community Health Center (Puskesmas) staff teach kader in the target villages in selected health procedures. The kader, in turn, were responsible for teaching groups (mothers with children under five, pregnant and lactating women). Topics included diarrhea prevention and rehydration, immunization, nutrition and early breast feeding. These particular interventions were chosen because they were most directly related to the target groups' needs.

As described previously, CARE's strategy was designed to have VPHC staff work with community leaders and the subdistrict management/training teams that are normally responsible for Posyandu services. CARE's objective is to stimulate the existing Posyandu/kader system in an effort to assist mothers with children five years and younger to take advantage of existing PHC services.

CARE's VPHC field staff conducted workshops and planning sessions with community leaders and GOI officials designed to improve Posyandu and kader services. Kader refresher training opportunities were organized and conducted in cooperation with the local officials. VPHC staff assisted the kader to form their own support groups, set up home visiting schedules and mother group

education meetings in the respective villages. VPHC staff also followed up on all Posyandu sessions and assist the communities maintaining contact with the local Puskesmas.

CARE planned to withdraw from the subdistrict level with the understanding that subdistrict officials would have the experience to sustain the VPHC program. Activities were replicated in surrounding villages in order to increase the target population with minimal assistance from CARE. This was accomplished through a natural process of village to village dissemination and by targeting specific villages in which GOI counterparts could implement health activities similar to the prototype developed by CARE at the pilot sites. Though the progress CARE has made in the past year is significant and positive, the evaluation team is not convinced that the Subdistrict Management Teams are ready to adopt and carry out all of the innovative approaches introduced.

Review of Objectives

Oral Rehydration Therapy (ORT)

The specific objective stated in the VPHC Work Plan (prepared in May 1987) was: "Increase the ability of mothers or caretakers to reduce severity of dehydration associated with diarrhea diseases among children under five years of age in all targeted sites". CARE proposed to achieve this objective through: group health education conducted by kader.

The VPHC work plan provided realistic and quantifiable indicators to measure how successfully the objective was achieved. For this purpose survey questionnaires identified as KAP -- knowledge, attitude and practice -- were developed. Records kept by the project staff as well as the CARE trimester narrative reports, indicate that the activities planned have been implemented. The time frame presented in the work plans have been adhered to in implementating the project. This is especially true in West Java.

CARE is aware that implementating this project falls short of solving all the problems related to Child Survival in the respective project sites. For example, rather than attempting to educate all mothers in ORT, it was decided to aim for a more moderate goal of educating 60% of mothers in the pilot sites and 30% in the satellite sites. Considering the problems of cultural, educational and other constraints in most of the villages this more modest level of achievement can be considered realistic.

Immunization

The VPHC work plan objective was to "reduce diseases which can be prevented by immunization by facilitating the implementation of immunization sessions in CARE assisted sites". This objective was expected to be achieved through the following activities:

- Educate and train resource persons (kader)
- Conduct weekly group health education sessions for mothers
- Promote immunizations for children of 3-14 months. [Immunization provided by Puskesmas staff.]
- Encourage TT immunization for pregnant mothers.

Implementating these activities is scheduled and outlined on a time projection. Review of the records and reports indicates that the majority of the activities planned have been implemented in the project pilot sites and started in the satellite villages.

The indicators selected for measuring the successful achievement of the objectives are well stated and quantifiable. Besides identifying the number of children 3-14 months of age and pregnant mothers, they also measure the improved knowledge of immunization by the mothers. The targeted level of achievement is considered reasonable.

Nutrition

The stated nutrition objective was: "increase ability of mothers or caretakers with children under five years of age to correctly identify available food and practice feeding patterns which promote healthy growth and development of their children under five years of age." The type of activities planned and conducted to achieve this particular objective included:

- Conducting regular mother group health education sessions
- Monthly weighing and growth monitoring.
- Promotion of early breast-feeding.

The indicators selected for measuring the achievements of the objective are also quantifiable. For example the indicators range from simply monitoring the number of mothers with improved knowledge in nutrition to a reduction in the number of children suffering from malnutrition. The indicators are designed to be verified through a KAP survey.

Technical Adequacy of Intervention Design and Implementation Strategy

Instead of establishing field guidelines the project management has taken a different approach to directing the field workers' activities. Each of the Field Officers is required to prepare a monthly work plan which is reviewed by their supervisor in each Field Office.

Training materials have been written by each Field Office staff in an effort to address the local needs. Adult education principles and participatory training techniques are appropriately used. The evaluation team has reviewed the training materials and found them to be complete.

Supervision of the project activities in each province is the responsibility of a full time Senior Field Officer or Project Manager who works directly with the Field Officers. The exercise of preparing monthly work plans and reviewing achievements provides a built-in supervision procedure. In addition, the Chief Representative and his designate supervise the daily activities of the project.

EFFECTIVENESS/IMPACT OF SERVICES

The evaluation team visited each of CARE's three field offices, reviewed VPHC project reports and interviewed the VPHC staff members. In addition, the evaluation team met with local government representatives responsible for PHC services. The evaluators also visited a total of 16 VPHC target communities: West Java (two pilot sites, two satellite sites), East Java (three pilot sites, two satellite sites), and NTB (four pilot sites, two satellite sites, one control site). The team interacted with community leaders, kader and mothers with children under five years of age in each of the villages. Based on this review of project activities the evaluation team has made the following conclusions:

- Provincial work plans have been completed and approved by government counterparts.
- Senior national staff members have made the transition from village based implementors to "change agents" working with government and village leaders to plan and facilitate community projects.
- Subdistrict management training teams and village leaders workshops have been conducted on community operation of Posyandu and appropriate supervision.
- Designated pilot villages are functioning and replication of project activities to satellite villages has begun.

Specific influences that the VPHC project had on the target population included:

- Enhanced community utilization of Posyandu services has been found in most of the CARE sites. Ninety-five Posyandu have been established and operate regularly serving children under five years of age. The coverage of Posyandu in the pilot sites for children under five averages 65% (NTB), 79% (East Java) and 80% (West Java).²
- On average more than 30 % of children 0-11 months have received basic immunization at Posyandu.
- Malnourished children, under five years of age, identified during the Posyandu occasion were provided with a special follow-up. Kader conducted counselling and Posyandu funds were used for supplementary foods. It was found that the messages concerning high calorie foods and frequent feeding was not provided and that services for malnourished children was only sporadically provided.
- A number of communities provide financial support for Posyandu activities through existing institutions such as the RKB PKK (Rukun Keluarga Bahagia Pendidikan Kesejahteraan Keluarga) (NTB), GHS (Gerakan Hidup Sehat) (West Java), NKKBS (Norma Keluarga Kecil Bahagia Sejahtera) (East Java). This indicates active support for Posyandu.

² CARE Monitoring Reports.

- Various systems have been explored in cooperation with the Puskesmas and communities to minimize kader dropout. For example active kader are provided with Free Medical Service Cards, which entitle them to treatment and medicines free of charge from the Puskesmas. This is also an expression of appreciation from the local district government for kaders' voluntary work in village development.
- In selected sites in West Java and East Java, local leaders have started to use a traditional Health Fund scheme, which pays for medical treatment of participating community members. To date fees are still being collected in kind, i.e. rice set aside before cooking, known locally as "beras perelek".

Overview of Evaluation Team's Findings

The following are observations made at Posyandu sessions and in conversations with kaders and mothers. Immunizations at the two Java locations were offered at Posyandu sessions every three months, on Lombok every month. Kaders and mothers seemed to understand the importance and purpose of immunizations and were not deterred by the side-effects sometimes experienced. The vaccines were carried to the Posyandu in a special cold box with ice or ice packs. In the process of immunizing only the number of vials needed were out of the storage container. Needles were kept in the sterilizer and removed one at a time as needed and afterwards put to the side and not reused. Immunizations were recorded on each child's Road to Health Card (KMS) and in the official registry. In some sites the kaders themselves kept their own immunization book. No list was made of children/women who had previously been immunized, needed an additional vaccination, but did not appear.

Mothers, particularly on Java, seemed to understand the need for oral rehydration (ORT) when a child had diarrhea. They could demonstrate preparation of the sugar/salt/water solution (LGG) and knew about Oralit, but many viewed it as a drug to be used only in severe cases. In West Java Oralit depots were available in every hamlet visited, in East Java in some hamlets, but in Lombok only through the health center. Unfortunately, some physicians improperly criticized mothers bringing children with diarrhea too early to the health center.

At all Posyandus attended, children were weighed correctly. However, in places where rice scales were used the kaders requested a more accurate instrument. The kaders seemed able to correctly record the weight on the KMS card, but made no special list of children who were below normal or who had lost weight three months in a row. Mothers breast-fed freely and were told to begin giving supplementary foods at four months (three months in West Java) and to feed their child healthy foods as displayed or illustrated in the kader book. Unfortunately, no kaders recommended feeding malnourished children more often or giving them some additional high calorie foods.

In all sites one kader acted as a nutrition educator and sat behind a table, as part of the team. This was not an optimum counselling situation, since the line would get backed up behind the mother receiving nutrition counselling with mothers waiting to get their children immunized. At the

same time a long line of mothers stood and waited with children in their arms for their child to be weighed. Some had walked great distances to attend, and the longer wait made the procedure more difficult for them.

At some sites samples of nutritious food (tempe/tahu, eggs, green leafy vegetables and fruits) were displayed. Only one Posyandu included high calorie foods like oil, nuts and coconut. Most Posyandus gave a cup of green lentil soup to each mother for her child. In one remote area eggs were distributed. The date of the last dose of Vitamin A was rarely noted on the KMS card.

Family planning was not part of the VPHC project objectives, however, CARE East Java was requested by the government counterparts to promote family planning as a component of the project. CARE did not make a commitment to measure the impact. The evaluation team found that many mothers reported following some method of family planning. Most women use the method most available, which is, in some cases, the combination pill, (not recommended for nursing mothers). In East Java, the IUD is widely used. Some women interviewed believed that they could not conceive, if their pre-pregnancy menstrual cycle had not returned. A representative from BKKBN sometimes counselled mothers about family planning. In some subdistricts there were enclaves of strong resistance to family planning and in one area even opposition to immunizations. These were not CARE project villages, but they were located in the same subdistrict.

Kaders expressed a desire for uniforms (at the very least a piece of material for them to make a blouse), so that they could be seen as more credible to mothers. Many had not been given an individual certificate at the completion of their training. None had received official-looking badges. Some community leaders said they did not have the resources to give kaders any rewards. Others contributed the food given to children at the Posyandu and some paid for kaders' medical care. Dropout rates varied, but were highest in NTB where kaders often resigned as soon as they married.

Subdistrict and village Management Teams spoke favorably about the CARE training that they had received. Many team members seemed enthusiastic and well-motivated. However, some had been transferred to other districts and others said they lacked transportation money to visit and monitor the village activities, usually done outside their office hours.

The chart on page 17 provides a comparison of VPHC project village level achievements during the past year. The VPHC project in West Java and NTB made the most significant progress towards reaching children five years of age and younger.

Comparison Before and After CARE Intervention Introduced 1987 and 1988

SUBJECT	WEST JAVA		EAST JAVA		NTB	
	BEFORE 1987	AFTER 1988	BEFORE 1987	AFTER 1988	BEFORE 1987	AFTER 1988
Village Posyandu Management Teams	0	12	0	9	0	4
Hamlet Posyandu support Groups	0	0	0	60	0	14
Mother Neighborhood Education Groups	0	189	0	292	0	179
ORS Depots	12	69	0	0	0	0
Posyandus Established	115	115	39	41	7	33
Number of children <5's	4253	4884	3424	3559	1925	2024
Children <5's enrolled in Posyandu	3820	4494	2910	3381	595	2024
Children <5's weighed in Posyandu	3820	4494	2226	3212	245	1334
Kaders trained	263	404	180	223	56	239
Kaders active	220	337	108	201	23	157
Village leaders trained	0	232	0	190	17	126
Mothers trained in ORT	2057	5992	665	2128	245	2009
Mothers trained in proper Nutrition	2057	5992	1113	2128	245	2009
Mothers trained about Immunizations	2057	5992	622	2292	245	2009

On the whole CARE staff has done a superb job of soliciting government support at all levels and of effectively training subdistrict Management Teams and teams of trainers from these Management Teams, who trained village leaders and volunteers. The communities visited demonstrated a sense of ownership and feeling of responsibility for their health post (Posyandu). Attendance at Posyandu has increased. The kaders' knowledge of basic child survival messages was excellent in the two Java locations and good on Lombok where conditions are more difficult due to a low level of kader education and lack of community infrastructure.

In a majority of the VPHC target sites a good start has been made towards achieving the project objectives. Village participation is high, government support is positive, and some replication has started as planned. There still is, however, a great deal of room for improving the quality of the Posyandu and kader services. Village leaders are still not fully supportive of the Posyandu and kaders are not regularly following up "At Risk" children. Common problems still encountered are :

- * Kader recruitment criteria has not been clearly established.
- * There is limited instruction at Posyandu.
- * Home visits are not conducted regularly. (Note: Mothers interviewed did know who the local kader are and their job responsibilities).
- * Limited follow up of sick or malnourished children.
- * Limited village leader support for kader and Posyandu (village leaders frequently do not clearly understand how to support or supervise kader activities).
- * There is a need to include more religious leaders and TBAs in Posyandu support activities.
- * Health data feed back systems are not yet effectively provided to the kader or community.
- * Lack of necessary supplies (i.e. oralit, KMS cards and scales).

The evaluators would like to stress that CARE's VPHC project has made good progress, given the time constraints, the problems inherent in modifying the project strategy and the degree of difficulty of implementing a voluntary PHC service. The evaluation team supports CARE efforts to modify and adjust the operational strategy in an effort to find a sustainable and realistic village based service delivery system.

PVO/HOST GOVERNMENT COOPERATION

During the past year, CARE made an all out effort to establish meaningful relationships with the local district and subdistrict government departments responsible for implementation and monitoring of village level PHC services (Posyandu). The 1987 midterm evaluation stressed that CARE must "increase and improve the quality of overtures to the provincial government and, where lacking, to the district health offices, showing a spirit of collaboration in this process. Part of this process should involve a more consultative approach, not the presentation of final documents for "approval".

In response, CARE's revised work plans were reviewed in detail and approved by each of the concerned provincial governments. Meetings with government counterparts were regularly held and monthly progress reports were submitted to selected GOI departments. This closer collaboration with local government officials at all levels (provincial, district and subdistrict) has resulted in positive active government participation in the projects implementation and monitoring.

CARE, this year, organized a total of three districts and 38 subdistrict training seminars. [NTB (26), East Java (10) and West Java (2)]. In addition, a total of 58 Village Management Team workshop on kader and Posyandu operations were conducted [NTB (22), West Java (16) and East Java (20)]. These training sessions focused on team building, management of intersectoral collaborative activities, Posyandu concept and activities and health education, nutrition-immunization-diarrhea control. The major outcomes of these seminars were:

- Implementation strategy, operational guidelines, monitoring and evaluation instrument prepared.

3
 Child Survival FY 1987 Annual Report for CARE Indonesia's
 Village Primary Health Care Project, Jakarta, Indonesia,
 September 1987.

- Participatory kader training conducted.
- Functional Management Teams established at the district, subdistrict, and village level.

CARE's VPHC project overall performance has contributed to the government activities in the primary health and child survival sector in the following manner:

Village Level

- Neighborhood group meetings serve as forum for health education discussions. Each group is led by one or two neighborhood kaders. Approximately 15-20 mothers attend each session. These group discussions are conducted once a week.
- Increased number of village mothers are utilizing the Posyandu services, (weighing, immunization, nutrition counselling).
- With the support of village/hamlet teams, the kader have organized and extended health education through home visit and regular group discussion with the mothers.

Subdistrict Level

- Integrated Subdistrict Management Teams have been established and are functioning from the subdistrict down to the village and hamlet level in West Java and East Java.
- Teams are divided into two separate functions. The Management Team is responsible for providing supervision and extension services, and the trainers team is responsible for designing and facilitating workshops and kader training sessions at the village level.
- The subdistrict Management Team conducted supervisory visits to the Posyandu once every three months.
- PHC workshops for subdistrict officials were conducted to establish subdistrict team work plans, how to conduct participatory and kader training, recording, management, supervision and evaluation.
- PHC training for subdistrict trainer teams are conducted to provide the required training skills.
- Problem solving and feed back sessions on program management are conducted once every month.
- Village leaders are trained by the subdistrict Management Team and CARE in basic PHC services and simple management skills. At the end of the training village leaders themselves set up village plans of action and established village Management Teams for operating PHC activities. The village leaders are actively involved in selecting kaders, and establishing and supervising hamlet and mother groups'.

District Level

- Posyandu management workshops for district officials are conducted at the district level to establish solid cooperation among the institutions involved in the program and to upgrade teamwork and skills required for implementation of PHC programs.
- Supervisory services are conducted once every three months by the subdistrict teams in an effort to solve problems and provide feed back on PHC activities conducted.
- District team are involved in designing training materials for subdistrict and village training as well as facilitating training sessions.

SUSTAINABILITY

It is not yet possible to measure the long-term, carry-through of the VPHC project. VPHC has only been operational for three years. During the past 18 months, CARE has built a solid foundation in all three provinces on which to develop the project's effectiveness and expand its impact. Though CARE staff have not been active in any of the target villages for almost four months, it was clear that Posyandu and kader services introduced were continuing. It is believed that the modified strategy did enhance subdistrict government involvement in supervising Posyandu services. This was most evident in West Java. Community leaders expressed a desire for CARE to remain in contact with them and to continue to provide stable leadership. Leadership was considered the most valuable services CARE could provide.

Factors that Hinder Sustainability

Many people are of the opinion -- health staff included -- that the Posyandu is an extension of government health services. As a result, kader and community leaders do not try to independently conduct Posyandu activities.

The criteria set by the Ministry of Health in Java is not appropriate for many villages outside of Java where the populations are dispersed in small hamlets. The ideal solution in small hamlets is to establish child weighing, nutrition and ORT education groups which could be managed independently by kader.

Selection of kader which is usually done through appointment by the village headmen has frequently resulted in poor or less than enthusiastic kader. The headmen find it difficult to identify motivated people willing to work voluntarily. The low level of education among kader and community members also makes it hard for kaders and mothers to absorb health related skills.

There is limited coordination among the sectors (puskesmas - subdistrict teams - village leaders) responsible for Posyandu.

Inappropriate recording and reporting procedures hinder follow-up support by village leaders and kaders.

Excessive demands are imposed on volunteer kader by the government without adequate incentives and support.

The government health personnel are actively supporting the implementation of posyandu program but limited funds hinder effective results.

General Recommendation on How to Increase Sustainability

1. Appoint project managers to take up the role as liaison officer at the district down to subdistrict level.

Enhance cooperation with all institutions at the subdistrict level, by promoting the Posyandu program. It is expected that by creating close cooperation with PKK and the health center through the Management Teams CARE can build a better understanding of the project activities and create a sense of "ownership" by the participating parties.

2. Develop and activate all institutions at both village and hamlet level by providing management support.
3. Project success at the village level will depend on the support obtained from formal/informal leadership as well as community members. This is crucial for the long-term growth of the project. One possible means of achieving support is by providing the formal and informal leaders and kader with refresher courses, opportunity to go on study tours, and small incentives to boost morale such as certificates of appreciation.

PROJECT FINANCES

The total three year VPHC project budget was \$1,026,300. AID/W allocated \$313,000 and CARE's proposed match was \$713,300.

As of September 30, 1988 all AID/W funds have been expended. CARE USA has contributed \$591,078 to the match and the Government of Indonesia has contributed \$13,474 for a total of \$604,552. Despite a shortfall of CARE funds due to budgetary constraints in FY 87, CARE's overall contribution accounted for 64% of the total project budget over a three year period.

LESSONS LEARNED CHILD SURVIVAL I CARE INDONESIA

Change in Strategy

The Child Survival project was considered relatively successful given the time limitations. However, it was determined that even a greater potential was possible if CARE adopted a facilitator's role rather than focusing on the direct implementation of health activities.

During the second year of the project period CARE developed, with government counterparts, a prototype suitable for expansion to other villages by the Government of Indonesia.

General Concerns with Child Survival Program and Lessons Learned

Comments on Strategy Changes

Institutional change is undoubtedly the most essential task in a development approach but it is also the most difficult. Again, given the short life cycle of the project, changing the operational procedures was a major gamble. CARE is not yet sure what the long-term contributions or impact, if any, on policy direction may be. It is known that the changing strategy process temporarily diverted attention away from assisting mothers and their children at the village level. However, it was regarded as worth this risk in order to implement project activities that would be sustainable over a long period of time.

Kader Training

It has become evident to CARE that to sustain kader activities more follow-up support than originally anticipated is required. Local health centers are not sufficiently staffed or equipped to provide all the necessary support. In addition, because of CARE's operational role, village leaders tended to depend on the CARE field staff, with the expectation that CARE would independently implement and maintain the project.

In addition, it was found that kader frequently do not recognize appropriate opportunities for encouraging specific Child Survival behaviors. There is a tendency for the kader not to respond to the needs of the mothers or to the situation found in the home. Also home visits were found to be time consuming. Neighborhood group meetings worked more efficiently.

To enhance kader effectiveness and reduce dropout it is essential to establish village kader solidarity groups and provide frequent refresher training and cross visit opportunities for the kader in an effort to upgrade their performance and maintain their interest. This, unfortunately, takes a lot of time and becomes costly.

A less expensive alternative and a means of continuing to provide assistance and motivation, is through village leader group meetings. Leaders representing four to five villages come together every three to four months in one host village to plan and evaluate PHC interventions that they are implementing independently. These meetings have proven to be a stimulating events and a form of encouragement for village leaders. Three such meetings were conducted during this past year. The majority of the expenses for these sessions were provided by the communities involved.

Government Relations

Developing the host country understanding and support for the Child Survival project is extremely important. This is especially true in Indonesia. The government is genuinely interested in monitoring NGOs activities.

Unfortunately, it takes patience and time to make all the appropriate contacts. It is a process that often appears endless. Assistance from the host government's appropriate officials in streamlining procedures to monitor and assist with specific Child Survival projects can be extremely helpful.

Clear agreement and understanding by all parties about the Child Survival projects aims and individual roles within the project is essential from the start. An agreed upon time frame for each operation is equally important.

Time Frame

The evaluation team concluded that three years to implement an effective Primary Health Care project is not enough time. It takes many years to develop viable and sustainable programs, especially in a country as diversified and complex as Indonesia. Five years would be a more reasonable. Longer funding periods for fewer projects is an approach worth exploring. Longer project life should help ensure that the funded projects have the best chance of success.

All organizations wishing to submit a proposal should be encouraged to include substantial start up time. This is not a luxury but an absolute essential, especially for organizations without previous experience working in the health field.

Evaluation

Although evaluation and record-keeping is important, experience shows that placing strong emphasis on establishing monitoring procedures during the first year of the project is difficult to manage effectively. Quality monitoring should not be required the first year but should be established during the second year after the project activities have been implemented. This enables the project staff to draw upon their first year's experience to prepare appropriate evaluation procedures.

While respecting the donor's need for information the Tier I, II, III, prepared by AID posed serious problems within the Indonesian context. The age categories were not the same as those of the Indonesian Health Departments. To collect this data would have required a monitoring system of its own. It would not have been possible for the CARE Field Staff to have done this alone. Example: CARE had serious questions about the validity of burdening health volunteers with additional reporting forms when their skills at fulfilling the governments information requirements were still minimal.

If possible, process indicators should be included within the USAID monitoring structure. In projects where process and structural building were imperative for real sustained change the apparent lack of interest in this information often left project staff frustrated and feeling that the very real progress being made was undervalued.

Reporting

Reporting criteria requested by USAID/W are frequently cumbersome and not provided to CARE on a timely basis. Feed back on reports is also limited. Example: to date there has been no response to the second 1986 Annual Report.

More effort must be made to upgrade and streamline the reporting format. Involving program managers, who are required to fill out the reports in the preparation of the basic documents, would result in an improved format.

Annual reporting and midterm evaluation procedures have proven to be an excellent time for reflection, providing the opportunity to review the project strategy and assess achievements.

RECOMMENDATIONS

The following recommendations were prepared by the evaluation team. The recommendations focus primarily on areas that will enhance the VPHC project continued implementation.

Community Participation and Support

- The evaluation team supports the VPHC II strategy designed to upgrade the management skills of the village and/or hamlet teams, so that they, in turn, can independently support Posyandu and kader services.
- Training should focus on problem solving functions related to management and monitoring of kader and Posyandu services.
- The VPHC project should focus on the village and/or hamlet teams as the primary support for kader health promotion activities and enhance their ability to solve problems and function as effective managers.

Training

- Continue to use the effective adult, non formal education methods that have been well received, e.g., role playing.
- Enlarge the curriculum to include counselling the "At Risk" child and pregnant women.
- Training for village leaders and kader supervisors should include specific work responsibilities and expectations.
- Insure that all training objectives are related to the VPHC intermediate goals and that training does not become side tracked into less relevant areas.
- Continue to use village cross visits to stimulate village leaders to learn from their peers.
- Emphasize that the posyandu services are preventive as well as referral for treatment.

CARE Staff Training

- Continue to provide additional training and materials for CARE personnel in health topics, related public health strategies, identification of at risk children, training methods, research techniques and how to conduct effective focus group discussions.
- Upgrade the skills of CARE personnel in areas relevant to each persons position, for example: project officers' ability to speak the local language.

Posyandu

- Improve the posyandu analysis of data by focusing on the "At Risk" children and mothers.
- Provide a clear definition of "At Risk" as well as the high risk for every component of intervention.
- Establish a protocol for follow up which increases communication between the kaders.
- Investigate, in limited areas, the usefulness of the "Nilai" system as an educational approach for mothers and instrument for describing the nutritional status of the entire population of children, five years of age and younger.
- Compare the "Nilai" system with the letter system recorded in the kader books used to describe a child status on the KMS chart (growth chart).
- Utilize mothers time at the posyandu by planning an activity for those waiting in line. Possible activities could include:
 - health education
 - child mental stimulation toys
 - vitamin A deficiency relating to night blindness
- Oralit depots at selected kader homes should be established and monitored closely, i.e., rate of utilization.

The evaluation team strongly recommends that CARE develop a check list for kader that lists the items for the simple posyandu services (without immunizer) that should be conducted.

Messages

- Review the health messages now taught to kader and mothers and consider adding additional important information :
 - feed the underweight child with high calorie foods, (coconut milk, oil and chopped peanuts should be added to rice porridge).
 - feed the underweight child (seven months of age or older) at least five time a day.
 - children at four months of age should begin eating solid foods.

- Develop a quick reference card system that kader can easily refer to when counselling mothers or helping "at risk" children.

Government Relations

- Continue to foster a cooperative relationship with the different levels of government (District, Subdistrict, Health services, Puskesmas).
- Intensify the effort to keep all parties well informed by sending progress reports to all the appropriate levels of the government and copies of these reports to all other related sectors. Be sure to address these reports to the responsible person in the department.
- CARE should continue to make every effort to assist their government counterparts in a manner that is regarded by both, as appropriate. In addition, CARE should focus future efforts on directly training village leaders to more effectively manage Posyandu and kader services. This dual approach will ensure that within the short period of time available to CARE to implement the VPHC II project, villages will be activated to a level that can independently support their own Posyandu services.
- In the future, CARE should direct its staff attention toward village and kader leaders and minimize intensive interaction with the government managers.
- CARE should consider requesting local government counterparts in each province to be assigned to work with CARE. This would facilitate training opportunities and enhance communications.

Health Components

Establish immunization, nutrition education and ORT as the basic child survival components and then expand to include others : e.g., family planning, prenatal, natal and postnatal care, and prevention of acute respiratory infections. When the initial three components are well established additional messages can be added in a systematically phased approach, so as not to overwhelm kaders and mothers. CARE should establish targets for achieving the establishment of the specific components.

Kaders

- Kader need more training in the area of nutrition. The kaders interviewed had limited knowledge in how to assist mothers with children that were beginning to lose weight. A kader follow up system for children losing weight needs to be implemented.
- Broaden the criteria of selection of kader to allow highly motivated candidates to serve in a capacity for which they are qualified. For example an illiterate person would not be a suitable record keeper, but could be an effective counsellor.

- Create a core of kader supervisors or kader leaders from the existing kader groups that would maintain programs in the villages by systematically checking the activities of the other kaders. Provide additional counselling for mothers with "at risk" children, analyze posyandu records, make a list of children/women at risk for each component. Share this list with leaders and neighborhood kaders and monitor the follow-up of the neighborhood kaders.
- Encourage recognition/rewards for kaders by the community, e.g., a training certificate and a piece of material to make an official kader blouse. Other incentives could be photos, which are posted and then given to the kaders, five year pins or plaques, transportation money. [Identifying appropriate kader incentives that are linked with kader productivity will be a valuable contribution of the project.]
- Continue to establish village level kader support groups.
- Encourage kader to be assertive in making posyandu needs known to puskesmas personnel, as well as village and hamlet leaders.

Monitoring

- CARE should, in the future, try to use the existing village and government reporting systems to facilitate the collection of the information required.
- Develop check list of important items to be monitored to all levels. For example, check list should be prepared for subdistrict management team, village team, hamlet team, and kader.
- Create a large master KMS wall chart, which could be made out of wood, painted and use color-coded thumbtacks to track children's growth. Children below the accepted lines would be noted with special color thumbtacks, and a follow-up list from the Posyandu kaders to the Neighborhood kaders could inform the latter of any "at-risk" children in their area. This list could also include children/women who had missed a vaccination or had recently had diarrhea.
- Provide counsellors with cards that would highlight the important points that should be shared with mothers of children at-risk.

Planning

- State and clarify for all concerned CARE's VPHC project objectives, which must be measurable and verifiable. Include in these objectives: 1) the development of a model package, i.e., a step-by-step written plan of action that clearly explains the procedures necessary to replicate CARE's VPHC Model, 2) the establishment of effective Management Teams and kaders, 3) increased immunizations (specify % of increase), 4) decreased severe dehydration (measured by number brought to health centers and hospitals in the area), 5) fewer malnourished (as indicated in sample surveys), 6) more cases of ARI identified and properly referred.

- Establish revised criteria for subdistrict site selection for VPHC II, e.g., high infant mortality rate (IMR), low economic status, lack of services and geographically isolated.
- Continue to work in designated hamlets in VPHC I CARE subdistrict if particular places pose unique challenges and opportunities for experimentation and learning.
- Consider in what way the concept of pilot-satellite site could continue to be a part of the project.
- CARE Indonesia as an organization should make more of an effort to assist the staff to become part of the organization and not just members of a specific project. CARE should make a reasonable long term commitment that will ensure staff continued loyalty.

GENERAL COMMENTS ON VPHC PROJECT AND EVALUATION PROCESS

The majority of the project sites have achieved the objectives of establishing model village based PHC services, i.e., promotes immunizations, education on diarrhea management and nutrition. The coverage of the targeted, children and mothers are quite satisfactory. Creativity and motivation are needed to improve the quality of primary health care services and to continue the momentum of the village awareness and the people's willingness to participate in their development.

Inviting people with different backgrounds to participate on the evaluation team, created a dynamic interaction of views. The diverse ideas and impressions enriched the evaluation process.

ATTACHMENT #1

1988

SURVEY RESULTS

VPHC

SURVEY REPORT
VILLAGE PRIMARY HEALTH CARE PROGRAM
CARE INDONESIA
FY87

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Introduction

This paper is intended to be a quantitative complement to the "CARE Indonesia Village Primary Health Care External Evaluation: Child Survival I Grant 1985-1988" report. Primarily it contains numerical information with limited narrative description. The reader is therefore advised to consult this report only after having carefully reviewed the CARE Indonesia Village Primary Health Care Evaluation.

In the context of improving the health care system in rural Indonesia, CARE Indonesia conducted a village primary health care project/child survival (VPHC) in select areas of Nusa Tenggara Barat (NTB), West Java, and East Java. To facilitate fundamental infrastructure and behavior changes CARE staff interacted with subdistrict health center officials, integrated community teams (Posyandu), health center workers, community leaders and mothers with children under five.

CARE Indonesia introduced a plan of core and satellite sites in an attempt to expand the number of villages receiving assistance. A select number of core sites were identified in each subdistrict to serve as models for three or four surrounding villages. Local government officials and village leaders from the satellite sites were invited to attend training sessions and to make cross visitations. As discussed in the CARE Indonesia Village Primary Health Care External Evaluation report, the West Java project was able to effectively implement the concept in its region, while NTB and East Java both experienced difficulties due to limited or marginal Government of Indonesia interaction and acceptance of the strategy; there was an especially weak village infrastructure in NTB..

Despite the problems associated with the core and satellite plan, all the provincial level projects made achievements in the management and timely delivery of health services. Subdistrict doctors and Posyandu Kaders maintain that advances have been made in both peoples understanding and practices concerning immunization, diarrhea, and nutrition issues. The survey evaluation results support their statements.

In the year that CARE staff assisted Kaders and community leaders in Nusa Tenggara Barat (NTB) important strides were made toward creating a milieu conducive to the meeting basic health needs of villagers. Figures from the evaluation survey show that statistically significant improvements were made in 95% of the individually measured indicators.

Care staff was successful in their attempt to assist rural health workers in West Java create a social environment that enhanced the ability of community members to respond to village health needs. A significant improvement was achieved in over 65% of the individual indicators tested in the survey. Among others, the number of women attending health education training sessions increased from 45% to 87.8%; the number of children receiving immunizations rose from 73.4% to 86.1%; and the prevalence of childhood diarrhea cases declined from 72.3% to 54.6%.

The rural health care system was strengthened in the villages

that CARE East Java operated. Roughly 89% of the individual indicators tested in the survey had significant gains. Subdistrict health center doctors from East Java reported that the number of children being immunized at CARE assisted villages exceeded that found in others. The child immunization close out survey average for BCG, DPT, polio, and measles was 76.9%. This is only 3.1% below the 'herd level', or the reported level needed to successfully inhibit the transmission of communicable diseases. According to 1982, GOI department of health vaccination statistics, the national averages for BCG, DPT1, and DPT2 immunizations were 45%, 39%, and 31%, respectively(1).

VPHC Goals

The final goal of CARE Indonesia's VPHC program was to reduce the mortality and morbidity rates for children under-five and pregnant women.

Intermediate goals one through three represent findings reported in the external evaluation report, which were also confirmed by CARE field staff. Intermediate goals four and five are discussed using survey data.

1. Subdistrict officials support and adopt the VPHC project strategy throughout the subdistrict.

Summary Outcome: GOI Subdistrict personnel have adopted the VPHC project strategy in six of the nine subdistricts that CARE Indonesia operated. The subdistrict teams are reported to be independently replicating the VPHC model and actively engaging in the organization, training, and supervision of village health activities.

2. Sustainable community managed and operated Posyandu (integrated community health centers) in the pilot and replication sites with the active support of the government subdistrict health center team. This includes establishing Posyandu where needed.

Summary Outcome: Posyandus are functioning according to planned scheduling in both pilot and replication sites. Subdistrict teams are conducting health education training for Posyandu staff and routinely visiting villages and Posyandus every three months on the average.

3. Reduce diseases which can be prevented by immunization through facilitating the implementation of immunization sessions in CARE assisted sites(2).

Summary Outcome: Subdistrict health center doctors in East and

-
1. Central Bureau of Statistics and United Nation Children's Fund 1984
 2. Immunization was not part of the NTB VPHC project.

West Java have reported to CARE staff that the immunization coverage in their respective territories has improved. This has been confirmed by the external evaluation team. Subdistrict health centers are providing immunizers to individual or clusters of Posyandu every one to three months depending on logistical concerns.

Senior Kaders (volunteer community health workers) have completed the CARE training workshops which includes a section on the transfer of immunization knowledge from Posyandu Kaders to villagers.

CARE immunization training sessions were held for traditional birth attendants (TBAs). Over sixty percent of TBAs successfully completed the training session in West Java; the figure for East Java was slightly lower.

4. Increase the ability of mothers or caretakers to reduce the severity of dehydration associated with diarrhea diseases among under-five children in all target sites.

Summary Outcome: Key personnel have satisfactorily completed diarrhea training in all subdistricts. Posyandu staff are conducting village group health education sessions every one or two weeks. The attendance level at the sessions has increased in West Java. Although, NTB and East Java did not measure attendance levels, the number of women that understood the causes of diarrhea increased. When all the survey items on diarrhea are averaged together the figures show a stastically significant difference. NTB close out figures rose by 50.4 percentage points (from 25.3% baseline to 75.7% closeout). East Java close out figures showed a difference of 39.6 percentage points (20.4% baseline and 60.0% closeout). West Java close out figures improved by an overall 23.3 percent (52.0% baseline and 75.3% at close out).

5. Increase ability of mothers or caretakers with under-five children to correctly identify the feeding patterns which will promote the healthy growth and development of their children using locally available foods .

Summary Outcome: Posyandus are conducting village group nutrition education sessions in all the subdistricts every one or two weeks. The attendance level at the sessions has improved in NTB and West Java. East Java did not record attendance levels, but the number of women that understand improved nutrition practices has increased.

When all the survey items on nutrition are averaged together the figures show stastically significant improvements. NTB close out figures increased by 49.2 percentage points (37.9% baseline and 86.1% closeout). East Java close out figures rose by 30.6 percentage points (42.0% baseline and 72.6% closeout). West Java close out figures advanced by 25.4 percentage points (59.0% baseline and 84.4% closeout).

Research Design

A pre and post intervention test was designed to measure the effects of CARE Indonesia VPHC project. Prior CARE interventions, a baseline survey measured the knowledge and practice (KAP) of respondents. KAP levels were re-measured in a close out survey after project completion. To establish whether or not percentile changes were due to CARE interventions, a control group was selected and tested against the CARE group.

The target population was women with children under-five and pregnant women. A pre survey census was conducted in each village to compile target population lists. The sample size for each village was based on a graduated percentage scale. Respondent numbers were: NTB 175 baseline and 178 close out CARE sites, 49 baseline and 45 closeout control sites; West Java 522 baseline and 419 close out CARE sites, 106 baseline and 82 close out control sites; East Java 126 baseline and 109 close out core sites, 187 baseline and 174 close out satellite sites. No replacement for missing respondents was added. Respondents were selected using a stratified random sampling method. Stratification was done at the hamlet level.

The dependent variables are respondents' knowledge and practice concerning immunization, diarrhea, and nutrition; in East Java family planning was added. The independent variable is assumed to be CARE interventions.

The same precoded questionnaire was used in both the baseline and close out survey. Surveyors were trained in advance and selected for their willingness to work in a rural setting and competency in the local language. East and West Java hired outside interviewers to conduct interviewing; NTB used its own staff because competent surveyors could not be identified.

Data processing was conducted at the Health Services Research and Development Center (P4K) in Surabaya, under the guidance of Subagyo Martodipuro, MD, MPH, Ph.D. and Richard Columbia M.A., A.B.D. Dr. Subagyo then compiled the data and prepared a draft. The baseline and close out surveys were compared using the student's t-test, chi square (X²), and other tests where appropriate. The SPSS program was used to analyze data. All significant difference/no significant differences are shown as [S]/[NS].

Data from the core and satellite sites were averaged together for the analysis in NTB and West Java. Significant and no significant differences for each indicator refers to the combined core and satellite site percentage changes between the baseline and close out survey (CARE sites). Data from the core and satellite sites were analyzed separately in East Java, but combined for a village average presented at the bottom of each table. It is therefore possible to examine the significant or no significant differences for both core and satellite villages, as well as, their combined average.

Significant/not significant difference does not take into account actual percentage levels. It only refers to statistical change between aggregate numbers. It is therefore advisable to review figures using a benchmark of 60% to 70% to determine the status of an indicator.

Research Design Limitations

Problems were encountered in the tabulation and analysis of data due to the research design. Question of validity was often marginal thereby leaving many CARE indicators inadequately addressed. Questionnaires were modified to meet specific field level needs which further complicated question validity and made any cross comparisons difficult.

Strict criteria were not followed correctly for control site selection which resulted in inadequately matched CARE and control site baseline figures. Consequently, changes due to CARE interventions are under-represented because the variance between baseline CARE and control site percentages proportionately affects the probability of obtaining a significant difference.

Baseline and close out survey methodological uniformity was difficult to maintain because of no missing respondent list, ad hoc guideline adjustments, and the loss of certain key CARE personnel that designed the survey. Therefore, each office addressed its research problems independently when conducting the close out survey.

East Java was able to carry out the pre and post intervention test according to design with minor adjustments. Satellite sites were used as control sites for the core/control site analysis because no control site was selected. Two villages were dropped during data analysis due to logistical considerations. In Nglaran, a new sample had been selected; the analysis showed a 27.9% decline between the baseline and close out figures. The raw baseline data for Wonokarto was misplaced which made the data incompatible for comparison with other villages.

Data reliability has been reduced in East Java because 13.5% of the original baseline respondents were unable to be located for the close out survey. Despite the drop-out rate and the other changes discussed above, the results are considered ample for CARE Indonesia purposes.

Nusa Tenggara Barat (NTB) followed the pre and post intervention survey, except for selecting a new sample group for the close out survey. Data analysis was done between percentages, because the raw baseline data was destroyed during an office move. In effect, these changes mean that the results are invalid for making change-over-time statistical inferences. However, they can still be used to compare differences between the pre and post intervention percentages and thus meet CARE requirements.

CARE West Java was able to conduct the pre and post intervention test according to design, but had a respondent drop-out rate of 20%. Data reliability is reduced, but comparisons remain valid.

Despite these various limitations the P4K statistic institute and Dr. Subagyo both considered the data valid for reflecting project impact in the three provinces.

Lessons Learned

- The following is a brief summary of the measures taken to improve the VPHC FY1989 evaluation system. The changes are based upon FY1987 experiences.
- CARE staff has discussed closeout survey problems and received extensive training on research methods at a VPHC workshop conducted in December 1988.
- A Questionnaire has been developed and tested by Dr. Subagyo (consultant) so that validity is assured.
- Standardized research methods that have been developed will be distributed to each office. Any proposed deviations will be cleared through CARE Jakarta.
- Future surveys will be conducted by trained and competent individuals who are not involved in the project.
- The baseline and closeout surveys will be carefully monitored by a special designated team.
- Data analysis is expected to be handled by an Indonesian statistics firm and under the close supervision of the CARE Evaluation Officer.
- The summary report will be written by the Evaluation Officer so that it addresses issues relevant to the VPHC project.
- CARE field staff should partake in preparing all reports so that statistical findings can be fully explained.
- A monitoring system has been designed, by an Indonesian consultant, that will assist CARE staff identify potential weak project areas. A full-time staff has been hired and trained on data collecting techniques.

VILLAGE PRIMARY HEALTH CARE
FY1987
NUSA TENGGARA BARAT

The Nusa Tenggara Barat (NTB) VPHC program began in July 1986 in the subdistricts of Gerung, Narmada, Gangga and Aikmel. From each subdistrict one village was selected as a CARE site; Gapuk, Sesaot, Kayangan, and Karang Baru. Within each village a select number of hamlets were chosen as core sites; seven of 32 hamlets. These sites served as models for neighboring hamlets, where local government and community leaders attended training and made cross visits. The

expectation was that the VPHC project would replicate in adjacent hamlets thus expanding the VPHC coverage.

Table 1: Sample Size for NTB Survey

	Baseline	Closeout	Total
CARE sites:	175	178	353
Control site:	49	45	95

Survey Results

Diarrhea: The average percentage for questions on diarrhea in NTB was significantly higher in the close out survey. The figures for individual items were all significantly different except for 'heard of diarrhea' which had a high baseline figure of 83.4%. This indicates that the mechanisms used for disseminating health information are operating well and villagers are benefiting.

1. Diarrhea Causes

The baseline average was 16.6%. Close out survey results indicated that 69.1% of the respondents could correctly state the causes of diarrhea (table 2).

2. Diarrhea Prevention

The average percentage on how to prevent diarrhea was significantly higher in the close out survey than in the baseline; from 16.6% to 69.8% (table 3). The percentages are almost identical to the findings associated with indicators related to the causes of diarrhea. Which suggests that the Kaders were conducting well balanced Posyandu education sessions.

3. Diarrhea Treatment

The average percentage response for the correct treatment of diarrhea was significantly higher in the close out survey than in the baseline; from 52.6% to 93.3% (table 4).

Table 2: Comparison of baseline and close out data in CARE site and its Chi square (X2) significance. subject: cause of diarrhea. NTB

Cause of Diarrhea: correct responses	CARE Sites		
	Pre (n=175)	Post (n=178)	
1. The cause of diarrhea	38.5	86.5	S
2. Drink unboiled water	21.1	75.0	S
3. Eat food that is not washed	9.1	66.4	S
4. Food not protected from flies	10.6	67.1	S
5. Eat spoiled food	8.3	46.7	S
6. Hands not washed	11.7	73.0	S
Average	X2 = S 16.6	69.1	

S = significant, NS = not significant.

Table 3: Comparison of baseline and close out data in CARE sites and its Chi square (X2) significance. Subject: prevention of diarrhea. NTB

Prevention of Diarrhea: correct responses	CARE Sites		
	Pre (n=175)	Post (n=178)	
1. How to prevent diarrhea	24.5	83.6	S
2. Boil drinking water	25.5	82.9	S
3. Wash food before eating	12.3	69.9	S
4. Cover food before consuming	11.9	71.2	S
5. Cook food properly	4.1	37.7	S
6. Wash hands before eating	21.4	73.3	S
Average	X2 = S 16.6	69.8	

S = significant, NS = not significant.

Table 4: Comparison of baseline and close out data in CARE sites and its Chi square (X2) significance. Subject: Diarrhea. NTB

Diarrhea Treatment: correct responses	CARE Sites		
	Pre (n=175)	Post (n=178)	
1. Heard of diarrhea	83.4	94.9	NS
2. Action for child with diarrhea	50.9	94.4	S
3. Preparation of salt/sugar solution	44.0	89.8	S
4. Action for child with severe diarrhea	32.0	94.4	S
Average	X2 = S	52.6	93.3

S = significant, NS = not significant.

In summary there was a significant increase in the number of respondents who correctly identified the causes of diarrhea. In relation to this, the number of people who could discuss preventative measures also increased i.e., the need to boil water, wash hands before preparing and eating food, and how to properly store food. There was a significant increase in correct responses concerning how to prepare ORS, and what to do when a child has diarrhea. In addition, more mothers correctly reported how often to give liquids and the importance of going to the health clinic (Puskesmas) with severe diarrhea cases.

Nutrition

The average percentage for the questions about nutrition was significantly higher in the close out survey as compared to the baseline; from 48.7% to 88.6% (table 5). Every individual item showed a significant improvement. This suggests that the Kaders are well trained and that mothers are learning the health messages presented at the Posyandu.

Table 5: Comparison of baseline and close out data in CARE sites and its Chi square (X²) significance. Subject: nutrition. NTB

Nutrition: correct responses	CARE		
	Pre (n=175)	Post (n=178)	
1. Received nutrition education	1.7	94.4	S
2. Three kinds of food for baby	68.6	74.7	NS
3. Frequency of giving baby food	75.4	96.6	S
4. The benefit of weighing	49.1	89.3	S
Average X ² = S	48.7	88.6	

S = significant, NS = not significant.

In summary, the number of participants that attended the Posyandu nutrition education sessions increased significantly in the NTB CARE sites. In reference to table five above it is evident that these educational presentations were more effective at promoting the importance of frequently feeding a baby than improving the type of foods actually fed to children.

Comparison of the CARE Site and Control Site: in NTB

To determine if there was a significant difference between CARE and control site percentage changes, the student's t-test was used. Refer to appendix D for a complete break-down of baseline and close out survey results.

The percentage difference between the CARE and control sites were all significantly different. When items on diarrhea, the cause and prevention of diarrhea and nutrition were aggregated and tested with the student's t-test, the difference was significant; to (df = 24, 0.05) = 9.260 > ttab (df = 24, 0.05) = 2.064. The two tests conclude that achievements in the CARE sites were due to NTB CARE project activities.

Respondents' knowledge concerning diarrhea prevention and importance of and ability to properly maintain body fluids was significantly higher in the CARE sites than in the the control site. There was also a significant difference related to the improved nutrition knowledge of respondents, such as importance of feeding a child and ability to identify neighborhood Kader.

VILLAGE PRIMARY HEALTH CARE PROGRAM
WEST JAVA
 FY87
 DISTRICT OF GARUT AND CIAMIS

In collaboration with the government of Indonesia, CARE West Java conducted a VHPC program in the subdistricts of Panjalu and Wanaraja. The coordinated effort was to generate community interest in the development and use of Posyandu services and improve the management capabilities of Government of Indonesia (GOI) subdistrict health related management teams.

The sample size for Panjalu was 195 baseline respondents and 152 close out respondents. In Wanaraja the baseline sample size was 327 respondents and 267 close out respondents. Wanaraja had a larger target population than Panjalu and therefore more respondents because sample size was based upon a percentage of the total village target. There are roughly 20% fewer respondents in the close out survey for both subdistricts because no missing respondent list was created. The sample size is described in table 1 below.

Table 1: Sample size for West Java Survey

Panjalu Subdistrict			
	Baseline	Close out	Total
CARE site:	195	152	347
Control site:	106	82	188
Wanaraja Subdistrict			
	Baseline	Close out	Total
CARE site:	327	267	594
Control sites:	89	67	156

Study Results: Panjalu Subdistrict, Ciamis District, West Java

Immunization--Panjalu, West Java: The average percentage for immunization indicators increased from 53.7% to 73.1%, refer to tables 2 and 3. When each item was tested individually, the number of women and children receiving immunizations increased significantly. Mother's knowledge of the childhood diseases prevented by

immunization, the timing of the first and subsequent child immunizations all increased (refer to table 2,3).

Posyandu Kaders have been able to successfully recruit mothers to immunize their children. The percentage of children and pregnant women that have been immunized has increased. The two immunization rates are higher than respondent knowledge about immunization requirements and its benefits. It is interesting to note that the percentage of children being regularly weighed at the Posyandu (86.4% table 7b) is equivalent to the percentage of immunized children. Although not tested, this may suggest that Kaders are utilizing the KMS cards which contain both immunization and weighing information to follow up on a child's immunization.

1. Underfive immunization

The combined percentage for underfive immunization shows a significant increase from 57.2% in the baseline to 77.5% in the close out, refer to table 2 for a complete break-down. The most striking increases are mothers knowledge of the diseases prevented by immunizations and awareness of when they should have their children immunized.

Table 2 : Percentage of correct answer on immunization matters, in CARE site, baseline (pre), close out (post), Chi Square (X2) and its significance. Panjalu Subdistrict, West Java.

Underfive immunization: correct responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. Importance of immunization	91.1	94.0	NS
2. Diseases prevented by immunization	31.3	60.5	S
3. Age infant is to be immunized	55.2	75.0	S
4. Immunization schedule for children	35.1	71.7	S
5. Child has received immunization	73.4	86.1	S
Average	X2 = 57.2	77.5	

S = significant, NS = not significant

2. Level of pregnant Women Immunization in Panjalu West Java

The combined average for pregnant women immunization has increased significantly from 47.7% to 65.7%, refer to table 3. The survey results indicate that the women surveyed had significantly increased their awareness of the important of Tetanus Toxoid immunization and corresponding received two required doses. Unfortunately, women in the project sites apparently are not sure of what the Tetanus Toxoid does. This could indicate that this information is either too technical or that the questions asked were phrased incorrectly by the interviewers.

Table 3: Percentage of correct answers on matters of immunization of pregnant mothers, in CARE site, baseline (pre), close out (post), Chi square (X2) and its significance. Panjalu Subdistrict, West Java.

Pregnant women immunization: correct responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. What immunization pregnant women need	21.7	58.3	S
2. Why pregnant women need immunization	63.4	61.2	NS
3. Pregnant woman received proper immunization	58.2	77.4	S
Average	47.7	65.6	

S = significant, NS = not significant

Overview on Responses to Questions Related to Prevention and Treatment of Diarrhea: Panjalu, West Java.

Diarrhea - Panjalu: All the individual items for diarrhea have increased significantly except for 'why oralite is useful', which already had a high baseline figure of 93.1%. The percentage of women using oralite did not increase, but this may be due to the decline in the number of diarrhea cases within the same time period, refer to tables 4a and 4b.

The average percentage for diarrhea indicators improved from 63.1% to 87.5%. Most of the individual indicators showed a significant increase, (Table 4A). The percentage for many diarrhea items roughly corresponds to the number of women that attend group education sessions. This suggests that the sessions were effective.

The the number of reported underfive diarrhea episodes declined significantly during the survey period (table 4B). This may be due to seasonal variation and/or to the improved environmental sanitation practices of the community members resulting from the health education sessions and the completion of CARE water systems in two villages, (table 5).

Table 4A: Percentage of correct response on diarrhea matters, in CARE sites, baseline (pre), close out data (post), Chi square (X²) and its significance. Panjalu Subdistrict, West Java.

Diarrhea treatment: correct responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. Attended diarrhea training	38.0	89.8	S
2. Definition of diarrhea	60.7	92.1	S
3. The causes of diarrhea	27.9	77.0	S
4. Signs of dehydration	54.1	80.9	S
5. Can make oralites	72.8	94.1	S
6. Can make sugar/salt solution	71.9	98.0	S
7. Why oralites are useful	93.1	95.4	NS
8. Method to give oralites	78.8	90.8	S
9. Have ever used oralites	70.7	69.5	NS
Average	63.1	87.5	

S = significant, NS = not significant

There was a significant increase in the number of mothers that correctly stated the causes of diarrhea, had the ability to prepare an oralite solution, and who understood when to administer it to a sick child. However, there was no significant change in the number of mothers that claimed to have given oralite to their children when they had diarrhea. It appears that mothers that report using ORS are eager to learn more about diarrhea and how to prevent it. This data could also indicate that there is a 'hard to reach' group of mothers that are not getting involved in the educational programs. An additional explanation could be that the insignificant increase in the reported use of oralite is related to the reduction in diarrhea cases found

during the same time period. Refer to table 4B which indicates that in fact there was a drop in the number of diarrhea cases reported.

Table 4B: Percentage of child that have had diarrhea, Chi square (X²) and its significance. Panjalu Subdistrict, West Java.

Children with Diarrhea	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. Has child had diarrhea	72.3	54.6	S
Average	72.3	54.6	X ² = S

2. Sanitation Practice--Panjalu

There was also a significant increase in the use of both private and public latrines. At the same time, use of ponds for human excretion decreased significantly (table 5).

The increased use of public latrines could be in part due to the CARE water project which has been constructing public latrines in Panjalu.

Table 5: Frequency distribution on the use of latrines, and the management of diarrhea in CARE site, baseline, close out, Chi square (X²) and its significance. Panjalu Subdistrict. West Java

Sanitation Practice: correct responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
Where do families have bowel movement ?			
1. Private latrine	8.8	22.4	S
2. Public latrine	1.6	25.7	S
3. River	0.0	0.7	S
4. Pond	89.6	51.3	S
5. Have own latrine	35.4	42.1	NS

S = significant, NS = not significant

3. Where Assistance is Sought if Diarrhea Occurs--Panjalu, West Java

There was a significant increase in mothers seeking Kaders assistance when their child had diarrhea. At the same time, the number of respondents going to a health center significantly decreased (table 6). This is a favorable development. It indicates that people are assuming greater responsibility for their own health care. It also increases the amount of time subdistrict health workers are able to devote to other health matters.

Table 6: Frequency distribution of respondents about where assistance is sought if there is diarrhea episode. Chi square (X²) and its significance. Panjalu subdistrict, West Java

Where assistance is sought: responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. If diarrhea go to health center	68.8	69.1	NS
2. If diarrhea go to Kader	49.4	84.8	S
3. If diarrhea go to health center worker	27.0	8.6	S

S = significant, NS = not significant

Nutrition--Panjalu West Java

The combined average for child nutrition issues increased significantly from 66.4% to 80.5% (table 7a). The number of women that attend nutritional training increased from 45.7% to 91.2%. At the same time, the close out figures for 'children that have ever attended a weighing session' and 'those that attend every month' were 96.6% and 86.4%, respectively. This indicates that mothers better understand how to maintain and improve the health of their children through proper nutritional practices.

Table 7a : Correct answers on nutrition matters, baseline line (pre), close out (post) situation, in CARE sites, Chi square (X²) and its significance. Panjalu Subdistrict, West Java.

Child nutrition knowledge: correct responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. Age to breast feed the baby	84.5	91.4	NS
2. Why colostrum is important for baby	54.3	80.1	S
3. Age to give additional food to baby	47.6	58.6	NS
4. Kind of food for baby	74.9	88.0	S
5. Frequency of feeding a child	84.5	88.1	NS
6. Type of foods for children	83.0	91.3	S
7. Foods that prevent nightblindness	36.2	65.8	S
Average X ² = S	66.4	80.5	

S = significant, NS = not significant

Despite the sharp rise in the number of mothers attending nutrition training courses, after the VPHC project began, there was no significant difference in the number of mothers that brought their children to the Posyandu to be regularly weighed or understood how to correctly use the KMS card. This indicates that the education sessions had no apparent impact on increasing the mothers ability to understand the KMS card or growth pattern of their child. Concerning weighing attendance, villagers' should be given credit for the outstanding baseline and close out figures of 80.5% and 86.4%, respectively.

Table 7b: Child nutrition practice in the CARE sites, baseline, close out, Chi square (X²) and its significance. Panjalu Subdistrict, West Java.

Child nutrition practice: correct responses	CARE Sites		
	Pre (n=195)	Post (n=152)	
1. Attend nutrition training	45.7	91.2	S
2. Have had child weighed at Posyandu	95.8	96.6	NS
3. Attend weighing session every month	80.5	86.4	NS
4. Can understand KMS Card	39.5	37.8	NS
Average X ² = NS	65.4	78.0	

S = significant, NS = not significant.

Comparison of CARE and Control Sites--Panjalu Subdistrict, West Java.

To determine if percentage changes were due to CARE West Java activities, comparisons were made between the CARE and control sites using the student's t-test.

The CARE and control sites showed statistically similar percentage changes; CARE site figures were only slightly higher than the control site figures. The non-significant difference may have resulted from the criteria used to select the control site. That is, there were external factors that influenced respondent knowledge of survey questions which were not taken into account when the control site was selected. There could also have been other outside factors, in addition to CARE West Java interventions, which contributed to CARE site achievements.

CARE Site Results: Wanaraja Subdistrict, West Java

Immunization: Wanaraja: The village average for knowledge about child immunizations did not increase significantly; 46.3% baseline, 58.1% close out (refer to table 9). The village average for indicators about immunization for pregnant women showed no significant difference (baseline 34.8%, close out 35.8, table 10). However, when the indicators were examined individually, respondent attendance at immunization training sessions increased significantly from 50.5% to 88.0%.

These results indicate that women are attending the immunization training sessions, but learning is slow. Current methods of teaching may warrant adjustments to fit local concerns.

Table 9: Percentage of correct immunization responses in the CARE sites, baseline (pre), close out, Chi square (X2) and its significance. Wanaraja Subdistrict, West Java.

Child immunization: correct responses	CARE Sites		
	Pre (n=327)	Post (n=267)	
1. Attend immunization training	50.5	88.0	S
2. Importance of immunization	48.2	53.9	NS
3. Scheduling for child immunization	40.3	32.4	NS
Average	46.3	58.1	X2 = NS

S = significant, NS = not significant.

There was no changes in women's knowledge or practices related to and receiving Tetanus Toxoid immunization. This data clearly indicates that much more of an effort needs to made in CARE West Java projects sites to reach women and increase their participation in Tetanus prevention services. Refer to table 10 for a list of the percentages.

Table 10: Percentage of correct answers on matters of immunization for pregnant women in the CARE sites, baseline, close out Chi square (X2) and its significance. Wanaraja Subdistrict, West Java.

Pregnant women immunization: correct responses	CARE Sites		
	Pre (n=327)	Post (n=267)	
1. What immunization pregnant women need	26.5	30.3	NS
2. Importance of immunization for pregnant women	41.8	40.8	NS
3. Has pregnant women received immunization	36.1	36.3	NS
Average	34.8	35.8	X2 = NS

S = significant, NS = not significant.

Diarrhea Indicators--Wanaraja, West Java: The average for diarrhea indicators has significantly increased from 52.9% to 79.7% (refer to table 11). All individual items increased significantly. The level of women's attendance at diarrhea education sessions rose sharply. The percentage of women that knew the causes of diarrhea, reported the use of oral rehydration solution (ORS) as well as understood when to administer ORS increased. These results suggest that women are learning about diarrhea issues at Posyandu village health education sessions.

Table 11: Percentage of correct answers on matters of diarrhea at the CARE site, baseline, close out, Chi square (X2) and its significance. Wanaraja Subdistrict. West Java.

Diarrhea: correct responses	CARE Sites		
	Pre (n=327)	Post (n=267)	
1. Attend diarrhea training	46.9	85.8	S
2. Definition of diarrhea	63.7	80.5	S
3. Cause of diarrhea	37.3	67.8	S
4. Signs of dehydration	34.5	69.3	S
5. When to give oralite	68.2	90.3	S
6. Ever used oralite	66.6	84.6	S
Average X2 = S	52.9	79.7	

S = significant, NS = not significant.

Nutrition--Wanaraja, West Java: Indicators for nutrition showed a significant average increase from the baseline to the close out survey; 48.6% to 67.0%. All individual items increased significantly except for the response concerning 'the age to give babies additional food' (table 12). More mothers, however, are attending nutrition training sessions which may have contributed to their improved knowledge about proper nutrition for babies, children, and lactating women.

Table 12: Percentage of correct answers on matters of nutrition in the CARE site, baseline, close out, Chi square (X²) and its significance. Wanaraja Subdistrict, West Java.

Nutrition: correct responses	CARE Sites		
	Pre (n=327)	Post (n=267)	
1. Attend nutrition training	44.3	84.3	S
2. Colostrum for newborn baby	51.1	71.9	S
3. Age to give additional food to baby	54.5	54.7	NS
4. Kind of food for a baby	54.2	86.1	S
5. Kind of food for a child	42.1	52.8	S
6. Food to prevent nightblindness	36.5	47.9	S
7. Food for lactating mother	57.7	71.2	S
Average X ² = S	48.6	67.0	

S = significant, NS = not significant

Comparison of Intervention and Control Sites--Wanaraja Subdistrict West Java.

To indicate whether percentage changes were due to CARE West Java activities, the significance of difference for group averages was tested using the student's t-test.

The CARE and control sites showed statistically similar percentage changes; CARE site figures were only slightly higher than the control site figures. The non-significant difference may have resulted from the criteria used to select the control site. That is, there were external factors that influenced respondent knowledge of survey questions.

There appears to be two factors that influenced the control sites. One of the control site was located relatively close to a CARE core sites; within one kilometer. Interaction between villagers was highly likely. The second factor was the government leaders. The officials were involved in all aspects of the VPHC project and interested in replicating what they had learned. West Java staff reported that the district the government officials had been very active during the year implementing the core and satellite development approach. Even if desirable, there was no way of keeping the government counterparts from independently introducing the activities in the control sites.

VILLAGE PRIMARY HEALTH CARE
 District of Pacitan
 East Java

CARE East Java VPHC program was conducted in nine villages, serving a target population of 3,903. From the subdistricts of Tulakan, Kebonagung and Ngadirojo, the villages of Wonoanti, Katipugal and Wonodadi Wt. were selected as core sites. The remaining six villages were designated as satellite sites. That is, local government personnel and village leaders from these villages were invited to the core sites, or model sites, to attend health and management training sessions. The expectation was that CARE programming would spread to the satellite villages through cross visits and training. (For further information on the core and satellite plan refer to the "CARE Indonesia Village Primary Health Care External Evaluation report.

CARE was able to convey the techniques on how to implement the core and satellite site plan to GOI counterparts with varying success which can be examined in detail in the tables and appendix C.

Table: Sample Size for East Java:

	Baseline	close out	total
Core sites:	126	109	235
Satellite sites:	187	174	361

Results: East Java

Unlike CARE West Java and NTB, evaluation results from East Java have been analyzed and presented by individual village. This was done at the request of the East Java GOI. As a result, significant and no significant differences can be determined for each village: The core sites listed in the tables have been underlined for easy identification.

Immunization: The percentage average for indicators concerning immunization had significantly increased. The percentage of children receiving immunizations far exceeds the respondents knowledge about the subject, except for those that 'have heard of immunization' (tables 1A, 1B). This means that despite a lack of knowledge mothers

are still having their children immunized. The immunization coverage of underfives was added to the close out questionnaire. The results are presented in table 1B.

Indicator 1a: Respondents that have heard of immunization.

The average baseline percentage of 62.4% was increased to 92.8% in the close out survey. There was a significant increase in all the villages except Wonoanti and Wonodadi Wt. where the baseline figures were already above 90% a considerable achievement of the local Puskesmas.

Indicator 1b: Respondents that know the importance of immunization.

The average baseline percentage was 40.0% which increased to 56.2% in the close out. There was a significant increase in every village except for Klesem and Wonoanti where the figures decreased significantly. The reason for this decrease is not known.

Indicator 1c: Respondents that understand what diseases are prevented by immunizations.

The average baseline percentage was 10.7%. The average increased to 39.1% in the close out survey. All the villages showed a significant increase except for Kalikuning.

Indicator 1d: Respondents know how many times immunizations should be given to babies.

The baseline average percentage was 22.3%, which increased to 36.3% in the close out survey. Klesem and Katipugal showed no significant gain.

Indicator 1e: Respondents that know what immunizations pregnant women need.

The average baseline percentage was increased from 9.8% to 32.6% in the close out survey. Kalikuning and Bodag had no significant gain.

Table 1 A: Frequency distribution of immunization indicators by village in percentage of correct answers, pre and post compared with its Chi square significance.
East Java

	Heard of immunization			Importance of immunization			Disease prevented by immunization			Number of immunization		
	pre	post		pre	post		pre	post	pre	post		
	[A]		[B]		[C]				[D]			
<u>Wonoanti</u> (pre 60; po 51)	98.3	96.5	NS	71.7	68.4	NS	20.0	45.6	S	13.8	33.3	S
<u>Katipugal</u> (pre 36; po 33)	65.7	100.0	S	48.6	93.9	S	5.7	63.6	S	51.4	51.5	NS
<u>Wonodadi Wt</u> (pre 30; po 25)	93.5	100.0	NS	20.0	92.0	S	20.0	72.0	S	6.7	52.0	S
<u>Kalikuning</u> (pre 44; po 39)	22.2	79.4	S	8.3	14.7	S	2.8	8.8	NS	1.4	11.8	S
<u>Klesem</u> (pre 63; po 61)	54.0	100.0	S	69.0	70.5	NS	4.8	39.3	S	46.0	29.5	NS
<u>Kar. Nongko</u> (pre 36; po 35)	72.2	94.3	S	22.2	31.4	NS	11.1	37.1	S	11.1	40.0	S
<u>Bodag</u> (pre 44; po 39)	59.1	87.2	S	27.3	53.8	S	15.9	41.0	S	29.5	66.7	S
Average X2 =	62.4	92.8	S	40.0	56.2	S	10.7	39.1	S	22.3	36.3	S

S = significant, NS = not significant; pre = baseline; po = close out survey

Indicator 1f: Respondents that know why pregnant women need tetanus toxoid.

The baseline percentage increased from 12.9% to 35.2% in the close out survey. Wonoanti, Kar. Nongko, and Katipugal showed significant increases.

Table 1 A continued:

Frequency distribution of immunization indicators by village in percentage of correct answers, pre and post compared with its Chi square significance.

East Java

Village	Immunization pregnant women need			Why tetanus toxoid immunization is needed		
	pre [E]	post [E]		pre [F]	post [F]	
<u>Wonoanti</u> (pre 60; po 51)	5.0	42.1	S	6.7	36.8	S
<u>Katipugal</u> (pre 36; po 33)	11.1	51.5	S	11.1	90.9	S
<u>Wonodadi Wt</u> (pre 30; po 25)	3.3	40.0	S	3.3	24.0	NS
Kalikuning (pre 44; po 39)	2.8	5.9	NS	4.2	2.9	NS
Klesem (pre 63; po 61)	17.5	50.8	S	28.6	39.3	NS
Kar. Nongko (pre 36; po 35)	0.0	17.1	S	5.6	28.6	S
Bodag (pre 44; po 39)	27.3	25.6	NS	27.3	46.2	NS
Average	X2 = 9.8	32.6	S	12.9	35.2	S

S = significant, NS = not significant.

Table 1B: Immunization coverage for the underfives,
by village. Close out survey. East Java

Village	BCG	DPT	Polio	Measles	Completed
<u>Wonoanti</u> (n= 51)	93.0	87.7	89.5	82.5	75.4
<u>Katipugal</u> (n= 33)	93.9	87.9	87.9	87.9	87.9
<u>Wonodadi Wt</u> (n= 25)	92.0	84.0	76.0	76.0	64.0
Kalikuning (n= 39)	63.2	45.6	45.6	23.5	22.1
Kleseem (n= 61)	82.0	77.0	73.8	72.1	68.9
Kar.Nongko (n= 35)	97.1	97.1	97.1	85.7	77.1
Bodag (n= 39)	74.4	61.5	56.4	61.5	43.6
Average	85.1	77.3	75.2	69.9	62.7

In summary, mothers knowledge of immunization increased significantly in the close out survey in East Java. More mothers know what childhood diseases are prevented by immunizations and the number of immunizations required. A greater percentage of women can tell why it is important for pregnant women to receive the tetanus Toxoid immunization, as well. The figures indicate that Kaders have been able to begin to successfully transfer their understanding of immunization issues to mothers that attend the educational sessions. At the same time, the close out coverage still remains relatively low which means that a lot more work has to be done.

Diarrhea: All of the individual item averages showed a significant increase. The figures suggest respondents' curative knowledge about diarrhea issues exceed their preventive knowledge. For example, 62.6% of the respondents could recognize 'the signs of severe diarrhea'; 77.9% have 'used ORS'; and 69.3% knew 'when to use them'. But only 43.5% could 'tell at least three causes of diarrhea'.

Indicator 2a: Respondents that have heard of diarrhea.

The average baseline percentage was increased from 20.1% to 74.7% in the close out. There was no significant increase in Bodag and Wonodadi Wt.

Indicator 2b: Respondents that know the meaning of diarrhea.

The average baseline percentage increased from 23.3% to 62.6%. Klesem had no statistically significant increase, but the close out figure was 82.0%, which was well above the village average for this question.

Indicator 2c: Respondents that can explain the three causes of diarrhea.

The average baseline percentage was increased from 11.5% to 43.5% in the close out. Kalikuning and Bodag did not increase significantly.

Indicator 2d: Respondents that can tell three signs of severe dehydration.

The average baseline increased from 2.9% to 37.2% in the close out. Kalikuning and Bodag had no significant difference. This would indicate the teaching methods were not effective and proper adjustments should be sought.

Indicator 2e: Respondents that have used sugar and salt solutions.

The average baseline percentage was increased from 35.1% to 77.9% in the close out survey. All villages showed a significant increase.

Indicator 2f: Respondents that were able to make sugar and salt solutions.

The average baseline percentage was increased from 3.1% to 34.4% in the close out. Once again, Katipugal and Bodag showed no significant increase.

Indicator 2g: Respondents know when to give oralites or sugar and salt solutions.

The baseline average was increased from 39.2% to 67.3% in the close out survey. Kalikuning and Wonoanti showed no significant difference.

Table 2: Frequency distribution of diarrhea indicators by village in percentage of correct answers, pre and post compared with its significance. East Java

Village	Heard of diarrhea			Meaning of diarrhea			3 causes of diarrhea			Signs of severe Dehydration		
	pre	post		pre	post		pre	post		pre	post	
	[A]			[B]			[C]			[D]		
<u>Wonoanti</u> (pre 60; po 51)	8.3	87.5	S	8.3	66.7	S	3.3	29.8	S	1.7	28.1	S
<u>Katipugal</u> (pre 36; po 33)	19.4	87.9	S	2.8	87.9	S	2.8	39.4	S	0.0	36.4	S
<u>Wonodadi Wt</u> (pre 30; po 25)	80.0	100.0	NS	36.7	76.0	S	30.0	76.0	S	3.3	72.0	S
<u>Kalikuning</u> (pre 44; po 39)	2.8	42.6	S	2.8	19.1	S	1.4	8.8	NS	1.4	7.4	NS
<u>Klesem</u> (pre 63; po 61)	12.7	93.4	S	69.8	82.0	NS	1.6	88.5	S	3.2	91.8	S
<u>Kar. Nongko</u> (pre 36; po 35)	25.0	80.0	S	5.6	68.6	S	0.0	34.3	S	0.0	17.1	S
<u>Bodag</u> (pre 44; po 39)	29.5	48.7	NS	31.8	66.7	S	56.8	43.6	NS	11.4	12.8	NS
Average X2 =	20.1	74.7	S	23.3	62.6	S	11.5	43.5	S	2.9	37.2	S

S = significant, NS = Not significant

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Table 2 continued.

Village	Used salt/sugar solution			Can make salt/salt solution			When to use oralites ?		
	pre	post		pre	post		pre	post	
	[E]			[F]			[G]		
<u>Wonoanti</u> (pre 60; po 51)	45.0	94.7	S	0.0	26.3	S	68.3	78.9	NS
<u>Katipugal</u> (pre 36; po 33)	30.6	97.0	S	0.0	51.5	S	13.9	75.8	S
<u>Wonodadi Wt</u> (pre 30; po 25)	43.3	100.0	S	13.3	76.0	S	39.3	88.0	S
<u>Kalikuning</u> (pre 44; po 39)	1.4	22.4	S	4.2	7.4	NS	20.9	22.1	NS
<u>Kleseem</u> (pre 63; po 61)	39.7	98.4	S	1.6	60.7	S	58.7	83.6	S
<u>Kar. Nongko</u> (pre 36; po 35)	61.1	91.4	S	2.8	42.9	S	27.8	91.4	S
<u>Bodag</u> (pre 44; po 39)	45.5	74.4	S	2.3	2.6	NS	27.3	61.5	S
Average X2 =	35.1	77.9	S	3.1	34.4	S	39.2	67.3	S

S = significant, NS = not significant.

In summary, the number of mothers in East Java that have heard about diarrhea increased significantly in the close out survey. More women can correctly describe diarrhea, its causes, and signs of severe dehydration. At the same time, a greater number of mothers were able to prepare a salt and sugar solution and knew when to use ORS. These factors may have in part been responsible for the reported increased in use of the salt and sugar solution.

The figures also suggest that women who are attending the education sessions are learning about diarrhea related issues. The actual percentages vary to a large degree which clearly illustrates the strong and weak areas in women knowledge and practices. For example, a higher percentage of women understood the meaning of diarrhea than its cause or the signs of severe dehydration. The percentage of women that reported to have used ORS was greater than those that could prepare it correctly. Refer to table 2 for exact percentages.

Nutrition: All the individual indicator averages had a significant increase except for 'heard about nutrition' which had a high baseline average of 87.1%. Good nutrition habits for babies had the highest close out percentages i.e., colostrum for infants--42.3% to 85.5%; type of foods for babies--61.9% to 93.4%; and age to stop breast feeding--75.6% to 84.3%. Among the greatest percentage increases were appropriate foods for lactating women--17.9% to 53.9%; and foods that prevent nightblindness--3.8% to 43.5%.

Indicator 3a: Respondents that have heard of nutrition.

The baseline average was a high 87.1%. The close out average was increased to 90.2%. Katipugal was the only village to have a significant increase from 83.3% baseline to 100% in the close out survey.

Indicator 3b: Respondents know why colostrum should be given to newborn babies.

The baseline average in the number of correct nutrition related responses was increased from 42.3% in the baseline to 85.5% in the close out survey. Only Katipugal showed no significant increase.

Indicator 3c: Respondents know the three food groups.

The average baseline percentage for those that knew the food groups was increased from 22.1% to 57.2% in the close out survey. Once again, there was no significant increase in Bodag and Kalikuning.

Indicator 3d: Respondents know the foods lactating mothers need.

The baseline average was increased from 17.9% to 53.9% in the close out survey. Bodag showed a significant decrease.

Indicator 3e: Respondents know at what age additional food must be given to babies?

The baseline average was increased from 30.0% to 59.7% in the close out. Kar. Nongko and Bodag had no significant increase.

Indicator 3f: Respondents know the additional food needed for babies over three months.

The baseline average was increased from 61.9 to 93.4%. The villages of Kalikuning and Bodag showed no significant difference.

Table 3: Frequency distribution of nutrition indicators by village, in percentage of correct answers, pre and post compared, and its significance. East Java

Village	Heard of nutrition			Infant need for colostrum			3 groups of food			Food for lactating women		
	pre [A]	post		pre [B]	post		pre [C]	post		pre [D]	post	
<u>Wonoanti</u> (pre 60; po 51)	90.0	91.2	NS	16.7	84.2	S	6.7	94.7	S	21.7	43.9	S
<u>Katipugal</u> (pre 36; po 33)	83.3	100.0	S	69.4	66.7	NS	0.0	100.0	S	2.8	93.9	S
<u>Wonodadi Wt</u> (pre 30; po 25)	100.0	100.0	NS	26.7	100.0	S	3.3	72.0	S	6.7	84.0	S
<u>Kalikuning</u> (pre 44; po 39)	76.4	72.1	NS	55.6	95.6	S	12.5	26.5	NS	2.8	7.4	NS
<u>Kleseem</u> (pre 63; po 61)	84.1	93.4	NS	52.4	95.1	S	28.6	39.3	NS	19.0	93.4	S
<u>Kar.Nongko</u> (pre 36; po 35)	91.7	91.4	NS	41.7	88.6	S	30.6	97.1	S	8.3	60.0	S
<u>Bodag</u> (pre 44; po 39)	93.2	94.9	NS	27.3	56.4	S	72.7	2.6	S	63.6	28.2	S
Average X2 =	87.1	90.2	NS	42.3	85.5	S	22.1	57.2	S	17.9	53.9	S

S = significant, NS = not significant.

Indicator 3g: Respondents know when to wean a baby.

The baseline average of 75.6% was increased to 84.3% in the close out survey. Wonoanti showed no significant increase and Kalikuning decreased significantly.

Indicator 3h: Respondents know what kind of food should be given to the children to prevent night blindness.

The baseline percentage average was increased from 3.8% to 43.5% in the close out. Every village showed a significant increase.

Table 3 continued.

Village	Age to give additional food to baby		S	Type of food for baby		S	Age to stop breast feeding		S	Foods that prevent nightblindness		S
	pre	post		pre	post		pre	post		pre	post	
	[E]			[F]			[G]			[H]		
<u>Wonoanti</u> (pre 60; po 51)	36.7	70.2	S	75.0	94.7	S	83.3	70.2	NS	6.7	56.1	S
<u>Katipugal</u> (pre 36; po 35)	33.3	63.6	S	52.8	97.0	S	55.6	90.6	S	2.8	27.3	S
<u>Wonodadi Wt</u> (pre 30; po 25)	36.7	68.0	S	53.3	96.0	S	50.0	96.0	S	3.3	76.0	S
<u>Kalikuning</u> (pre 44; po 39)	1.4	44.1	S	68.1	80.9	NS	91.7	69.1	S	1.4	17.6	S
<u>Klesem</u> (pre 63; po 61)	31.7	62.3	S	55.6	100.0	S	81.0	96.7	S	4.8	77.0	S
<u>Kar. Nongko</u> (pre 36; po 35)	33.3	57.1	NS	25.0	97.1	S	69.0	94.3	S	0.0	20.0	S
<u>Bodag</u> (pre 44; po 39)	52.3	61.5	NS	86.2	89.7	NS	68.2	89.7	S	6.8	30.8	S
Average X2 = S	30.0	59.7	S	61.9	93.4	S	75.6	84.3	S	3.8	43.5	

S = significant, NS = not significant.

In summary, 90.2% of women interviewed in East Java had heard about nutrition. Mothers were better able to discuss the importance of colostrum for infants, the age additional food should be given to babies, as well as, the type of foods, and when a child should be weaned. More women knew the three food groups, foods lactating women should eat, and what foods help prevent nightblindness.

Nutrition questions related practices for babies was in general higher than for the others. This suggests that information on nutritional practices not related to babies needs greater attention.

Family Planning: Respondent knowledge about family planning issues increased significantly except for 'heard of family planning' which had a high baseline average of 99.1% and the 'number of prenatal examinations needed by a pregnant woman'.

Respondent knowledge about 'three kinds of contraceptives' was higher than their knowledge of the 'benefits of family planning'; 75.5% to 50.6%, respectively. Still, it is interesting to note that the growth rate for Pacitan is less than one percent, which is one of

lowest on Java (3).

Indicator 4a: Respondents that have heard of family planning.

The average baseline and close out percentage remained essentially the same; 99.1% baseline 98.4% close out.

Indicator 4b: Respondents that know the benefit of family planning.

The baseline average was increased from 13.5% to 50.6% in the close out. Wonoanti, Kalikuning, and Bodag showed no significant increase.

Table 4: Frequency distribution of indicators on family planning and mother and child health (MCH) in percentage of correct answers, pre and post compared with its significance.

Village	Heard of family planning			Benefits of family planning			Three kinds of contraceptives		
	pre	post		pre	post		pre	post	
	[A]			[B]			[C]		
<u>Wonoanti</u> (pre 60; po 51)	98.3	100.0	NS	20.0	29.8	NS	25.0	78.9	S
<u>Katipugal</u> (pre 36; po 33)	100.0	100.0	NS	2.8	90.7	S	55.6	97.0	S
<u>Wonodadi Wt</u> (pre 30; po 25)	100.0	100.0	NS	10.0	48.0	S	66.7	88.0	NS
Kalikuning (pre 44; po 39)	98.6	94.1	NS	8.3	14.7	NS	1.4	27.9	S
Klesem (pre 63; po 61)	100.0	100.0	NS	11.1	86.9	S	74.6	93.4	S
Kar. Nongko (pre 36; po 35)	97.2	100.0	NS	0.0	65.7	S	63.9	100.0	S
Bodag (pre 44; po 39)	100.0	97.4	NS	38.6	35.9	NS	61.4	76.9	NS
Average X2 = S	99.1	98.4	NS	13.5	50.6	S	45.0	75.5	S

3) Central Bureau of Statistics and United Nations Children's Fund 1984.

Indicator 4c: Respondents that can mention three kinds of contraceptives.

The average baseline figure was increased from 45.0% to 75.5% in the close out. Bodag and Wonodadi Wt. had no significant increase.

Table 4: Family planning and MCH continued.

Village	Number of prenatal examinations			When is the first prenatal examination			Who should perform the examination		
	pre	post		pre	post		pre	post	
	[D]			[E]			[F]		
<u>Wonoanti</u> (pre 60; po 51)	75.0	66.7	NS	5.0	47.4	S	96.7	100.0	NS
<u>Katipugal</u> (pre 36; po 33)	61.1	72.7	NS	2.8	90.8	S	100.0	100.0	NS
<u>Wonodadi Wt</u> (pre 30; po 25)	60.0	48.0	NS	36.7	88.0	S	93.3	100.0	NS
Kalikuning (pre 44; po 39)	16.7	32.4	S	8.3	23.5	S	58.3	91.2	S
Kleseem (pre 63; po 61)	73.0	86.9	NS	7.9	72.1	S	100.0	98.4	NS
Kar. Nongko (pre 36; po 35)	94.4	100.0	NS	25.0	97.1	S	91.7	100.0	NS
Bodag (pre 44; po 39)	77.3	5.1	S	31.8	5.1	S	81.8	94.9	NS
Average X2 = S	61.9	58.5	NS	14.4	55.2	S	86.8	97.5	S

S = significant, NS = not significant.

Indicator 4d: Respondents that know how many times a pregnant woman should be examined.

The village average percentage decreased from 61.9% to 58.5%. This was due to the drastic decrease in Bodag (77.3% baseline and 5.1% closeout). Only Kalikuning showed a significant decrease.

Indicator 4e: Respondents have had their first pregnancy examinations.

The baseline average percentage was increased from 14.4% to 55.2% in the close out. Every village had a significant increase.

Indicator 4f: Respondents know with whom a pregnant woman should seek consultation.

The baseline average percentage increased from 86.8% to 97.5% in the close out survey. Due to the high baseline figures only Kalikuning had a significant increase; 58.3% baseline, 91.2% close out.

In summary, 98.4% of the women interviewed in East Java had heard of family planning at the time the close out survey was conducted. More women understood the benefits of family planning and could mention three forms of contraceptive.

The number of women that knew when the first prenatal examination should occur, and who is best qualified to perform the exam, both improved significantly. Women's knowledge of the number of examinations needed did not increase. In theory, this particular bit of prenatal care information should have the least impact on a woman's health care because she can be reminded when to return during her first visit.

Comparison of the Core and Satellite Sites

To determine if there was a significant difference between core and satellite percentage changes a student's t-test was conducted (Appendix C).

No control sites were selected for comparison. Therefore satellite sites have been designated to serve this purpose. The core and satellite analysis can be examined from the perspective that comparative changes are due to CARE interventions. But it is important to keep in mind that information passed to the satellite sites due to the core and satellite strategy. The analysis can also be used to determine how effective information is disseminated from the core to satellite sites.

All five indicators in the subdistrict of Tulakan were significantly higher in the core sites than in the satellite sites. This indicates that core site respondents have improved their knowledge and practices in child and pregnant women immunization, diarrhea, nutrition, and family planning.

In the subdistrict of Ngadirojo indicators for diarrhea, child immunization, and nutrition were significantly higher in the core sites than in the satellite. This indicates that core site mothers have improved knowledge and practices concerning child immunization, nutrition, and diarrhea issues. At the same time core and satellite respondents both made progress toward improving their knowledge and practice concerning pregnant women immunization and family planning.

In the subdistrict of Kebonagung, a significant difference existed for knowledge and practice concerning child immunization issues. The statistics support the idea that Kader in both core and satellite sites made significant progress toward improving the knowledge and practices of pregnant women, increasing immunization, nutrition, diarrhea knowledge, and family planning among the target population: The combined close out figures average for the satellite site in Kebonagung was 74.9%, while the combined averages for the three core sites were 79.0%, 73.7%, and 65.2%. This would suggest that the core and satellite system is functioning effectively in the Kebonagung subdistrict.

CONCLUSION

Improving rural health care is one of the most difficult tasks confronting a community developer. Economic, social, and geographic limitations often intertwine to create an intricate web of obstacles that make progress tedious and mask tangible results. CARE Indonesias' Village Primary Health Care project was not exempt from the common problems experienced throughout much of the underdeveloped rural areas of the world. For example, the availability of rural community immunizers was limited by under-staffing at the health centers, government regulation that limit the role of CARE, lack of reliable transportation, inability to use existing resources effectively, and often limited supplies.

Cultural beliefs can lead to the under-utilization of GOI health services. For example, in some areas, diarrhea is not always considered a disease, but associated with the natural development of a child. When a baby learns to stand loose stools are anticipated. This is also assumed to be true when the child begins to walk. The traditional methods used to treat the disorders can be harmful, such as interrupting breast feeding or restricting fluid intake.

Certain taboos prohibit the consumption of some potentially beneficial locally available foods because they are deemed to possess deleterious properties for pregnant and lactating women, infant and child development, and specific illnesses.

Another example is cited by a subdistrict health center doctor who reported that up to 20 percent of the children in his territory did not complete a second series of immunizations due to mothers' concern about adverse side-effects. Some mothers refuse to bring their children to be immunized because of misconceptions concerning the purpose and inevitable risk involved with doing so.

In lieu of these limiting environmental factors CARE Indonesia successfully implemented its village primary health care program in NTB, West Java, and East Java. The concerted effort put forth by subdistrict staff, Posyandu Kader, community members, and CARE resulted in advancement toward tangible improvement for the rural community health care system.

Management training courses were held to enhance the ability of

subdistrict health personnel to organize, train, and supervise village health activities.

Posyandus were established with the mutual support of subdistrict staff and community members. Subdistrict health personnel and CARE staff conducted health training courses for Posyandu staff and encouraged them to hold regular village group health education sessions as a way to build local knowledge about nutrition, diarrhea, immunization concerns.

Subdistrict personnel also provided the logistical support that Posyandus needed to be more fully utilized, such as providing ORS packets, immunizers, growth chart and immunization cards, and scales when ever possible.

It is too early to ascertain whether or not CARE Indonesia's long term goal of reducing the mortality and morbidity rates of under-five children and pregnant women was achieved. However, the evaluation indicators measured in the surveys which were partially intended to indirectly indicate the status of mortality and morbidity rates showed promise. The survey figures explicitly demonstrate that CARE Indonesia facilitated the strengthening of Indonesias' rural health care system. The figures also implicitly suggest that the mortality and morbidity rates should drop if subdistrict health workers, Posyandu staff, and villagers are able to maintain and continue to build upon the gains made.

West Java

In general respondent knowledge and practice improved in both subdistricts. The group averages for immunization of children, diarrhea, and nutrition were above the 70% standard in Panjalu. Improvement was also found in Wanaraja. The group of indicators for diarrhea issues was above the 70% benchmark. All the other indicator groups, except for pregnant women immunization, made significant progress, but remained below the 70% benchmark.

From the figures obtained in the close out survey, it may be concluded that:

1. Items which indicate respondents' knowledge showed an increase.
2. Practices improved as illustrated by the greater use public and private latrines, increased levels in the number of children being weighed and immunized, and mothers participation in health information training sessions.
3. Respondent confidence in Kaders has improved. This is indicated by the increased number of respondents seeking their assistance when a child suffers from diarrhea.
4. The number of persons attending Posyandus immunization and weighing sessions has increased.

NTB

The VPHC project in NTB has made progress in the implementation of ORT and nutrition interventions over the past two years. From the survey results it is evident that the knowledge and practice of mothers has improved in every CARE assisted site. This was a considerable achievement considering the weak village infrastructure--limited formal leadership systems--and the extremely low socioeconomic status of the target population.

Survey results indicate that the core and satellite system--encouraging Kaders in the satellite sites to visit and replicate activities learned in the core sites--has been effective in development and promotion of Posyandu services.

East Java

The CARE team in East Java focussed a great deal of their effort on organizing appropriate training opportunities for government counterparts. The impact of this approach was not evaluated in this survey. As reported by the CARE staff, and confirmed in part by the survey results, less time and attention was directed towards actual village level primary health care service interventions. Data from the East Java VPHC project survey were analyzed by village and not combined as was done with the results from West Java and NTB.

Survey results suggest that the core and satellite site system has been effective in conveying the importance of immunization. The number of target mothers that knew what childhood diseases are prevented by immunization rose significantly from 10.7% to 39.1%. This was complemented by 62% of the children actually having completed the immunization series.

A problem has been identified with the diarrhea prevention aspect of the project. Although the reported use of ORS has increased significantly it was discovered a majority of mothers were making the solution incorrectly. The potential danger of improperly mixing the solution is self evident and requires that CARE focuses its attention on ensuring that mothers follow correct procedures.

All topic interventions related to nutrition had a significant village average increase. Actual practices were not verified, but targeted mothers show a definite improvement in their knowledge of why infants need colostrum, and of the foods that lactating women should eat and which prevent nightblindness.

Family planning interventions were only conducted in East Java project area at the request of the GOI. It is noteworthy that the VPHC project was able to assist in improving target mothers awareness of the benefits of family planning and the different contraceptive services available to them. Unfortunately, there is no data on reported usage.

Recommendation for Improving CARE Indonesia VPHC Project:

1. Immunization for communicable diseases must target the 'herd immunity' level of 80% coverage. Other diseases such as tetanus and TB must target 100% coverage.
2. The severity of childhood dehydration must be curtailed. This needs careful monitoring. Cases must be recorded and followed up. For example, referral to health centers or hospitals must be checked and feedback to related institutions given.
3. The overall nutritional status of all children 0 - 2 years must be improved. High risk children must be identified, continually monitored and offered special assistance.
4. The high risk approach is one strategy for improving maternal services in rural areas. This approach still needs to have criteria developed for the identification and treatment of high risk cases. For example, high risk pregnancies must be monitored by competent health workers. At the present traditional birth attendants (TBAs) assist 80% of the rural births (4). Unless midwives and nurse midwives are made available this will continue.
TBAs could continue to assist low risk pregnancies and deliveries. But care and delivery for high risk pregnancies should be done by trained midwives or nurse midwives and considered part of their normal work-load.
General guidelines for high risk pregnancy exist at the national level. But adjustments need to be made to take into account varying local considerations. Whether or not the high risk approach is adopted, the health care delivery system must be improved in rural areas.
5. The baseline data should be issued to local administrators so that they can identify weak areas needing attention.
6. In conclusion: If a higher score of KAP survey is expected, an intensive long term, community participatory health and nutrition education activities must be implemented.

4) The incidence of high risk pregnancies in Indonesia is estimated to be between 40 - 60% (Agustina, 1986; Alisyahbana, 1987; Martodipuro, 1987).

APPENDIX A
West Java Panjalu

Table 1: Percentage of correct answer on immunization matters, in CARE site, control site, baseline (pre) and close out (post). Panjalu Subdistrict West Java.

Child immunization: correct Responses	Study		Control	
	Pre (n=195)	Post (n=152)	Pre (n=106)	Post (n=82)
Diseases prevented by immunization	31.3	60.5	21.4	48.8
Frequency of immunization of baby	35.1	71.7	54.3	69.5
Age infant should be immunized	55.2	75.0	57.7	64.6
Importance of immunization	91.1	94.0	98.1	100.0
Your children been immunized	73.4	86.1	61.6	91.5
Average	57.2	77.5	58.6	74.9

(df = 4, 0.05 > = 0.612 < ttab (df = 4, 0.05 > = 2.776

Table 2: Percentage of correct answers on matters of immunization of pregnant mothers, in CARE sites, control site, baseline (pre) and close out (post). Panjalu Subdistrict. West Java.

Immunization of pregnant women correct response	Study		Control	
	Pre (n=195)	Post (n=152)	Pre (n=106)	Post (n=82)
What immunization pregnant mother	21.7	58.3	18.4	48.8
Why pregnant mother immunized	63.4	61.2	49.5	58.5
TT immunization of pregnant mother	58.2	77.4	62.9	40.5
Average	47.7	65.6	43.6	49.3

m (df = 2, 0.05 > = 0.785 < ttab (df = 2, 0.05 > = 4.303

Table 3: Percentage of correct answers on diarrhea matters, in CARE sites, control site, baseline data, close out data. Panjalu West Java.

Diarrhea: correct responses	Study		Control	
	pre (n=195)	post (n=152)	pre (n=106)	post (n=82)
Definition of diarrhea	60.7	92.1	68.8	69.5
The causes of diarrhea	27.9	77.0	20.8	50.0
Child ever diarrhea	72.3	54.6	67.6	53.7
Signs of dehydration	54.1	80.9	40.6	64.6
Can make oralite	72.8	94.1	61.0	74.4
Practice of making oralite	40.7	72.6	57.1	44.0
Can make sugar salt solution	71.9	98.0	67.3	91.5
Practice sugar salt solution	16.0	44.4	8.3	21.3
Method to give oralite	78.8	90.8	76.7	93.7
Why oralites is useful	93.1	95.4	98.1	100.0
Average TT-test = NS	59.9	79.0	56.6	66.3

(df = 9, 0.05) = 2.236 < ttab (df = 9, 0.05) = 2.262

67

Table 4: Correct answers on nutrition matters, baseline (pre) compared with close out (post) situation, in CARE sites and control site. Panjalu West Java.

Nutrition: correct response	Study		Control	
	Pre (n=195)	Post (n=152)	Pre (n=106)	Post (n=82)
Age to breast feed the baby	84.5	91.4	80.2	92.2
Age to give additional food	47.6	58.6	63.2	70.7
Kind of food for baby	74.9	88.0	85.7	75.6
Daily food for the child	83.0	91.3	84.8	69.5
Frequency of feeding of a child	84.5	88.1	84.8	98.9
Food to prevent nightblindness	36.2	65.8	20.2	54.9
Colostrum important for baby	54.3	80.1	82.4	23.5
Weigh at Posyandu	95.8	96.6	97.9	95.1
Can read KMS	39.5	37.8	38.8	48.8
Join nutrition lessons	45.7	91.2	28.3	63.4
Weighing sessions every month	80.5	86.4	91.7	85.4
Average TT-test = NS	66.0	79.6	68.9	70.7

(df = 10, 0.05) = 1.434 < ttab (df = 10, 0.05) = 2.228

APPENDIX B
West Java Wanaraja

Table 1: Percentage of correct answers on matters on immunization, in intervention site, control site, baseline (pre), close out survey (post). Wanaraja Subdistrict, West Java.

	Study		Control	
	Pre (n=327)	Post (n=267)	Pre (n=89)	Post (n=67)
Child immunization correct response				
Join lessons on immunization	50.5	88.0	60.2	85.1
Importance of immunization	48.2	53.9	46.0	41.8
Frequency of Polio immunization	39.7	33.9	14.3	31.3
Frequency of DPT immunization	42.2	19.0	18.2	14.3
Frequency of Measles immunization	37.7	45.0	66.7	25.0
Frequency of BCG immunization	41.7	31.4	83.3	41.7
Average	43.3	45.2	48.1	39.9

(df = 5, 0.05 > = 0.874 < ttab (df = 5, 0.05 > = 2.571

Table 2: Percentage of correct answers on matters of immunization of pregnant mothers, in the intervention site, control site, baseline and close out survey. Wanaraja, West Java.

	Study		Control	
	Pre (n=327)	Post (n=267)	Pre (n=89)	Post (n=67)
Immunization of pregnant women correct response				
Prevent disease by immunization	27.0	50.4	8.2	17.9
Immunization of pregnant mother	26.5	30.3	2.8	7.6
Frequency of immunization	69.3	66.7	12.5	19.4
Why immunization of mothers	41.8	40.8	15.1	25.4
Immunization status of mother	36.1	36.3	12.3	23.9
Average	40.1	44.9	10.2	18.9

(df = 4, 0.05 > = 0.758 < ttab (df = 4, 0.05 > = 2.776

Table 3: Percentage of correct answers on matters of diarrhea in the intervention sites, control site, baseline and close out survey. Wanaraja Subdistrict, West Java.

Diarrhea: correct response	Study		Control	
	Pre (n=327)	Post (n=267)	Pre (n=89)	Post (n=67)
Definition of diarrhea	63.7	80.5	52.9	43.3
Cause of diarrhea	37.3	67.8	37.3	52.2
Symptom of dehydration	34.5	69.3	45.3	73.1
Ever used oralite	66.6	84.6	66.3	76.1
Can make oralite	42.9	15.7	26.7	25.8
When to give oralite	68.2	90.3	50.6	67.2
Join lessons about diarrhea	46.9	85.8	79.5	59.7
Average TT-test = NS	51.4	70.6	51.2	56.8

(df = 6, 0.05 > = 1.404 < ttab (df = 6, 0.05 > = 2.447

Table 4: Percentage of correct responses on matters of nutrition in the intervention site, control site, baseline and close out survey. Wanaraja Subdistrict West Java.

Diarrhea: correct response	Study		Control	
	Pre (n=327)	Post (n=267)	Pre (n=89)	Post (n=67)
Age of additional food	54.5	54.7	23.0	35.8
Kind of food	54.2	86.1	51.8	59.7
Daily food of the child	42.1	52.8	24.1	46.3
Food to prevent night blindness	36.5	47.9	18.4	17.9
Food for lactating mother	57.7	71.2	53.5	55.2
Three groups of food	43.3	64.4	54.0	67.2
Colostrum for newborn baby	51.1	71.9	54.0	41.8
Give second breast for baby	90.3	91.8	93.1	86.6
Average TT-test = NS	53.7	67.6	46.5	51.3

(df = 7, 0.05 > = 1.641 < ttab (df = 7, 0.05 > = 2.365

APPENDIX C
East Java

Table 1 : Frequency distribution of correct answers of respondents on questions on immunization of children, core site compared with satellite site, Chi square and its significance East Java

Immunization correct response	Tulakan		Kebonagung		Ngadirojo	
	Core (n=57)	Satel (n=68)	Core (n=33)	Satel (n=90)	Core (n=25)	Satel (n=39)
1. Heard of immunization	96.5	79.4	100.0	97.9	100.0	87.2
2. Why immunization.	68.4	14.7	93.9	56.8	92.0	53.8
3. Disease prevented	46.4	8.8	63.6	38.5	72.0	41.0
4. Frequ. of immunization	33.9	11.8	51.5	33.3	52.0	66.7
5. BCG immunization	93.0	63.2	93.9	87.5	92.0	74.4
6. DPT immunization	87.7	47.2	87.9	84.4	84.0	61.5
7. Polio immunization	89.5	45.6	87.9	82.3	76.0	56.4
8. Measles immunization	82.5	23.5	87.9	77.1	76.0	61.5
9. Immun. completed	75.4	22.1	87.9	71.0	64.0	43.6
Ave. TT-test =	74.8	35.0 S	83.8	70.0 S	78.7	60.7 S

Tulakan: (df = 8, 0.05> = 8.201 < ttab (df = 8, 0.05> = 2.306
kebonagung (df = 8, 0.05> = 3.617 < ttab (df = 8, 0.05> = 2.306
Ngadirojo (df = 8, 0.05> = 3.687 < ttab (df = 8, 0.05> = 2.306

Table 2 : Frequency distribution of correct answers of respondents on questions on immunization of pregnant women, core site compared to satellite site, Chi square. East Java.

Immunization correct	Tulakan		Kebonagung		Ngadirojo				
	Core (n=57)	Satel (n=124)	Core (n=33)	Satel (n=90)	Core (n=25)	Satel (n=39)			
1. Type immunization for pregnancies	42.9	5.9	51.5	38.9	40.0	25.6			
2. Correctly answered need TT 2x	60.7	13.2	51.5	52.1	64.0	64.1			
3. Reason for immunization	36.8	2.9	90.9	36.6	24.0	46.2			
4. When are TT shots needed	42.1	14.7	93.9	89.6	36.0	87.2			
Ave. TT-test =	45.6	9.1	S	71.9	54.3	NS	41.0	55.8	NS
Tulakan	(df = 3, 0.05> = 8.696 < ttab (df = 3, 0.05> = 3.182								
Kebonagung	(df = 3, 0.05> = 1.410 < ttab (df = 3, 0.05> = 3.182								
Ngadirojo	(df = 3, 0.05> = 1.034 < ttab (df = 3, 0.05> = 3.182								

Table 3 : Frequency distribution of correct answers of respondents on questions on diarrhea, core site compared with satellite site, X2, Chi square and its significancy (p < 0.05). East Java

Diarrhea: correct response	Tulakan		Kebonagung		Ngadirojo				
	Core (n=57)	Satel (n=124)	Core (n=33)	Satel (n=90)	Core (n=25)	Satel (n=114)			
1. Heard of diarrhea	87.5	42.6	87.9	88.5	100.0	50.0			
2. Meaning of diarrhea	66.7	19.1	87.9	77.1	76.0	66.7			
3. Cause of diarrhea	29.8	8.8	39.4	69.5	76.0	43.6			
4. Signs of dehydration	28.1	7.4	36.4	65.3	72.0	12.8			
5. Used oralit	94.7	22.4	97.0	95.8	100.0	74.4			
6. Make salt sugar solution	26.3	7.4	51.5	54.2	76.0	2.6			
7. When to give oralites	78.9	22.1	75.8	86.5	88.0	61.5			
8. Weaned if diarrhea	64.3	45.6	66.7	86.5	80.0	28.2			
Ave. TT-test =	59.5	21.9	S	67.8	77.9	NS	83.5	42.5	S
Tulakan	(df = 7, 0.05> = 5.144 < ttab (df = 7, 0.05> = 2.365								
Kebonagung	(df = 7, 0.05> = 1.933 < ttab (df = 7, 0.05> = 2.365								
Ngadirojo	(df = 7, 0.05> = 5.510 < ttab (df = 7, 0.05> = 2.365								

Table 4 : Frequency distribution of correct answers of respondents on questions on nutrition, core site compared with satellite site, Chi square and its significance (p < 0.05) East Java.

Nutrition: correct response.	Tulakan		Kebonagung		Ngadirojo				
	Core (n=57)	Satel (n=124)	Core (n=33)	Satel (n=90)	Core (n=25)	Satel (n=114)			
1. Heard of nutrition	91.2	72.1	100.0	94.7	100.0	94.9			
2. Colostrum given	84.2	95.6	66.7	93.7	100.0	56.4			
3. Kind food for children	94.7	26.5	100.0	60.4	72.0	2.6			
4. Food for lactating women	43.9	7.4	93.9	82.1	84.0	28.2			
5. Age additional food	70.2	44.1	63.6	60.4	68.0	61.5			
6. Food at three months	94.7	80.7	97.0	99.0	96.0	89.7			
7. Age stop breastfeeding	70.2	69.1	90.9	95.8	96.0	89.7			
8. Food prevent nightblind	56.1	17.6	27.3	56.8	76.0	30.8			
Ave. TT-test =	75.6	51.6	S	79.9	80.4	NS	86.5	57.4	S
Tulakan (df = 7, 0.05> = 2.760 < ttab (df = 7, 0.05> = 2.365 Kebonagung (df = 7, 0.05> = 0.056 < ttab (df = 7, 0.05> = 2.365 Ngadirojo (df = 7, 0.05> = 3.023 < ttab (df = 7, 0.05> = 2.365									

Table 5: Frequency distribution of correct answers of respondents on questions on family planning and mother and child health, core site compared with satellite site, Chi square. East Java.

Family planning correct response	Tulakan		Kebonagung		Ngadirojo				
	Core (n=57)	Satel (n=124)	Core (n=33)	Satel (n=90)	Core (n=25)	Satel (n=114)			
1. Heard family planning	100.0	94.1	100.0	100.0	100.0	97.2			
2. Benefit of F.P.	29.8	14.7	90.9	82.6	48.0	35.9			
3. Type of F.P.	78.9	27.9	97.0	95.8	88.0	76.9			
4. Number of prenatal exams	66.7	32.4	72.7	91.7	48.0	5.1			
5. When get first prenatal	47.4	23.5	90.9	82.1	88.0	5.1			
6. Who should conduct exam	100.0	91.2	100.0	100.0	100.0	94.9			
Ave. TT-test =	70.5	47.3	S	91.9	92.0	NS	78.9	52.5	NS
Tulakan (df = 5, 0.05> = 3.311 < ttab (df = 5, 0.05> = 2.571 Kebonagung (df = 5, 0.05> = 0.047 < ttab (df = 5, 0.05> = 2.571 Ngadirojo (df = 5, 0.05> = 2.039 < ttab (df = 5, 0.05> = 2.571									

Appendix D NTB

Table 2 : Comparison of baseline data (pre) and close out survey (post) in the CARE and control sites and its significance: Chi square and Student t-test (X2 and TT). NTB

	CARE		Control	
	Pre (n=175)	Post (n=178)	Pre (n=49)	Post (n=45)
Diarrhea: correct response				
1. Heard of diarrhea	83.4	94.9	75.5	80.0
2. If child got diarrhea	50.9	94.4	42.9	53.3
3. Water for salt sugar solution	44.0	89.8	26.5	48.9
4. Composition of salt sugar sol.	30.9	81.4	20.4	26.7
5. Sugar for salt sugar solution	30.3	84.7	10.2	20.0
6. Salt for salt sugar solution	26.9	77.8	8.2	6.7
7. If child got severe diarrhea	32.0	94.4	22.4	75.6
Average TT-test = S	42.6	88.2	29.4	44.5

(df = 6, 0.05> = 4.509 < ttab (df = 6, 0.05> = 2.447

Table 3 : Comparison of baseline data (pre) and close out survey (post) of CARE and control site, its significance: Chi square and Student t-test (X2 and TT). NTB

Cause of diarrhea correct response	CARE		Control	
	Pre (n=175)	Post (n=178)	Pre (n=49)	Post (n=45)
1. The cause of diarrhea	38.5	86.5	50.0	31.1
2. Drink unboiled water	21.1	75.0	12.5	28.6
3. Food not washed	9.1	66.4	4.7	28.6
4. Food not covered from flies	10.6	67.1	21.9	35.7
5. Eat spoiled food	8.3	46.7	4.7	14.3
6. Hands not washed	11.7	73.0	6.3	7.1
Average TT-test = S	16.6	69.1	16.7	24.2

(df = 5, 0.05> = 7.196 < ttab (df = 5, 0.05> = 2.571

Table 4 : Comparison of baseline data and close out survey of CARE and control site and its significance: Chi square and Student t-test (X2 and TT). NTB

Prevention of diarrhea correct response	CARE		Control	
	Pre (n=175)	Post (n=178)	Pre (n=49)	Post (n=45)
1. How to prevent diarrhea	24.5	83.6	22.4	31.1
2. Boil drinking water	25.5	82.9	19.4	35.7
3. Wash food before eating	12.3	69.9	11.2	28.6
4. Cover food before consuming	11.9	71.2	16.3	14.3
5. Boil food properly	4.1	37.7	2.0	7.1
6. Wash hands before eating	21.4	73.3	28.6	28.6
Average TT-test = S	16.6	69.8	16.6	24.2

(df = 5, 0.05> = 9.781 < ttab (df = 8, 0.05> = 2.571

Table 5 : Comparison of baseline data (pre) and close out survey (post) of CARE and control site, and its significance: Chi square and Student t-test (X2 and TT). NTB

Nutrition: correct response	CARE		Control	
	Pre (n=175)	Post (n=178)	Pre (n=49)	Post (n=45)
1. Received nutrition education	1.7	94.4	0.0	42.2
2. Three kinds of food	68.6	74.7	44.9	31.1
3. Frequency of taking food	75.4	96.6	87.8	66.7
4. Efforts if child refuse to eat	32.0	65.7	32.7	20.0
5. The benefit of weighing	49.1	89.3	28.6	48.9
6. Know RKBPKK kader	0.6	96.0	0.0	35.6
Average TT-test = S	37.9	86.1	32.3	40.7

(df = 5, 0.05> = 5.919 < ttab (df = 5, 0.05> = 2.571

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Appendix E: Supplimentary Tables

Table 1: Frequency distribution of select nutrition indicators pre and post comparison. NTB, West Java, East Java.

Nutrition	n =	NTB		West Java		East Java	
		pre	post	pre	post	pre	post
		175	178	522	489	313	283
1. Attend Nutrition training or understand its meaning		1.7	94.4	44.7	77.2	87.1	90.2
2. Why colostrum is important		-	-	52.7	76.0	42.3	85.8
3. Foods for babies		68.6	74.7	64.6	87.1	61.7	93.4
4. Foods for lactating women		-	-	57.7	71.2	17.9	53.9

Table 2: Frequency distribution of select diarrhea indicators pre and post comparison. NTB, West Java, East Java.

Diarrhea	n =	NTB		West Java		East Java	
		pre	post	pre	post	pre	post
		175	178	522	489	313	283
1. Attend diarrhea training or understand its meaning		83.4	94.9	42.5	87.8	20.1	74.7
2. Know 3 causes of diarrhea		16.6	69.1	32.5	72.4	11.5	43.5
3. Can make salt/sugar solution		44.0	84.6	71.8	98.0	3.1	34.4
4. How to administer salt/sugar solution or steps to be taken when diarrhea is contracted		50.9	94.4	72.1	90.6	39.2	67.2

Table 3: Frequency distribution of select immunization indicators pre and post comparison. West Java, East Java.

Immunization	n =	West Java		East Java	
		pre	post	pre	post
		522	489	313	283
1. Attend immunization training or understand its meaning		50.5	88.0	62.4	92.8
2. Why immunization is important		69.7	74.0	40.0	56.2
3. Children receiving immunization		73.1	86.1	-	76.9

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ATTACHMENT #2
RELEVANT TIER I INDICATORS

Attachment #2

RELEVANT TIER I INDICATORS

A. ORT

OUTPUTS

1. No. of project supported health workers in project area, by type of worker:
 - a. 2,586 kaders.
 - b. 169 Other health worker.
2. No. of health worker trained through project activities to teach ORT by type of worker:
 - a. 2,586 kaders.
 - b. 169 Other health worker.

EFFECTIVENESS

1. No. and type of service unit distribution points for ORS packets in project area.

a.	Puskesmas	9
b.	Puskesmas Pembantu	8
c.	Posyandu	94
2. Total no. of service units and distribution points in project area.
 - a. Puskesmas + Puskesmas Pembantu + Posyandu = 111 units.

B. IMMUNIZATION

OUTPUTS

1. No. of project supported health worker in project area, by type of worker:
 - a. 2,586 kaders.
 - b. 169 Other health worker.
2. No. of project health worker trained through project activities to teach about or give immunization , by type of worker:
 - a. 2,586 kaders.
 - b. 169 Other health worker.

EFFECTIVENESS

1. No. and type of service units in project area with specified vaccines in inventory.

a.	Puskesmas	9
b.	Satellite Clinics	8
2. Total no. of service units and distribution points in project area.

Posyandu = 94 units.

C. NUTRITION

OUTPUTS

1. No. of health workers trained through project activities to teach ORT by type of worker:
 - a. 2,586 kaders.
 - b. 169 Other health worker.

EFFECTIVENESS

1. No. and type of service units in project area providing growth monitoring service.

a. West Java	20 Posyandus
b. East Java	41 Posyandus
c. NTB	<u>33 Posyandus</u>
Total:	94 Posyandus
2. Number of Children (0 -11 and 12 - 59 months) enrolled in growth monitoring programs.
 - a. 9,164.
3. Number of children (0 -11 and 12 - 59 months) enrolled in growth monitoring programs weighed in last month.
 - a. 8,279.

ATTACHMENT #3

EVALUATION SCHEDULES

WEST JAVA

EAST JAVA

NUSA TENGGARA BARAT

WEST JAVA SCHEDULE

DATE	TIME	ACTIVITIES
October 6, 1988	09.00	Arrive in West Java Field Office.
	09.15 - 10.30	West Java program presentation.
	10.30 - 13.30	First group consisting of Rick Henning, Jennifer Brinch, Syoehada Kartawinata and Anny Andaryati heading to Ciamis District.
	13.30 - 14.00	Courtesy call to Ciamis District Head, meeting with Ciamis District Secretary and District Doctor.
	14.00 - 14.30	Lunch in Ciamis.
	14.30 - 15.30	Trip to Panjalu Subdistrict.
		Meet the second group in Panjalu Subdistrict.
	11.30 - 15.30	Second group consists of DR. Subagyo M., Dr. Purwanto, Andy Lunandi and Irawati heading to Panjalu Subdistrict.
	15.30 - 16.00	Courtesy call to Panjalu Subdistrict Head.
	16.00 - finish	Meeting with village leaders, kaders and target mothers in group discussion activities in Cipicung and Citaman hamlet, Sanding Taman village (satellite site).
		Stay the night in Tasik.
October 7, 1988	07.30 - 09.00	Meeting with Panjalu Management Team.
	09.00 - 11.30	Posyandu activities in Cidahu hamlet, Ciomas village (pilot site). Meeting with village leaders, kaders, and target mothers.
	11.30 - 13.00	Lunch in Garut.
	13.00 - 14.30	Trip to Wanaraja Subdistrict, Garut District.
	14.30 - 15.00	Courtesy call to Wanaraja Subdistrict Head.
	15.00 - 18.00	Meeting with village leaders, kaders and target mothers in group discussion activities in Sindangmekar village (pilot site).
	19.00 - 22.00	Evaluation Team internal meeting.
		Stay the night in Cipanas, Garut.

DATE	TIME	ACTIVITIES
October 8, 1988	08.00 - 08.30	Courtesy call to Garut District Head, meeting with Head of Public Welfare.
	08.30 - 09.00	Heading to Wanaraja Subdistrict.
	09.00 - 10.30	Meeting with Wanaraja Management Team.
	10.30 - 13.30	Meeting with village leaders, kaders and target mothers in Sindangratu village (satellite site).
	13.30 - 14.30	Lunch in Sindangratu village.
	14.30 - 16.30	Leave for Cipaku Indah Homestay, Bandung.
	19.00 - 22.00	Meeting with West Java Management Staff for feedback and reflection.
October 9, 1988	06.00	Leave for Yogyakarta in the first flight.

EAST JAVA SCHEDULE

DATE	TIME	ACTIVITIES
October 9, 1988	08.30	Arrived at Adi Sucipto, Yogyakarta.
	08.30 - 13.30	Travel Yogyakarta - Pacitan.
	13.30 - 14.30	Lunch at Pacitan.
October 10, 1988	08.00 - 09.00	Briefing at East Java Field Office.
	09.00 - 10.30	Meeting with District KKBS team.
	10.30 - 11.30	Meeting with District Health Service.
	11.30 - 12.30	Lunch.
	12.30 - 17.00	Internal meeting with East Java VPHC staff.
October 11, 1988	08.00 - 09.30	Travel to Ngadirojo subdistrict, Wonodadi wetan village.
	09.30 - 14.00	Meeting with Ngadirojo subdistrict KKBS team. Meeting with Wonodadi wetan, Bodag, Wonokarto villages KKBS team. Meeting with Kaders and Target Mothers.
	14.00 - 14.30	Travel to Tulakan subdistrict.
	14.30 - 18.00	Meeting with Tulakan subdistrict KKBS team. Meeting with Wonoanti, Kalikuning, Nglaran villages KKBS team. Meeting with Kaders and Target Mothers.
	18.00 - 19.00	Travel to Pacitan.
October 12, 1988	08.00 - 09.30	Travel to Kebonagung subdistrict, Katipugal village.
	09.30 - 15.00	Meeting with Kebonagung subdistrict KKBS team. Meeting with Katipugal, Klesem, Warung Nangka villages KKBS team. Meeting with Kaders and Target Mothers.
	15.00 - 16.30	Meeting with Kebonagung Community Health Center doctor.
	16.30 - 17.30	Travel to Pacitan.

DATE	TIME	ACTIVITIES
October 13, 1988	08.00 - 13.30	Feed back and reflection meeting with East Java VPHC staff.
	13.30 - 14.30	Lunch.
	14.30 - 19.30	Travel to Yogjakarta.
October 14, 1988	07.00 - 13.00	Leave for Mataram, NTB.

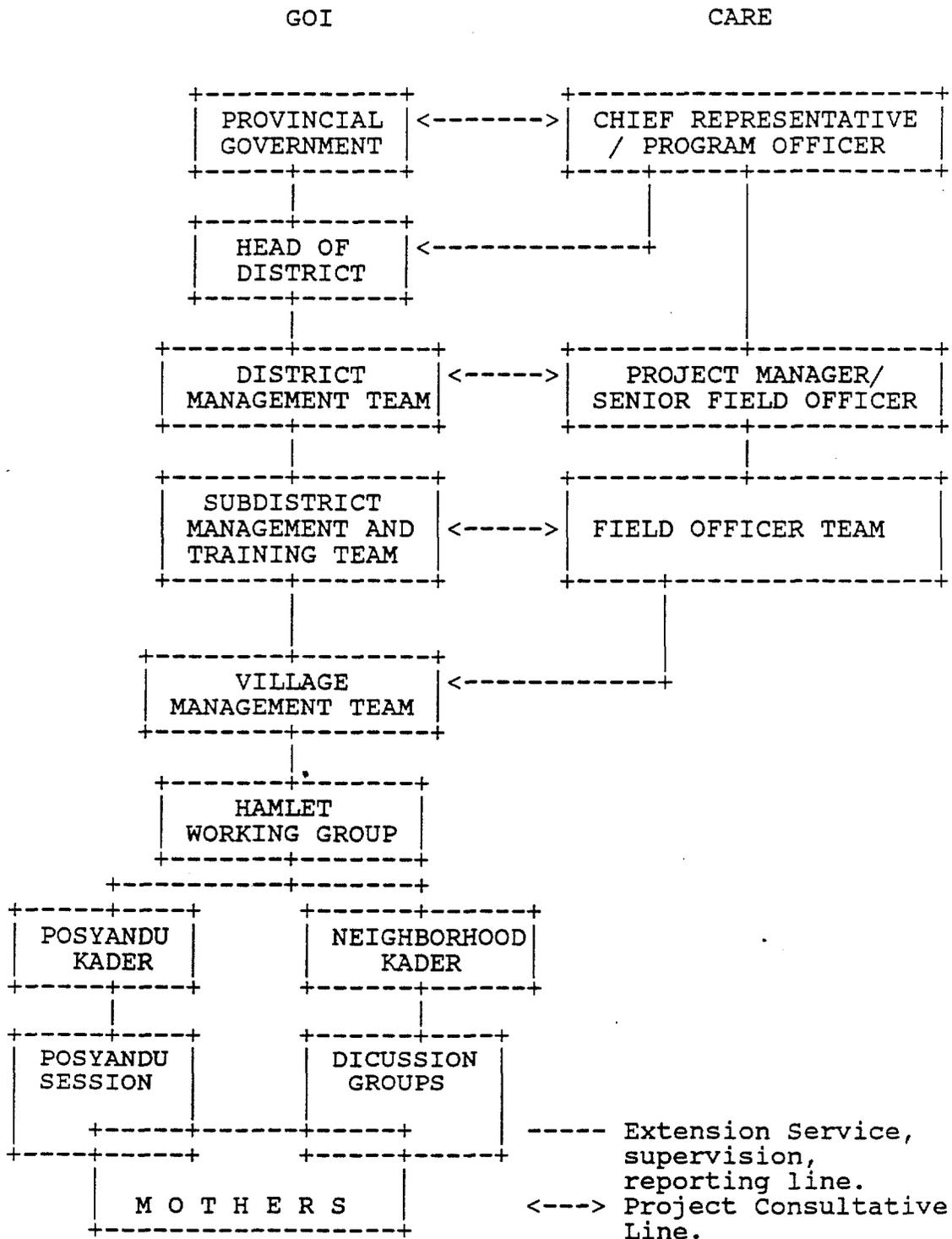
NTB SCHEDULE

DATE	TIME	ACTIVITIES
October 14, 1988	12.00 WITA	Arrived at Selaparang, Mataram.
	12.15	Check in to Granada Senggigi Hotel.
	13.00 - 14.00	Lunch.
	14.00 - 18.00	Briefing at NTB Field Office. Topics: a. Schedule adjustment. b. Evaluation team member adjustment. c. NTB program presentation by Koeswanto.
October 15, 1988	08.00 - 12.00	Evaluation team meeting at NTB Field Office. Topics: Recomendation draft of West Java and East Java.
	12.00 - 13.00	Lunch.
	13.15 - 14.30	Meeting with Gerung subdistrict Chief and Puskesmas doctor.
	14.45 - 18.00	Meeting with Mesanggok RKB PKK.
	14.45 - 18.00	Meeting with Kaders and Target Mothers. Meeting with Gapuk Village Chief.
October 16, 1988	08.30 - 13.00	Evaluation team sunday meeting at Granada Senggigi hotel. Topics: Team evaluation member discussion with NTB project staffs.
October 17, 1988	08.00 - 09.00	Meeting with Kanwil Depkes NTB. The representative is Dr. I Gde Geredeg, SKM.
	9.00 - 11.00	Jennifer, Any, travel to Desa Gapuk to see the posyandu occasion in Messanggok (pilot site) and Batumulik (replication site). And join with the team on 01.00 in Beraringan (pilot site of Kayangan village).
	09.00 - 11.00	Travel to Gangga subdistrict.
	11.00 - 12.00	Meeting with Gangga Puskesmas doctor.
	12.00 - 15.00	Meeting with Kayangan Village leader. Meeting with Beraringan RKB PKK (Labuh Gending). Meeting with kaders. Meeting with Mothers.
	15.00 - 16.00	Replication site visit (Rebakong).
	16.00 - 17.30	Control site visit (Lengkukun).
	20.30 - 23.30	Feedback and reflection meeting at Granada Senggigi hotel.

DATE	TIME	ACTIVITIES
October 18, 1988	08.00 - 09.00	Meeting with Dinas Kesehatan District Lombok Barat (dr. Asegaf Umar). (Jennifer and Dr. Subagiyo meet with Puskesmas Sedau dr. Sri and 11.00 o'clock left for the airport and left Mataram).
	09.30 - 10.30	Meeting with representative of Narmada subdistrict.
	10.45 - 11.45	Meeting with Sedau Puskesmas doctor (dr. Sri).
	12.00 - 16.30	Visit Sesaot village (Jurang Malang, Lembah Sempage and Repok Tatar) Team splitted into three siubgroups. Lembah Sempage: Any Andaryati and Drs. Lalu Sanusi. Jurang Malang: Dr. Purwanto and Said, SKM. Repok Tatar: Rick Henning and Koeswanto.
		Activities: Meeting with village leader. Meeting with RKB PKK. Meeting with kaders. Meeting with mothers.
October 19, 1988	08.30 - 10.00	Meeting with Bappeda Propinsi NTB. The representative is Drs. Muhiddin Azis (Assistant to the Chief of Bappeda Propinsi NTB).
	10.00 - 12.00	Report writing at NTB Field Office.
	12.00 - 13.00	Lunch.
	13.00 - 16.30	Report writing (continued)
October 20, 1988	08.00 - 12.00	Report writing at NTB Field Office.
	12.00 - 13.00	Lunch.
	13.00 - 16.30	Report writing (continued)
October 21, 1988	08.00 - 12.00	Report writing at NTB Field Office.
	12.30 WITA	Departure for Jakarta.

ATTACHMENT #4
RELATIONSHIP CHART

RELATIONSHIP CHART BETWEEN
CARE STAFF AND GOI COUNTERPARTS



ATTACHMENT #5

MID-TERM EVALUATION

REPORT

Village Primary Health Care Project

MID-TERM EVALUATION

REPORT

September 2-14, 1987

CARE Indonesia

Executive Summary

CARE Indonesia requested a combined team of government (national, provincial, and district), other PVO, USAID, University, and the CARE-Asia regional PHC advisor to visit eight of its VPHC sites in West Java, East Java, and Nusa Tenggara Barat (NTB). CARE asked them to interview government officials, doctors, cadres, community leaders, mothers, and CARE staff using interview forms and discretionary questions and observations. Based on these interviews, the evaluators judged the effectiveness of the interventions, the clarity of understanding with different levels of health officials, and estimated the sustainability and replicability of the project. CARE also requested recommendations as to improvements and appropriate future directions. The evaluation was conducted September 2-14, 1987.

The evaluators generally rated VPHC very high on the effectiveness of the interventions in increasing mother and child coverage, knowledge, and services. VPHC consistently received high commendations on its ability to elicit community involvement and fairly high on community management, with the reservation that the involvement did not achieve the ideal in the GOI's concept of primary health care (self-survey, problem-identification, and self-initiation of solutions). The evaluators found some degree of community management of services to occur in all sites, ranging from very high supervision and support to moderate levels. Although all of the communities and most of the cadres indicated they could and would continue their services without the CARE project staff, the local doctors and sub-district officials were slightly less confident, and the provincial officials were very dubious. The evaluators were somewhat less confident than the local doctors were that the services would continue but were nevertheless impressed by the villagers' commitment.

The mothers and cadres were judged to have excellent knowledge about ORT, immunizations, and nutrition in West Java where teaching had been conducted. This knowledge was associated with high community coverage of weighing and immunizations. In NTB, where education had not been formally established, the knowledge of the cadres was moderately good and that of the mothers was poor. The cadres in West Java were conducting interactive teaching and seemed to have very good facility at, and awareness of, what they were doing. In NTB, cadres conducted community rice collections in addition to the basic Posyandu to support their activities. Whereas the health staff and to a lesser degree the evaluators rated the West Java cadres' knowledge of and skills at Posyandu to be excellent, in East Java they were rated moderately high, and in NTB the officials rated the cadres' and the field officers' knowledge to be poor, an observation that they did not substantiate.

The VPHC government relations and collaboration were found to be good at the sub-district and village level, fairly good at the national, and needing much strengthening at the provincial and in some cases district levels. The evaluators were unable to assess the exact status of CARE and provincial health department relations in West Java, observed fairly good relations in East Java, but discovered a great deal of misunderstanding and need for additional work in NTB.

The evaluation team recommends major overtures to the provincial and district health offices in NTB to show a spirit of collaboration. They also recommend increased overtures and communication with those of West Java and East Java. They further recommend clarification of the strategy to the local training team in Ciomas. It is suggested that the project staff and the sub-district and district officials increase discussion and documentation of the costs to possibly be incurred through this approach. The team also concluded that a post-project evaluation to assess the sustainability of the Posyandus and the counterparts' use of the training techniques would be highly desirable. Finally, the team urges the use, with adaptation as necessary, of the health department's new cadre training modules.

The evaluators recognize that the VPHC project strategy was modified in May 1987 in an effort to improve the project's chances of replicability and sustainability through community management with improved government support. Part of this effort, begun in February 1987, was to enhance a sense of government collaboration. The evaluators consider the new strategy to be an improvement for East and West Java but expect further modification in NTB to satisfy health department concerns. All evaluators agreed that it was too early to fully judge the effectiveness of the new strategy but that it clearly was an improvement from both the government's and the evaluators' perspectives.

Glossary

ARI	Acute Respiratory Infection
Bappedda	Provincial Government Development Planning Body
Binkesmas	Directorate General of Community Health, the Ministry of Health
Cadre	Village volunteer, used here as health volunteer
Camat	The head of a sub-district (Kecamatan)
CDC	The Directorate General for Communicable Disease Control and Environmental Sanitation of the Ministry of Health (Depkes)
Depkes	The Republic of Indonesia Ministry of Health
Desa	An Indonesian "village", usually numbering from 1,000 to 10,000 inhabitants
Dinkes	A Provincial or Kabupaten (district) levels health office
Dirjen	The Director General, here used with Binkesmas
Dokabu	The doctor in charge of the Kabupaten health office
Dusun	A sub-division of an Indonesian village: a "hamlet"
IPVO	Indigenous Private (national or local) Voluntary Organization
Kabupaten	The sub-division of an Indonesian province: a "District" having a population of several hundred thousand to several million
Kakanwil	The head of the provincial office of the Ministry of Health, the Kanwil or Kanwilkes
Kanwilkes	The provincial office of the Ministry of Health
Kepala	The head man, as of the desa (village) or the dusun (hamlet)
Kecamatan	The major sub-division of a Kabupaten: a "sub-district"

KMS Card	The Indonesian under-fives growth chart
LKMD	The village level institution in charge of village development
LMD	A kind of village level assembly
Lokakarya	Workshop
Sistim Nilai	A grading system for the growth chart, ranging from 1 (below the 3rd percentile red line) to 10 (above the median, top band)
PKK	Indonesian women's group at the village level
Posyandu	An integrated health service post, intended to have a catchment of 100 children, and ideally having five health components, childweighing, ORT, family planning, MCH, and immunization
Puskesmas	The health clinic of a Kecamatan. Provides clinic and outreach public health services
PVO	Private Voluntary Organization
Tokoh	A leader in a community
VPHC	CARE Indonesia's Village Primary Health Care project

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Purpose and Methods

The evaluators were given the following general instructions:

The main purpose of the evaluation will be to ensure that the project's methodology is likely to be effective. The results will be primarily for CARE Indonesia and secondarily for inclusion in an annual report. You will visit sites from 1986 in which an intensive strategy was used, the CARE field officers living in the village and being responsible for community mapping, needs survey, community organizing, and cadre supervision. You will also visit villages served by a new strategy initiated in May 1987. In this strategy, CARE has attempted to obtain more government participation on all levels. The CARE field officers have been instructed to implement the programs through government training teams and village leaders, only intervening to ensure effectiveness. They together set up training villages, and then spread the program to "replication" villages, with the training team and village leaders in the training villages taking the lead to orient and train the leaders and cadres of the replication villages. The CARE field officers only act in a consultative role in these villages.

CARE would like your assessments and recommendations as to ways to improve the project. To make these recommendations, CARE would like you, as experts, to interview health officials at the provincial and kecamatan levels (Puskesmas doctors), Camat, Village Leaders (tokoh formal and informal), cadres (a random selection of five from each village), and mothers of young children (10 per village). Besides that, CARE field officers, supervisors, Chief Representatives, and the project manager should be interviewed. It is recognized that the sample size and methodology will not result in statistically valid findings; however, we hope that they will provide adequate exposure for you to provide mid-term guidance and feedback. On the basis of these observations, your expert advice as to the preceding questions will be appreciated. Essentially, the method of analysis will be professional judgment based on structured interviews. If there are important questions that you, the evaluators, feel are important to add to the structured interviews, you should feel free to do so but also should note the additional questions and the gist of findings. For our information, we would also appreciate a record of who and how many interviews you conducted and a brief summary of your recommendations.

Presentation of Findings:

The findings will be presented according to the specific questions CARE posed to the evaluators each followed by the

team's responses. Consensus conclusions and recommendations will be distinguished from individual evaluator's suggestions and responses to the greatest extent possible. The actual questionnaires given to the teams as interview guides are attached to the report in Appendix D, the names and positions of the evaluation participants in Appendix A, and the sites visited in Appendix B. The following findings and recommendations were those presented through discussions by the entire team at the end of each province visit. All team members were encouraged to hand in summary reports on the evaluation to be attached to this report in Appendix C.

Caveats About the Evaluation Process

The following limitations were confronted in the evaluation:

The sample was clearly not a random sample, nor truly representative of the villages. In the described process, CARE attempted to make it as representative as possible within the time constraints; however, this was only partially achieved.

The villagers in their enthusiasm and in the sense of Indonesian hospitality occasionally staged a Posyandu or other event rather than allowing it to occur in a truly normal fashion.

The judgments made by the evaluators were often subjective. In the case of government health officials, there was clearly some defensiveness of their system. These officials were very critical of perceived project deficiencies when they felt they had not been actively included as project collaborators. Their attitudes were markedly different in the cases in which they were actively involved.

As the findings will reflect, a strong attempt was made to include everyone's judgments even when they were not addressed to the specific question for discussion.

The team leader often had to participate through a translator and even team members occasionally did not know the local language and would have to interview through the CARE field staff.

Given these limitations, the evaluation revealed both many positive aspects of the program and useful recommendations.

Findings by Province:

I. West Java:

A. 1986 Villages (Walahaar and Nanggela):

1. What is your assessment of the effectiveness and impact of the 1986 approach in this village in regards to:

ORT,
Immunizations, and
Nutrition (KMS and Nilai system understanding in particular)?

The evaluation team agreed that the diarrhea and immunization knowledge in these villages were very impressive. Mothers gave excellent answers. Their understanding of the children's nutritional status as reflected by the KMS card appeared to be less complete. It was speculated that the reason possibly was that the cadres kept the cards. The mothers thus did not have the KMS cards to refer back to. The rationale for the cadres keeping the cards was that the mothers had frequently lost them previously. Immunization coverage appeared to be excellent, approaching 65% of pregnant women in their eighth month of pregnancy and 65% of children 3 to 14 months old with polio 3. Drop outs did not seem to be a major problem.

The evaluators questioned how representative the sample was in that it only included mothers at home in the mid-day, not field-workers nor vendors.

The teaching methods apparently had been good, incorporating visual aids and individual and some group instruction. The coverage in home education was facilitated in the villages by a high cadre to family ratio (75 to 447 in Nanggela).

The cadres also had good knowledge in all three areas. Some decline in their teaching frequency was apparent in these villages compared to the new villages.

2. Was the community approach well designed? How well is community management working in the village? What is the likelihood that the community will be able to sustain their activities?

Generally the community approach had been well implemented, but the evaluators thought the project would have been of greater assistance if it had focussed on the Kecamatan team. Of course, the question arose as to whether the field officers would have had the intensive understanding or self-confidence necessary to assist the Kecamatan team before they had participated in the village-based experience. The Kecamatan training teams, according to Dr. Otang, need strengthening in supervision and assistance techniques. The Puskesmas doctor in Ciwaringin concurred and suggested that he needed the support of the inter-sectoral training team. Further, in that the turn-over of puskesmas doctors is high, it was suggested that CARE should focus on the more permanent puskesmas staff and other members of the inter-sectoral training team. CARE interpreted these comments to be supportive of the new strategy.

The LKMD and LMD did not know their roles well in either village. The Kepala Desa in Walahar was weak in his leadership, but an informal leader was effectively coordinating cadres in three of the village's five dusuns.

3. **How would you evaluate the approach used in this village? Also, indicate whether it could be used by the government or an indigenous PVO.**

Part of the success of the 1986 strategy appeared to be due to the CARE field officers living in the villages. The evaluators strongly preferred the revised strategy as by inference apparently did the Camat in Mandirancan and the doctor in Ciwaringin. Further, the evaluators recommended involving Kanwil in selecting the Kabupaten in which to work. The Ciamis dokabu strongly suggested informing both Provincial and Kabupaten levels. In West Java, the provincial health office primarily knew about CARE's water program.

Although it may be too early to conclude that the program in Ciamis is as effective as the old strategy, the 1986 strategy was definitely personnel intensive and difficult to replicate; however, an International PVO is considering the approach.

A national PVO might be able to use the 1986 strategy without too much difficulty. The unique part of the approach is its focus on participatory development. Possibly it would be useful to use the approach in combination with a teaching institution.

B. For newly started West Java villages:

- 1. Assess the effectiveness of the implementation to date; i.e., does everyone (government staff, CARE staff, and village leaders) know their role in the project, what it will accomplish, and what they are supposed to do?; do the cadres and village leaders know and do what they are supposed to?; are the mothers learning the information and practices they are supposed to? Also, in particular discuss field officer orientation, training and support adequacy and additional requirements for this approach.**

A misunderstanding that became apparent to the evaluation team is that the government staff thought CARE's plan was to implement the project in the replication sites in the same manner as in Ciomas. Furthermore, there is a major expectation that a water project will follow the health activities. Otherwise, most know and perform their expected roles.

The Kecamatan PKK knows its role and is carrying out supervision and monitoring. The mothers knew the answers to the knowledge questions, but in some of the lessons the wording was too technical (e.g., "protein" instead of "body-building"). Of note was that where the cadres were religious teachers they seemed to be especially good and motivated.

- 2. Evaluate the community's and women's participation in planning and implementing this project and make recommendations as to ways to improve them.**

The project appears to have high community participation and does involve the PKK, therefore women. The team urged that women and the PKK be involved not only in implementation and supervision but also in self-survey, assessment of the problems, and planning the approach. Planning with the community is hard, but strengthening the PKK's involvement would be desirable. Several evaluators raised the issue that the community involvement increased workloads of the village and kecamatan officials. A second issue concerned whether there was any way to add in income generation or financial

subsidy to cover these increased costs. Such an activity could supplement government outreach through the community's subsidizing it. Of course, the problem would be the replicability of an income generation subsidy.

3. Review the strengths and weaknesses of CARE's work with the government and community leaders involved in training and the training and teaching methods used and make recommendations where appropriate for improvement.

CARE uses the government's approach (mini-Lokakarya, selection of cadres, self-survey, planning of the program, etc.). The difference is in the results, according to the evaluators. According to health department members of the team, the government has no skilled facilitators in using this approach in many areas. Without effective preparation, village motivation is low. CARE provides skilled facilitation. The government realizes that the problem is implementation due to the lack of skills and awareness. The government concept is good but not the results.

CARE has an excellent training approach; however, the evaluators suggested increasing the contact with national and provincial government health officials.

CARE makes a contribution with its teaching approach at the village level. Even the villagers realized the teaching approach was different and learned from it. The evaluation team's consensus was that CARE uses the mini-Lokakarya as well as nonformal teaching techniques effectively.

The evaluation team members made the following suggestions:

Use the Depkes health education modules in training the cadres.

Include follow-up in-service training in the program.

Increase communication with the national and provincial health departments about what CARE is doing.

4. **Assess the potential of this approach for sustainability and replicability by the government or IPVOs.**

The team generally concurred that the strategy would be useful for government trainers and other PVOs in working on the Kecamatan to village levels. It was even found that one district head was interested in how to apply the approach to other programs besides health.

Questions arose about the following issues:

Does funding exist on the Kecamatan level for adequate monitoring and supervision? Would the technique apply to more sparsely populated areas?

Further findings were that at least one Kabupaten provides 12 liters of fuel a month per Posyandu supported and that in some cases the communities themselves generate income which might be used for support of supervisory visits.

C. General Recommendations:

1. **Evaluate the strategy: is it a good idea? Make recommendations for improving it as appropriate.**

The team thought the modified (May 1987) strategy was a good idea. The level of input and the length of work at the Kecamatan level seem to be appropriate.

To improve the strategy, there was a general consensus that liaison with all levels of Depkes needed to be increased.

On the national level, liaison with PKK and CDC was suggested. It was also stressed that an agreement in principle on national and provincial levels would be desirable and that implementation details should be worked out on district and sub-district levels. The project needs to concentrate on mini-planning with the puskesmas. Increased liaison with LKMD might be helpful, but it was pointed out that LKMD is primarily concerned with physical, not operational, development.

Further address of the possible costs of increased activity by the government training teams was also recommended.

2. Do you think this project as currently constituted should continue beyond the next year?

The team recommended a longer term input at the Kabupaten level. For this, provincial negotiations would be required. For the future, some work with the Kabupaten training team would be desired, at least presenting the approach and effects.

3. For the project to be adaptable by the government and/or local PVOs, what changes would you recommend? What strategy would you use for adaptation?

The recommendation was to include the mini-planning and an up-front discussion about what additional expenses might be incurred by this approach. The project's experience needs to be shared with PVOs and the government. One suggestion was that the Kecamatan training team present what was done at least to the Kabupaten level. Another suggested approach would be to make a video of the effects and the steps which were used to achieve them.

4. Given the adaptations you have recommended, with what time-frame, what input (i.e., training, village organization, materials development, etc.), and at what levels of government would you suggest CARE work in any future continuation?

This question was not discussed at length. The recommendations of responses 1 to 3 are applicable and provide the desired information.

5. Do you have any recommendations as to the adequacy and appropriateness of the monitoring and baseline information/evaluation plans?

The only strong recommendation was to make sure that the community knew the results of the baseline and to involve the community in self-survey as much as possible.

6. Should CARE have acute respiratory infection (ARI) specific teaching or activities? If so, what?

Various team members concurred that an intervention against ARI would be appropriate. The Dokabu of Ciamis indicated he would be very supportive. CDC has cadre training modules for diagnosing severity and referring as well as simple prevention. The Kabupaten of Ciamis is piloting an intervention including treatment of severe cases by cadres using cotrimoxazole.

II. Questions for East Java Evaluators:

1. Is the CARE workplan appropriate and well designed? Consider the following in your response:

- a. Is there an appropriate role for the project in East Java? Should the project only focus on health education in support of the water project (i.e., hygiene and ORT education) as opposed to Posyandu?

- b. What is the government's reaction to the VPHC project and assessment of what CARE offers it in health?

Yes. There is an appropriate role for CARE. CARE's contribution should be in techniques to facilitate community motivation. The recommendation is to work with the puskesmas in how to motivate communities to support Posyandus. CARE's role might be in-service and refresher training and direct facilitation of the work with the communities.

The CARE field officers initially offended the puskesmases in beginning work including the baseline (which produced results very different from the health department's) without discussing the approach, uses, and purpose of the survey with them. This offense has largely been overcome. Relations are especially good with the Dokabu. The additional recommendation would be for the field officers to report activities and plans to the health staff for discussion and coordination.

2. In that you concluded that CARE should proceed in East Java, do the following:

- a. Briefly assess what has been done in East Java and the staff's capabilities;

- b. Assess the appropriateness of past and future project sites;

- c. Make recommendations as to ways to improve the workplan and what support services are required (guidance from CARE Jakarta, training, etc.).

The team's assessment was that the workplan was very good, but, despite excellent relations with the government, VPHC staff left the government out of the planning process. The VPHC staff need to be more cooperative.

Furthermore, in that they are not health professionals, it was recommended that project field officers receive further health training and be more consultative with the puskesmas doctors, realizing that VPHC does not have health or medical expertise. The field officers are recognized for their skills in community development and education. Furthermore, they need training and support in coordinating with officials.

The evaluators recommended preferably selecting villages that are not well organized. The problem, however, is that CARE has stated that it will work in sites having the water program.

Further suggestions included consulting with Kanwil about addressing ARI and providing supplementary training for referral and prevention.

The evaluators suggested that CARE make a prompt decision if it does not plan to continue the program in East Java.

Further needs include more technical supervision and direction from Jakarta and a project manager for the province.

III. The NTB findings of the evaluation team were as follows:

- 1. Do CARE and the NTB Provincial Department of health have a common understanding of the workplan? What should CARE do to improve coordination and cooperative planning in the future?**

A general understanding and acceptance of the workplan exists, but the evaluation team found that CARE needs to go through a formal approval and planning process with the provincial government. Although the officials agreed that CARE could proceed in implementing the new strategy, they indicated the need to go through the following process:

Bappedda, the government planning body, should invite concerned members of the Governor's team, especially Kanwil, and the Dokabus and Puskesmas doctors and CARE to meet, discuss the work plan, and do mini-planning. The workplan will include a satisfactory monitoring and evaluation system. The baseline survey will be used to the greatest extent possible with only general data collection to be modified (i.e., other than by survey). Future

projects can have additional community surveys jointly planned and implemented. Bappeda cannot convene a meeting before September 28th due to prior commitments; however, it was agreed that any further deliberations needed to be expeditiously resolved.

Kanwil agreed that, in that the CARE project is a pilot activity, modifications to support Posyandu, especially Tables 3 and 4 (KMS card marking and health education, respectively), could be tested as to their effectiveness and sustainability. Input in these areas would be especially welcome. Project staff further explained that the pilot consisted of: 1) Techniques for increased community support of and organization for management of Posyandu; 2) An approach to increased, sustainable community education; especially regarding nutrition and control of diarrheal diseases, and 3) A community-to-community replication procedure. Kanwil generally consented to the concepts.

The team further found that CARE needs to clarify the expected roles of Project Staff and the various government participants with Kanwil, arriving at agreement as to the expected inputs by all parties and the expected output indicators for evaluation. Furthermore, areas in which the consultative process is essential for any approach modifications (e.g., technical health teaching and those affected by government policy) and those in which the project has managerial discretion need to be resolved.

The health officials stated that the problem with the workplan at present is that the government has produced a new cadre training curriculum with which the CARE workplan may not comply. They said they need to review the workplan in light of the new curriculum. It also seemed that there was dissatisfaction with the consultative process, that in retrospect the officials realized they had not gone through all the appropriate procedures, and that they possibly wanted the project to indicate their collaboration in it on the title page (e.g., not "VPHC, CARE NTB" but "VPHC, A Joint Collaboration Project of CARE NTB and Kanwil-NTB").

CARE's major concern at this point is two-fold: Cadre training needs to be jointly planned and implemented by CARE and the puskesmas/Kecamatan staff starting in October; and is it still mis-perceiving the Kanwil's reservations and wishes? (CARE had thought until the time of the evaluation that it understood the correct procedures and had received approval of the work plan, only to be told that additional consultations were

necessary.) Furthermore, even though CARE has been told at Kanwilkes to proceed with implementation, the staff fear that it having been stated in the hearing of two of the involved four puskesmas doctors, Kabupaten health representatives, and an involved Camat, will interfere with implementation. Although it is clear that the present procedures are an improvement over the past, CARE's question remains whether they will expeditiously result in a common understanding. CARE has been reassured that this is the government's intent.

2. **How effective has CARE been in assisting the Puskesmas doctors to establish community managed, effective Posyandus and baby weighing activities? What should be improved?**

Generally, the government evaluators focussed on their dissatisfaction with CARE's coordination with the health department above the puskesmas level. A major cause of this was found to be the lack of resolution as to the appropriate counterpart, a problem which CARE believes will be resolved in the meetings to be called by Bappeda. The only pending problem is the lack of a letter of understanding. Kanwilkes has agreed that this should not stop project implementation. The general conclusion was that consultation and communication with provincial, district, and sub-district health and government officials should be strengthened. Bappeda will take the lead in this process.

The coordination with the Puskesmas doctors was found to be generally good but that the CARE field officers need to participate in mini-planning with them. The two Puskesmas doctors interviewed were generally very enthusiastic as to the benefits of having the field officers in the communities. One cited a list of techniques learned from the project field officers for approaching communities.

The evaluation team generally concurred that community involvement and the cadre activity level was impressive in the two hamlets visited; however, it was suspected that these were largely due to the continued presence and involvement of the project's field officers.

The team found that, although some of the mothers and many of the cadres knew some diarrhea messages well and about some aspects of Posyandu and the KMS card, the completeness and quality of this understanding was far from the desired levels. The health department officials, however, found that the full Posyandu is not being implemented nor understood. In that neither a

training program to teach the cadres to teach this information nor a community teaching program has been implemented to date, these findings should not be viewed as surprising.

3. **Is the work plan seen to be feasible (community management, group health education, village to village training, and cooperation with district inter-sectoral training team. What would improve it?**

The group had hesitations about the feasibility of village-to-village training despite some citations of its effectiveness. The key to the project's success was suspected to be the continued monitoring, not inter-sectoral training. The group withheld further judgment pending the discussions envisioned responses to question 1. above.

4. **Is the work plan in line with policy guidelines?**

The evaluation team withheld judgment pending the review of the government consultative group. The impression of the team leader is that there is no known conflict.

5. **Would the training model be adaptable to other areas of NTB? If so, under what conditions?**

Major problems or questions the evaluators expressed about the activities were the impression that the communities were too dependent on the project's field officers, whether the project would be sustainable without the field officers, whether replicability was highly dependent on the provision of a water supply and the presence of a field officer, and whether the project approach would work in communities with poor socioeconomic conditions. CARE agrees that all of these factors may influence the success of the project but feels that the design will test many of them.

6. **What costs will the local governments need to plan to take over (for example, transportation costs of the training team, training materials or Posyandu supplies)?**

It was agreed that CARE needs to document the costs of the different interventions, the estimated importance of each input, and present them to the government with adequate pre-warning for budget consideration. There was no further consideration of the costs of interventions at this point in that none other than the intensive involvement of the field officer was visible.

7. On what conditions should CARE be considered for a role after October 1988? For how long? In what areas? and How negotiated? (For example, work with other kabupatens, work on kecamatan or kabupaten level, etc.)

Further response to this question depends on program implementation, including planning for the future. The provincial agreement will depend on the government budgeting procedure and plans which will not be resolved until the end of November, 1987. CARE pointed out to the various parties that it would need at least tentative agreement as to a potential future joint collaboration by mid-November if it were to have a follow-on to the present activity. The Kakanwil expressed interest in services to socioeconomically difficult communities and strengthening Table 4 (education about the weighing results) of Posyandu. As long as the project and the related government agencies work together, no impediment to joint collaboration was foreseen.

Other:

Evaluation and monitoring plan: There was general concurrence with Kanwilkes that the baseline survey is adequate. The basic evaluation plan is seen as acceptable. Some additional indicators may be suggested following the Bappeda-initiated review. The provincial health officers strongly recommended a post-intervention evaluation of sustainability of the sites, occurring anytime from 6 months to 3 years after the CARE field officers left the sites.

The evaluation team further calls the attention of CARE Indonesia to the problems caused by: 1) Not compensating counterpart expenses which the project necessitates beyond their normal responsibilities (e. g., travel costs); 2) The absence of participatory planning with the counterparts; and 3) The lack of an agreement with Depkes.

Recommendations

The evaluation team made many recommendations as individuals and only a few with overall consensus. This section will attempt to reflect both.

Consensus recommendations were to increase and improve the quality of overtures to the provincial and where lacking to the district health offices, showing a spirit of collaboration in this process. Part of this process should involve a more

consultative approach, not the presentation of a final document for "approval". In the future and at present as much as possible, project representatives should present the broad outline of the approach, expected benefits, areas of expected consultation and collaboration, suggested indicators, and budgetary implications for discussion and modification. Another recommended step would be to share monthly progress reports and intended future directions. Finally, the evaluators encouraged the use of the government's newly revised cadre training modules to the greatest extent possible.

Additional recommendations address specific aspects of VPHC focus and methodologies and province-specific suggestions. The following do not represent consensus judgments but should be considered by the national project coordinator:

Further recommendations to improve government liaison and coordination:

Liaise with Depkes CDC and PKK at the national level.

Strongly consider a letter of understanding with the Ministry of Health.

On the provincial level, Kanwil should at least participate in strategy review and the definition and evaluation of impact indicators.

Concerning teaching:

Some of the evaluators suggested focussing on support of Table 4 of the Posyandu, the table where mothers are advised as to their children's nutritional status and what they should do about it.

To increase effectiveness of the intervention, the project should continue to focus on obtaining the support and participation of religious leaders and teachers.

For sustainability:

The project should always investigate and enlist, where feasible, the supervisory support of the PKK.

The project should plan for follow-up trainings for the training teams in the new strategy sites.

Also, to increase the Posyandu sustainability through envisioned activities, the project staff should attempt to document increased travel costs and coverage benefits due to outreach by the training team and present them to the local government for consideration of support.

A post-intervention evaluation of sustainability of the sites should be conducted from between six months to three years after CARE leaves them.

For replication:

Introduce the "kring" reporting system being used by the West Java staff as broadly as possible to encourage that all leaders understand the implementation process and activities in other hamlets and villages.

Arrange presentations to Kabupaten and Provincial health officials of project methods and successes, enlisting local health, government, and village participants in the presentation process.

Try to form a relationship with a training institute that might be able to carry-on the process and incorporate it in its basic curriculum.

West Java:

Consider an ARI intervention in Ciamis, consulting with the Dokabu and using CDC modules for training the cadres.

The CARE Chief Representative and Senior Program Officer should provide more status and support to VPHC activities, visiting sites for ceremonies and representing the project with Kanwil.

CARE staff also need to clarify the intended process regarding input level in replication villages and the possibility of a water project follow-on.

East Java:

The project's role should be to focus on community participation and education techniques as a complement to puskesmas activities.

Project staff need to be more consultative with the puskesmas about health matter, always remembering that the doctors are the health experts.

The National Coordinator needs to provide more technical support.

Train staff further in health and in techniques for consulting with doctors and other officials.

NTB:

Plan with the Bappeda invitees the specifics of the work plan, especially regarding messages and evaluation indicators. Discuss joint authorship and possible support for attendance at meetings and joint evaluation expenses. Clarify roles and expected inputs and participation of all collaborators, CARE, officials, and doctors.

Do mini-planning with the puskesmas doctors.

Document CARE field officer site visits and functions each month. Also record increased puskesmas and other staff's visits.

Ensure that project field officers and the cadres understand Posyandu and the various levels of Posyandu.

Support Table 4 (teaching from the KMS card) of Posyandu both in what occurs there and through community teaching.

Begin community education system as soon as possible (i.e., with puskesmas participation and when the government has approved the content of the messages).

Appendices

- A. Review Participants
- B. Sites Visited

Appendix A

Review Participants:

The evaluation participants in West Java were the following:

Dr. Otang	Dokabu, Dinkesmas, Ciamis, West Java
Dr. Hadi Pratomo	School of Public Health, U.I., Jakarta
Mr. Mohamad Bastari	Directorate of Community Participation, Dir Jend Binkesmas, Depkes, R.I.
Mr. David Kurth	Project Concern International, Southeast Sulawesi, R.I.
Mr. Chris Roesel	Regional Technical Advisor, CARE-Asia

The evaluation participants in East Java were the following:

Ms. Lalit Kraushaar	Child Survival Coordinator, USAID, Indonesia
Mr. Mohamad Bastari	Directorate of Community Participation, Dirgenl Binkesmas, Depkes, R.I.
Mr. David Kurth	Project Concern International, Southeast Sulawesi, R.I.

The evaluation participants in NTB were the following:

Dr. K. Gerudug	Yankesmas, Kanwil Depkes, NTB
Dr. I.G.P. Wiadnyana	Directorate of Community Participation, Dirgenl Binkesmas, Depkes, R.I.
Dr. Hadi Pratomo	School of Public Health, U.I., Jakarta
Dr. David H. M.	Dinkesmas, Lombok Barat, NTB
Mr. Supardi	Dinkesmas, Lotim, NTB
Mr. Chris Roesel	CARE-Asia

Also in attendance were:

Maruly Siregar	Secretary of Collaboration Program, NTB and CARE, Bappeda TK I
W. Natsir Basri	Bappeda TK I
Abu Masjunin	Camat, Narmada, Lombok Barat, NTB
Sri Peni Tjahjati	Dr. Puskesmas Sedau, Narmada, Lombok Barat, NTB
Erwinanto	Dr. Puskesmas Gerung, Lombok Barat, NTB
Muljanto	CARE NTB
Chris Sherringham	CARE NTB
CARE VPHC Field Officers	CARE NTB

Appendix B

Sites Visited:

West Java:

Ciomas and Kertamandala villages, Kecamatan Panjalu,
Kabupaten Ciamis
Walahar village, Kecamatan Ciwaringin, Kabupaten Cirebon
Nanggela village, Kecamatan Mandirancan, Kabupaten Kuningan

East Java:

Pacitan: Wiyoro Village
 Sidomulyo Village

NTB:

Dusun Lembah Sempaga, Sesaot village, Kecamatan Narmada,
Kabupaten, West Lombok
Dusun Messanguk, Gapuk village, Kecamatan Gerung, Kabupaten
West Lombok

ATTACHMENT #6

SUMMARY DESCRIPTION OF

VPHC MONITORING INSTRUMENTS 1988

Attachment #6

Summary Description of VPHC Monitoring Instruments 1988

The following is a summary of the monitoring instruments the VPHC staff developed in an effort to monitor the project activities.

Program Instruments

Kader Activity Monitoring Forms ("Buku Perkembangan Kegiatan Kader") are used by kader to help them track women and children in the 10-20 families for which they are responsible. The idea is that having health records at the local Integrated Health Post (Posyandu) -- which only meets once a month and is often several kilometers away -- is not enough in itself to enable kader to identify which women and children currently require special assistance. CARE has tried to limit the scope of the areas covered by these forms so that kader are not overwhelmed by either the amount or complexity of the information gathered. The primary areas covered are growth monitoring and immunization with some attention also given to family planning, and the occurrence and treatment of diarrhea.

Integrated Health Post Registers such as the Baby and Child Register are intended to assist specially trained Posyandu kader and government health workers from the Community Health Center both in preparing for the next Posyandu session to be held (e.g. number of children needing DPT immunizations this month) and in evaluating previous ones. In addition this register serves to alert kader to high risk pregnancies and cases of malnutrition. CARE has tried to encourage GOI counterparts to adopt a format identical to the Kader Activity Monitoring Form mentioned above for use as an Integrated Health Post Register in order to reduce the number of different forms used, but CARE has met with limited success to date. Due to the demands of GOI's many central bureaucracies, District and Subdistrict level counterparts have been reluctant to change. As a result, CARE is still in a state of transition with regard to the forms used at this level and at the village and subdistrict Puskesmas levels.

KAP Surveys CARE used two types of Knowledge Attitude and Practice (KAP) surveys. The first was a large scale baseline/impact survey conducted by outside surveyors once each year and the second being small scale self-surveys conducted by village kader and CARE field staff on a trimesterly basis. The actual contents of the two surveys is only marginally different and focuses almost entirely on indicators measuring target women's knowledge in the areas of Immunization, Diarrhea, Nutrition, Family Planning and Mother and Child Health Care (the latter two apply only to the East Java at the moment). The major difference between these surveys lie in their respective methodologies and objectives. Whereas the goal of the impact/baseline survey is to provide the CARE/GOI Management Team with a reasonably objective and scientific assessment of the program's impact on a yearly or even bi-yearly basis, the self survey has two major objectives, the first being to involve

target communities in the evaluation process to the greatest extent possible, and the second being to give the CARE/GOI Management Team a rough (+5%) estimate of program progress on a more or less instantaneous basis (ideally the turn around time for self survey should be no more than a week, including tabulation and presentation). CARE is still working out several small bugs in the methodology, but believes that the self survey can achieve both its goals effectively and economically.

Target Group Registers: These registers assist village leaders and CARE field staff both in preparing for KAP surveys and in monitoring program coverage in a particular community. They are an inexpensive alternative to more comprehensive census forms which can also be used in cases where GOI counterparts express a strong interest.

Village Profiles are filled out by CARE field staff on an annual basis (usually at the same time as the KAP survey) and serve to provide information on physical indicators such as percentage of malnourished children, percentage of children receiving certain types of immunizations, mortality and morbidity rates, as well as a rough picture of the population's general condition.

Kader Activity Book is a simple instrument designed to assist kader in keeping track of what they have taught and to whom.

Management Instruments

One of CARE's most useful tools for monitoring progress at the field level has been the **Planning, Implementation and Evaluation (PIE)** which is prepared by each field office every four months. The PIE lists project activities and measures level of accomplishment. The field staff clearly understand how to prepare and use this monitoring instrument. The evaluation team has reviewed the PIE reports, prepared in FY 88 and found them to be very comprehensive.

VPHC Detailed Work Plans are prepared every three - four months by the Program Managers in each office based on their Annual Detailed Implementation Plans (see FY 1987 Annual Report) as well as on the indicators described in their PIEs. The purpose of the form is to assist Program Managers in the planning and monitoring of their staff's activities on a weekly basis.

PIE Monitoring Forms for Field Staff were developed to assist Field Officers in tracking PIE indicators for which they are responsible. At present, it is being implemented by the NTB office on a trial basis. There is some concern that it places too much burden on the Field Officers and only serves to confuse them because of its relatively complex format. At the end of FY 1988 a recommendation will be made to continue or discontinue using the form or a modified version. It is very likely that a new instrument combining selected indicators from the PIEs with several additional indicators designed to assist Field Officers in assessing program quality on a routine basis (e.g. determining that Posyandu registers are maintained accurately, spot checks on kader

follow-up with malnourished children and percentage of planned monthly supervisory activities which were actually carried out by the subdistrict Management Teams) will be developed in the near future to replace the PIE Monitoring Forms.

A key point to note is that each CARE Field Office has its own variation of the instruments mentioned above due to constraints imposed both by its relationship with its particular provincial/district level GOI counterpart and by the particular conditions of its program area.

Additional Monitoring and Evaluation Forms Used by the VPHC Project

Laporan Bulanan Kelompok Penimbangan. This is a government form filled in at each Posyandu occasion by kader. Recorded are the number of children; who have been weighed, have increased in weight, are severely malnourished, and received Vitamin A.

Blanko Monitoring Balita. This form is used in VPHC sites to assist kader in monitoring of severely malnourished children.

Site Data Posyandu. The data form is for internal CARE use and compiles the results of Posyandu for all project sites each month.

Village Census Form. This form represents the data collected for each group of ten to twenty families (RKB-PKK groups) within the community.

Laporan RKB/PKK. Form submitted by RKB-PKK kader to the Village office on their activities each month.

Register Penimbangan Balita. Government registration and recording form for under fives attending Posyandu.

Keberhasilan Program. Form for monitoring program activity targets by CARE field staff every month.

Penelitian dari Rumah ke Rumah. House to house survey primarily to discover the level of knowledge of the programs health messages amongst mothers of under fives.

Travel Schedule. Travel Schedule are filled in monthly by CARE field and supervisory staff.

Monthly Target Form. Monthly work plans are filled in by CARE field and supervisory staff.

Monthly VPHC Supervisory Recommendation. Recommendations made to the CARE field staff by supervisors in order to improve performance and program development.

Survey Feedback Form. Form intended to assist feed back of survey results to kader and other village level program implementors.

CARE also tried to test the value of modifying growth monitoring procedures and include the introduction of a simple Master Chart. Age and weight data obtained monthly are converted into growth performance grades ("nilai"). Designers of the Grade System maintain that growth data in the form of "grades" are far easier for parents and kaders to understand, recall and use than the complex growth curves on the KMS cards. It also allows for the overall status of the weight of children under five years to be analyzed at a hamlet, village or even subdistrict level to be monitored easily and compared with previous month's results, instead of having to refer back to each child's individual growth card. This "Nilai" system was implemented in 12 villages in West and East Java. CARE has not yet formally evaluated the system to determine its possible benefit.

ATTACHMENT #7

IMMUNIZATION RATE

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Attachment 7

CALCULATIONS FOR RATE DATA FOR PVO
CS I FINAL EVALUATION
(THE ANSWER OF USAID CS I FINAL EVALUATION GUIDELINES)

1. Percent series completion by antigen for priority EPI groups, during the past twelve months.

PILOT PROJECT SITES	COVERAGE OF INFANTS				
	%BCG	%DPT3	%Folio3	%Measle	%TT2
Panjalu Subdis (WJ)	27.2	29.4	29.4	34.4	21.6
Wanaraja Subdis (WJ)	30.8	27.8	27.6	26.6	-
Kebon Agung Subdis (EJ)	34.1	37.8	37.8	29.4	-
Gerung Subdis (NTB)	34.8	53.6	53.6	33.3	-
Narmada Subdis (NTB)	76.0	66.8	67.1	56.0	-
Gangga Subdis (NTB)	21.2	28.0	28.0	11.8	-
Aikmel Subdis (NTB)	57.5	57.5	60	67.5	-

2. Project ability to target/focus on infants during the past 12 months.

% INFANTS COMPARED TO % UNDER 5

Panjalu Subdis (WJ)	34.4 : 5.1
Kebon Agung Subdis (WJ)	36.8 : 13
Ngadirojo Subdis (EJ)	150.7 : 43.5
Narmada Subdis (NTB)	78.5 : 21.2
Gerung Subdis (NTB)	536.0 : 145
Aikmel Subdis (NTB)	725.0 : 166.6

3. Dropout between initial and final immunization in the past 12 months.

	%DPT	%Polio	%TT
Panjalu Subdis (WJ)	14.5	3.2	12.2
Wanaraja Subdis (WJ)	9.8	9.8	6.8
Kebon Agung Subdis (EJ)	15.3	15.3	22.1
Ngadirojo Subdis (EJ)	32.4	32.4	35.4
Gerung Subdis (NTB)		no data	
Narmada Subdis (NTB)	21.0	19.0	-
Gangga Subdis (NTB)	+16.3	+16.3	-
Aikmel Subdis (NTB)	20.7	17.9	

Percent of infants (0-11 months) who received the following immunization series:

	West Java	East Java	NTB
BCG Vaccination	30 %	40 %	
DPT3 Vaccination	28 %	37 %	
Polio3 Vaccination	27 %	37 %	
Measles Vaccination	28 %	30 %	

Percent of eligible mothers who received

TT2 Vaccination 15 %