Detailed Implementation Plan

CHOICE

Child Health Opportunities Integrated with Community Empowerment

A partnership between PCI, USAID, MoH, NGOs and communities in Indonesia

Pandeglang District, Banten Province
October 2003- September 2007
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ACRONYMS
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ARI	Acute Respiratory Infection
AusAID	Australian development agency
AVSC	American Voluntary Service Corps
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin (vaccine against tuberculosis)
BEHAVE	The "BEHAVE Framework" for Behavior Change Programming
BFHI	Baby Friendly Hospital Initiative
BKPPASI	Working Group for Breast Feeding Practice Promotion
CATCH	Core Assessment Tool on Child Health
CDD	Control of Diarrheal Disease
CEI	Community Empowerment Institution
C/HH-IMCI	Community-Based Household Integrated Management of Childhood Illnesses
CHANCE	Community Health and Nutrition through Community Empowerment
CHOICE	Child Health Opportunities Integrated with Community Empowerment
CIDA	Canadian International Development Agency
CORE	The Child Survival Collaborations and Resource Group
CRC	Convention on the Rights of the Child
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CSSA	Child Survival Sustainability Assessment
CSTS	Child Survival Technical Support
DANIDA	Danish International Development Agency
DD	Diarrheal Disease
DHO	District Health Office
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DOTS	Directly Observed Therapy Short-Course
DPRD	District Legislature
DPT	Diphtheria-Pertussis-Tetanus
EBF	Exclusive Breast Feeding
FGD	Focus Group Discussions
FWO	Family Welfare Organization
GMC	Growth Monitoring Cards
GOI	Government of Indonesia
HFA	Health Facility Assessment
HH	Household
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrom
HKI	Helen Keller Internatiional
HPN	Health, Population & Nutrition (Division of USAID)
IA	Institutional Assessments

IDHS	Indonesian Demographic and Health Survey
IEC	Information, Education and Communication
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illnesses
IO	International Office (of Project Concern)
IPC	Interpersonal Communication
IR	Intermediate Results
I-STAR	Integrated System for Transformation, Assessment and Results
ITN	Insecticide-Treated Net
JHPIEGO	A nonprofit organization affiliated with Johns Hopkins University
Kaders	Indonesian volunteers trained to implement community-based activities
KMS	Road to Health Card
KNCV	An Indonesian Tuberculosis Agency
KPC	Knowledge, Practices and Coverage
LLR	Lower Level Results
LOE	Level of Effort
LOP	Life of Project
MCH	Maternal and Child Health
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
MW	Midwife
NCHS	National Center for Health Statistics (U.S.)
NGO	Non-Governmental Organization
NSS	Nutrition and Health Surveillance System
OR	Operations Research
ORS	Oral Rehydration Salts
PCI	Project Concern International
PD	Positive Deviance
PKK	Women's Group for Family Welfare
Posyandu	Indonesian community-based health support program
PPTI	Indonesian Tuberculosis Control Association (an NGO)
PRA	Participatory Rapid Appraisal
PTC	Provincial Training Center
Puskesmas	Indonesian Government Public Health Center
PVO	Private Voluntary Organization
QA	Quality Assurance
QI	Quality Improvement
QIVC	Quality Improvement Verification Checklist
RDPB	Regional Development and Planning Board
SCAT	Simple Capacity Assessment Tool
SD	Standard Deviation
SEAMEO	South East Asian Ministers of Education Organization
SO	Strategic Objective

SODIS	Solar Disinfection of Water
STI	Sexually Transmitted Illness
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TIP	Trials of Improved Practices
TKA	*Tumbuh Kembang Anak* (*Posyandu* for survival, growth and development)
TT	Tetanus Toxoid
UNHAS	Hasanudin University of Makassar
UNICEF	United Nations Children's Emergency Fund
USAID	U.S. Agency for International Development
USDA	U.S. Department of Agriculture
VHT	Village Health Team (Community Empowerment Institution)
VRB	Village Representation Board
W&S	Water and Sanitation
WHO	World Health Organization
YPSI	*Yayasan Pemerhati Sosial Indonesia* (PCI's Indonesian NGO Partner)

PCI CHOICE CHILD SURVIVALPROJECT
DETAILED IMPLEMENTATION PLAN (DIP)

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Child Survival Grants Program Project Summary

DIP Submission: Jul-30-2004
PCI Indonesia

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Project Information:

Project Description:	The ultimate goal of CHOICE is to improve the health and nutrition status of children under five, pregnant and lactating women, and mothers of children under five in the selected project area. This objective will be pursued through the achievement of three intermediate results, namely: 1) Improved access to quality maternal and child health care services, 2) Improved health-seeking and care-giving behaviors among caretakers, and 3) Successful implementation of PCI's community-based health development model by partner NGOs. CHOICE will employ a participatory program strategy which involves improving the quality and accessibility of facility and community-based health services; increasing community knowledge and skills and encouraging the adoption of key health-promoting behaviors; the establishment and strengthening of

	village-based health planning and management institutions;capacity building and partnership with local NGOs; and close collaboration with district health authorities.
Partners:	Yayasan Pemerhati Sosial Indonesia District Government of Pandeglang
Project Location:	Padeglang District, Banten Province, Indonesia

Grant Funding Information:

USAID Funding:(US $)	$1,499,739	**PVO match:(US $)**	$664,063

Target Beneficiaries:

Type	Number
0-59 month old children:	10,732
Women 15-49:	9,251

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
(No Data)	100%

General Strategies Planned:

Social Marketing
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Participatory Rapid Appraisal
Participatory Learning in Action
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing
Peer Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
CS Project Team	Local NGO Networked Group	Traditional Healers	Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions:

Immunizations 5 **%**
** IMCI Integration
** CHW Training
** HF Training
Nutrition 10 **%**
** IMCI Integration
** CHW Training
Acute Respiratory Infection 20 **%**
Control of Diarrheal Diseases 20 **%**
Maternal & Newborn Care 20 **%**
Breastfeeding 15 **%**
Tuberculosis 10 **%**

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	107	456	23.5	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	250	269	92.9	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	71	450	15.8	0.0

Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	11	16	68.8	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	63	130	48.5	0.0
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	65	73	89.0	0.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	48	94	51.1	0.0
Percentage of children age 12-23 months who received a measles vaccine	58	94	61.7	0.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	129	450	28.7	0.0
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	80	109	73.4	0.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	6	450	1.3	0.0

Comments
The module on HIV/AIDS was excluded from the KPC because after detailed discussions with partners, the project staff felt that the question were too sensitive and might cause some people to decline to participate further in the study.

A. EXECUTIVE SUMMARY

Project Concern International (PCI) is implementing the CHOICE (Child Health Opportunities Integrated with Community Empowerment) child survival and health project for Pandeglang district in Banten Province, Indonesia. CHOICE is a 4-year standard category project, which began on October 1, 2003, and will end on September 30, 2007. The total budget for the project is $2,163,802, including $1,499,739 in USAID CSHGP funds, and a PVO cost share of $664,063, or 31% of the total.

Pandeglang district of Banten Province lies at the western end of the island of Java. Within Pandeglang, the project interventions will be concentrated in the four most needy sub-districts, namely Patia (5 villages), Angsana (5 villages), Pagilaran (10 villages) and Saketi (10 villages), for a total of 30 villages. The direct beneficiary population in these villages includes 10,732 children under five and 9,251 pregnant and lactating women and mothers of children under five. In Pandeglang, approximately 62% of families live under the government-defined poverty line. With an infant mortality rate of 67.32/1,000 live births (Susenas, 2002) compared with 37 nationwide, Banten reports some of the worst child health indicators for the whole of Indonesia. The latest Indonesian Demographic Health Survey (2002-03) shows that Banten has the lowest percentage of full immunization coverage in the country (25.4%, as compared to the national average of 51.5%). The Health and Nutrition Surveillance System in Rural Banten (December 2002-March 2003) conducted by Helen Keller International revealed that only 4% of mothers exclusively breastfed their children for 4-5 months. Anemia prevalence is about 61% among children 0-59 months, and 8% among children 12-23 months. The proportion of underweight children aged 0-59 months is 44%, and the prevalence of stunting is 47%.

The population's access and utilization of quality health services remains a serious problem in the area. Only 15.8% of births of children aged 0-23 months were attended by a health provider. Health providers also lack adequate knowledge for proper management of the major preventable and treatable childhood illnesses. In addition, communities have limited understanding of appropriate childcare and healthy behavior practices. Only 28% of mothers of children 0–23 months can identify at least two signs of childhood illness that indicate the need for treatment. Only 1.3% of mothers with children 0–23 months report that they wash their hands with soap/ash before food preparation, before feeding children, and after attending to a child who has defecated.

The ultimate goal of CHOICE is to improve the health and nutrition status among children under 5, pregnant and lactating women, and mothers/caretakers of children under five in the selected project areas. This objective will be pursued through the achievement of three intermediate results, namely:

1. Improved access to quality maternal and child health care services
2. Improved health seeking and care giving behaviors among caretakers, and
3. Successful implementation of PCI's community-based health development model by their partner NGO.

These intermediate results will be supported by eight lower level results, as outlined in the results framework. CHOICE will employ a participatory program strategy that involves:

- Improving the capacity of health facilities to develop a sustainable and appropriate system to improve the quality of maternal and child health services applying the IMCI approach
- Strengthening the capacity of community-based institutions to identify health/nutrition problems, mobilize local resources, and plan, implement and manage sustainable community-based health/nutrition programs
- Strengthening networking mechanisms between community-based institutions and health facilities in providing better quality of maternal and child health services

- Capacitating families/communities for sustainable behavior change
- Establishing and strengthening of village-based health planning and management institutions
- Capacity and partnership building with local NGOs
- Collaboration with district health authorities, *Puskesmas* (Government Public Health Center), and District/Sub-District Survival, Development and Protection of Children and Women teams
- Outreach and awareness raising designed to educate communities about tuberculosis (TB) in order to reduce discrimination and encourage care-seeking and treatment compliance

Particular interventions have been designed through a participatory process of community needs identification and planning. Further refinements will be made as the project progresses, and as needs and opportunities become clearer. PCI expects to devote levels of effort to the interventions as follows: Nutrition and breastfeeding (25%); maternal and newborn care (20%); acute respiratory infection (ARI) (20%); control of diarrhea disease (20%); TB (10%); and immunizations (5%).

The project will work with research institutions such as SEAMEO (South East Asian Ministers of Education Organization), a local university, and/or private consultants to conduct an operations research study on the *Posyandu Tumbuh Kembang Anak* (a *Posyandu* [local health clinic program] for survival, growth and development) to determine if a multi-sectoral model for an enhanced *Posyandu* can increase the utilization of the *Posyandu*, increase the competence of *Kaders* (community-based volunteers), and increase community ownership and sustainability. PCI has selected one Indonesian NGO—*Yayasan Pemerhati Sosial Indonesia* (YPSI - Social Concern Foundation of Indonesia)—as the local NGO implementer of the project, and has been collaborating with them during project start-up activities, including the administration of the Knowledge, Practices, and Coverage (KPC), Health Facilities Assessment (HFA), and rapid water/sanitation surveys, and Detailed Implementation Plan (DIP) development. Their primary role will be to plan and implement the community mobilization component, including the establishment of working relationships with and orientation of key community leaders, local government and *Puskesmas* staff/village midwives, training of village health teams (in collaboration with *Puskesmas* staff), and monitoring and evaluating project activities at the community level. Other core partners are the District Health Office (DHO), in coordination with the existing Survival, Development and Protection for Children and Women Team, who will provide adapted IMCI training for *Puskesmas* staff, as well as supervision, monitoring and evaluation of *Puskesmas*/midwife activities.

Since the original project design phase, and throughout proposal and DIP development, PCI staff has been working in close collaboration with USAID/Indonesia, in particular with Dr. Sri Durjati Boedihardjo, Health and Nutrition Program Advisor; Molly Gingerich, Director of HPN; Lynn Krueger Adrian, Deputy Team Leader, HPN; and Jonathan Ross, Public Health Advisor, HPN. CSTS (Dr. Michel Pacqué) also provided two weeks of technical assistance prior to and during the DIP workshop to advance the CS sustainability framework as a key element of the project strategy. During the workshop and several follow-up discussions, the PCI-CHOICE team thoroughly discussed the results of the KPC, HFA, and rapid water and sanitation surveys, as well as the sustainability strategy, with their NGO partner, the local government, and other sector representatives as part of the process of developing this detailed and focused implementation plan.

The main authors of this DIP are Dr. Agustini E. Raintung, PCI-CHOICE Project Manager, and Linda Morales, MA, PCI Technical Officer for Maternal and Child Health. Significant contributors include: Glenn Gibney, PCI/Indonesia Country Director; Irfani Darma, PCI/Indonesia Program Director; Dr. Herti Herjati, PCI-CHOICE Health and Nutrition Specialist; Kuat Karyadi, PCI-CHOICE Community Development/Training Specialist; Titien Kustini, Director of YPSI; and Janine Schooley, MPH, PCI Vice President for Technical Services and Program Development. Jenny Choi-Fitzpatrick, PCI

Regional Desk Officer for Africa and Asia, is the main contact person for the project at the PCI International Office.

B. CSHGP DATA FORM

The CSHGP Form has been inserted following this page.

Note: During the KPC design process, in-country project staff determined that certain questions should be omitted from the KPC survey. The KPC module on HIV/AIDS was not included because, after detailed discussions with partners, the project staff felt that:

1. The questions were too sensitive and might cause some people to decline to participate further in the study
2. The questions could be addressed during follow-up qualitative research, such as Focus Group Discussions (FGD), and
3. HIV is not a focus of this project or a major health concern in the target area, and therefore not worth the risk identified above.

C. DESCRIPTION OF THE DIP PREPARATION PROCESS

1. Project Start-Up Activities

Between September and November 2003, the CHOICE Project Manager and country office staff engaged in the following logistical and human resource start-up activities: identified a suitable location for the project office; addressed utilities issues; procured office furniture; and began hiring project staff. Several meetings with the local NGO (YPSI) and the District Health Office (DHO) were conducted to: (1) orient them to the CHOICE project; (2) discuss the project's future organizational structure, including the number of staff needed for project implementation; (3) plan the baseline survey; and (4) develop rapport and build appropriate working relationships. In October and December 2003, two core project staff—the Health and Nutrition Specialist and the Training/ Community Development Specialist—and two support staff were hired. In November 2003, an agreement was signed with the NGO partner, *Yayasan Pemerhati Sosial Indonesia* (YPSI), to conduct the baseline survey and field preparation activities for the period of 7 months (November 2003 – May 2004) (see Annex 3A for a copy of the Memorandum of Understanding [MOU]). A team of three consultants was hired to train supervisors and enumerators in conducting the KPC survey; collect, enter, process, and analyze data; and write the KPC report.

In addition, informal meetings with the United Nations Children's Emergency Fund (UNICEF) and KNCV (a Dutch-funded International agency supporting tuberculosis programs) were conducted to gather information on the projects they support in Pandeglang District. For example, UNICEF is supporting the local government in maternal and child health programs in selected villages of five sub-district areas. To avoid duplication, the local government suggested that the CHOICE project work in the areas outside the UNICEF target sites. However, one sub-district that is also being served by UNICEF was recommended to project staff since it is one of the neediest areas in which post-UNICEF interventions (their project cycle ends in June 2004) will be particularly important. The CHOICE Project Manager also met with Dr. Lukman Siregar, a representative of KNCV in Banten Province, to gather information regarding the National TB Program they support in this area. KNCV is working closely with all DHOs in Banten Province to improve the quality of TB services by implementing a Directly Observed Therapy Short-Course (DOTS) strategy to eliminate adult pulmonary TB.

Between September and November 2003, PCI/Indonesia conducted numerous formal meetings with the Pandeglang government authorities and with the head and staff of the DHO, as well as key officials from the Planning and Development Board. The primary objectives of the meetings were to: further enhance working relationships and ensure coordination; orient all partners and stakeholders to the project; share ideas regarding sustainable behavior change for the improvement of maternal and child health status; define the criteria of project area selection; prepare the baseline survey; and to prepare a draft of the cooperative agreement between PCI and the government of Pandeglang. Field visits were also made after defining the potential sub-districts to assess the challenges and opportunities of working in these areas, as well as to identify potential villages to be selected.

Collaboration with the local government requires a formal agreement between PCI/Indonesia and the government of Pandeglang. After being approved by the District Legislative Body (*Dewan Perwakilan Rakyat Daerah)*, the MOU was signed on February 4, 2004 (see Annex 3B).

2. DIP Preparation

The KPC training for supervisors was conducted in November 2003 with two staff members from PCI and five staff members from YPSI. This was followed by training for enumerators in early December 2003. Field visits to selected villages were also made prior to the survey to solicit support from sub-district and village authorities. Fifteen students from the Serang Nursing Academy were hired as enumerators and participated in the 4-day training on how to conduct the KPC survey. The KPC survey was conducted during ten days in the 30 villages, while data entry and processing took three weeks. After being trained by PCI staff in December, 2003, 12 DHO staff participated as enumerators in the HFA. The HFA was conducted over five days, and included interviews and observation of client-provider interaction. The rapid water and sanitation survey was conducted between January 12-31, 2004, after the completion of a two-day training for PCI and YPSI staff. Approximately 90 days were spent on these activities. The methodology and key results of these baseline surveys are included in section E.I of this narrative and Annex 2.

The preliminary results of the baseline survey were presented to District Health Officers and PCI/YPSI staff prior to the DIP workshop in order to solicit input for the preparation of the workshop and document development. A three-day DIP workshop was took place between February 24-26, 2004, to share the results of the baseline surveys, including the KPC survey, the rapid water and sanitation survey and the HFA; to inform the stakeholders regarding the CHOICE project; to provide information on the importance of prioritizing the maternal and child health/nutrition program; to obtain inputs/recommendations for the development of a sustainable maternal and child health program (according to the Child Survival Technical Support (CSTS) sustainability framework); and to involve partners in the development of the DIP. A participatory method to assess NGO partner capacity, facilitated by PCI staff, will be used in a 2-day workshop planned for May 2004, applying the SCAT (Simple Capacity Assessment Tool) methodology. The total time spent for these activities, including writing and compiling the DIP, was 132 days.

3. Follow-up Activities

Between May-September 2004, the project will conduct the following activities:

1. Facilitate Institutional Capacity Assessments with YPSI and government partners
2. Determine appropriate baseline values in each of the sustainability framework dimensions
3. Sign the second MOU with YPSI (first week of June 2004) - the first was used for project start-up activities (baseline assessment, DIP development, etc.)
4. Meet with stakeholders to further engage them in project implementation (second week of June 2004)
5. Prepare field staff (third week of June–August 2004) through orientation and training in the following areas: FGDs and In-Depth Interview techniques, Participatory Rapid Appraisal (PRA) and community mobilization; BEHAVE (Behavior Change programming Framework) and "Doer/Non-Doer" Analyses, Community-Based

Household Integrated Management of Childhood Illnesses (C-IMCI), Positive Deviance/Hearth nutrition rehabilitation and maintenance program, and other important health/nutrition related issues as indicated by the KPC and HFA

6. Conduct FGDs, Doer/Non-Doer Analyses, and PRA, results of which will be used to further develop project implementation plans with the community (fourth week of June–third week of July)
7. Conduct census of children aged 0-59 months and pregnant women in the 30 villages (June–July 2004)
8. Organize workshop to develop monitoring system and tools (July 2004)
9. Initiate project interventions at the community level (August-September 2004), including trainings for *Puskesmas* staff/midwives and *Kaders*, and meetings with the community leaders/key persons

D. REVISIONS MADE TO THE ORIGINAL DESIGN

1. Number of Sub-Districts

The proposal indicated that the CHOICE project would be implemented in six sub-districts. Considering the fact that several geographic areas are extremely hard to reach, and contain very dispersed populations, the team (PCI and the local government of Pandeglang) decided to focus on the four most needy sub-districts with a total of 30 villages. Even with this adjustment, the total number of villages and beneficiary population remains the same as in the original application.

2. TB Intervention

The original design of the CHOICE TB component involved the use of midwives. However, because midwives are already overloaded, the government is not supportive of the idea of midwives taking up additional responsibilities related to TB. PCI has also discovered that midwives are not present in most of the villages where the CHOICE project is to be implemented. Thus the original concept of using midwives as a major part of the strategy for community-based TB interventions has been modified. While increasing midwife knowledge about TB is still a worthwhile pursuit, since they do play a major role in community-based health education and service delivery, this will not be a major part of the project's TB strategy. The project will also work with government and communities to advocate for midwives to be recruited and placed in villages where none are currently present.

After consultations with Dr. Benson Hausman, National Project Director for KNCV, Dr. Lukman Siregar, the KNCV representative responsible for TB in Banten Province, Dr. Komarudin, the head of Disease Prevention and Environmental Sanitation of Banten Provincial Health Office, Pak Yudi, the TB Program Supervisor of the Pandeglang DHO (District Health Office), Dr. Sri Boediharjo, of the USAID mission in Jakarta, among others at the mission, PCI has revised its TB component to emphasize complementarity with KNCV/government activities in Pandeglang District.

In Pandeglang District, Banten Province, KNCV is now working closely with the local government, the DHO, and all *Puskesmas* to combat TB by implementing the DOTS strategy

focusing on adult pulmonary TB. KNCV, funded by the Canadian International Development Agency (CIDA) and USAID, is focusing its assistance on increasing the capacity of health facilities to tackle TB problems by providing training, laboratory facilities, funding for quality control supervision, and monitoring meetings, equipment and vehicles. KNCV is now supporting 24 out of 29 existing *Puskesmas* in the Pandeglang District, including two *Puskesmas* in two sub-districts within the CHOICE project area. Because CHOICE is working in these particular sub-districts, KNCV has indicated a willingness to give them particular attention, resulting in a stronger, complementary approach that will involve both community and health service elements. Effective TB control requires properly functioning, well-managed health services with good diagnostic facilities, trained staff and available drugs. But these services will not be meaningful unless communities are educated about TB to reduce discrimination, and encourage potential TB cases to seek diagnosis and comply fully with treatment. PCI will therefore focus on supporting current TB efforts through a community awareness-building and outreach approach that links community TB/nutrition efforts with KNCV's approach that is focused more on health service delivery at the district and sub-district levels. KNCV is keen to have PCI working at the community level to increase awareness about TB, with an emphasis on two key messages: TB is treatable, and TB treatment is free for all at TB-ready *Puskesmas*.

It is important to note that PCI's approach is specifically designed to avoid creating a demand for TB services that are not yet available. PCI staff will work to ensure the support and involvement of both local and central government officials, as well as compliance with all relevant Government of Indonesia (GOI) policies and strategies. In addition, interventions will be introduced in stages as *Puskesmas* become equipped and trained to competently manage TB in their sub-districts.

3. Changes in the Level of Effort

Baseline measures of the Core Assessment Tool on Child Health (CATCH) indicators gathered during the KPC survey indicate the emerging and critical status of several intervention areas, including maternal and neonatal care, diarrhea/hygiene, breastfeeding, and immunizations (please see table below). Sixteen target villages were identified with a high percentage of undernourished children. In addition, the quality, frequency and quantity of complementary foods given to the children are still unanswered, since the survey did not explore these aspects. Even though the CATCH data reflects a fairly high percentage for children aged 0–5 months who were exclusively breastfed during the last 24 hours (48.5%), other KPC data, national figures, and other anecdotal information from discussions with health officials in the district indicate that the true situation is actually worse. For example, the KPC data indicates a low median average of one month of exclusive breastfeeding.

1. Percentage of children aged 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**23.5%**
2. Percentage of children aged 0–23 months who were born at least 24 months after the previous surviving child	**92.9%**
3. Percentage of children aged 0–23 months whose births were attended by skilled health personnel	**15.8%**

4. Percentage of mothers with children aged 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**68.7%**
5. Percentage of children aged 0–5 months who were exclusively breastfed during the last 24 hours	**48.5%**
6. Percentage of children aged 6–9 months who received breast milk and complementary foods during the last 24 hours	**89%**
7. Percentage of children aged 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday	**51.1%**
8. Percentage of children aged 12–23 months who received a measles vaccine	**61.7%**
9. Percentage of children aged 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night (project is not in a malaria risk area)	**0%**
10. Percentage of mothers with children aged 0–23 months who can identify at least two known ways of reducing the risk of HIV infection	**NA**
11. Percentage of mothers with children aged 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**1.3%**
12. Percentage of mothers of children aged 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	**28.7%**
13. Percentage of sick children aged 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	**73.4%**

(Please see Annex 5.B for the Rapid CATCH Summary Data.)

Based on these findings, the project staff decided to adjust the levels of effort (LOE) as outlined in the chart below. The control of diarrhea disease (CDD) intervention area LOE was reduced from 30% to 20%, not because of a reduction in its importance, but because the project will bring in other resources for water and sanitation (W&S) that will be used for latrine and water system construction and purification, allowing the project to focus on supplementary efforts such as hygiene practices. The 10% removed from CDD was reallocated to breastfeeding and nutrition (from 20% to 25%) and immunizations (5%).

Original	Change to
Breastfeeding and Nutrition: 20 %	25%
Pneumonia Case Management: 20 %	No change
Maternal and Newborn Care: 20 %	No change
Control of Diarrhea Disease: 30 %	20%
Immunization: 0%	5%
Tuberculosis: 10 %	No change

4. Objectives and Indicators

During the DIP workshop and subsequent discussions, the CHOICE project staff determined that the following refinements were necessary to add clarity to the original Results Framework. While the changes indicated below do not represent significant programmatic changes, the project staff felt that after careful reflection, the wording of the Strategic Objective (SO) and some of the Intermediate Results (IR) and Lower Level Results (LLR) could be polished, and that some of the indicators could be slightly improved upon, while others needed to be added to enable project staff to more realistically monitor progress towards results. (See the Results Framework on the following page.)

Strategic Objective (SO)

To improve specificity and accurately reflect the project's focused target group of the most vulnerable populations, a change was made in the wording of the SO. *"Improved health and nutrition status among children under five and women of child-bearing age in the selected project areas"* was slightly adjusted to read: *"Improved health and nutrition status among children under five, pregnant and lactating women, and mothers/caretakers of children under five in the selected project areas."*

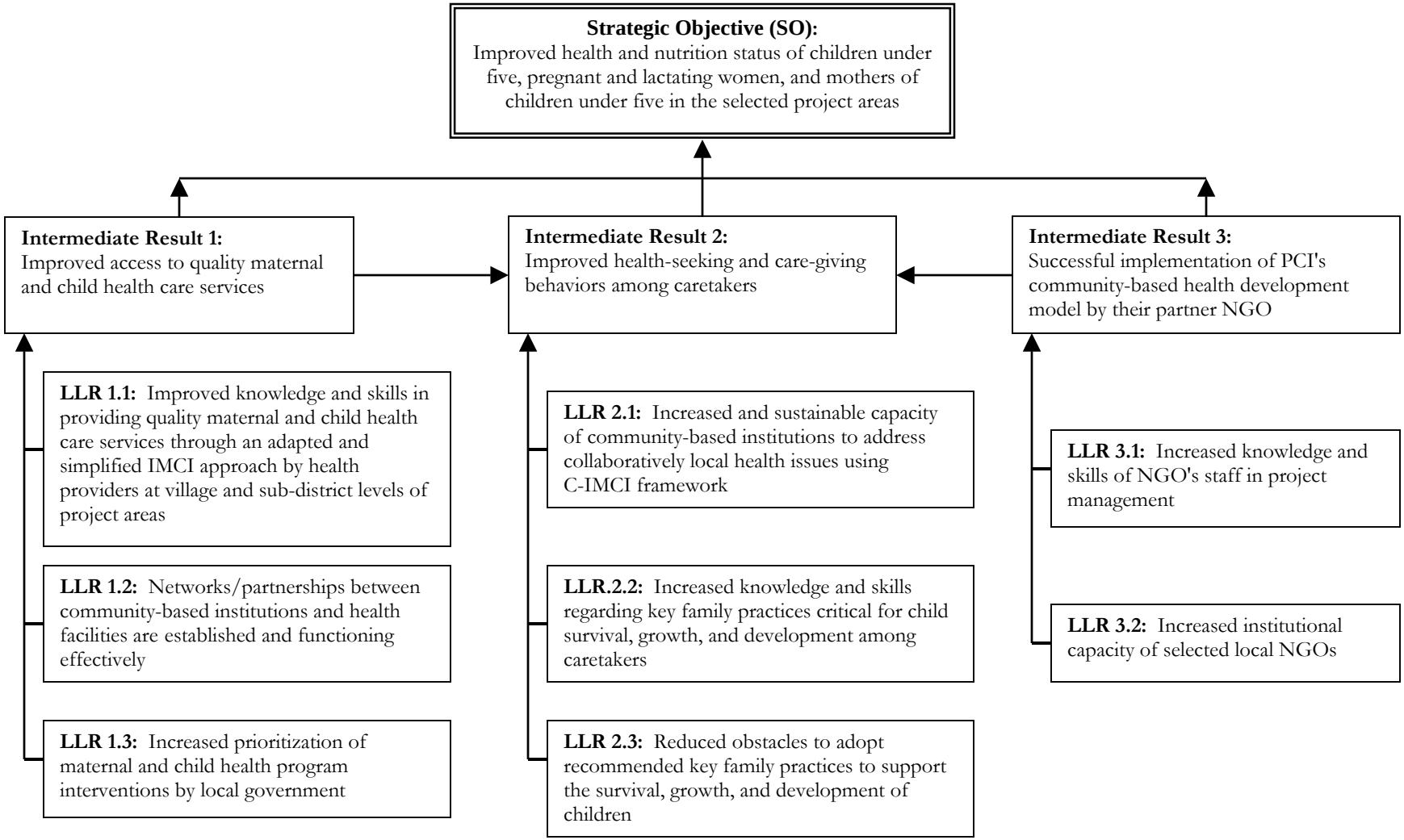
In addition, indicators were added to measure the achievement of the SO, as follows:

1. % under weight (weight/age <-2 SD) children aged 0-23 months in the 30 villages
2. % of mothers with chronic energy deficiency (MUAC of <22.5 cm)
3. % stunted (height/age < -2 SD) children aged 0-23 months in the 30 villages

Intermediate Result (IR) 1:

Original	Revision
IR 1 *Improved access to quality primary health care services* **Indicators:** 1. % of health providers in each of the facilities that correctly applies the clinical IMCI approach 2. % of health facilities that constantly maintain adequate stocks of essential drugs and supplies 3. % of health facilities users that express their satisfaction with the quality and accessibility of services provided 4. % of *Posyandu* sessions attended by the appropriate health facility staff	**IR 1** *Improved access to quality maternal and child health care services* **Indicators:** 1. % of health workers in the project areas who received at least one supervisory visit that included observation of case management in the last 6 or 12 months 2. Index of availability of essential oral rehydration treatment (a priority IMCI indicator at the facility level) 3. % of mothers with children aged 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child 4. % of children aged 0-23 months whose delivery was attended by a skilled health personnel 5. % of children aged 12- 23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday 6. % of children aged 12- 23 months who received a measles vaccine 7. % of children aged 0-23 months who received vitamin A

CHOICE Project Results Framework



"Primary health care" was adjusted to read "quality maternal and child health care services" in order to maintain consistency with the strategic objective. While primary health care carries a broader meaning, including general basic health services for the community, the direct beneficiaries of the CHOICE project will be children aged 0-59 months, their mothers/caretakers, and pregnant and lactating women.

The project will use the priority indicators for IMCI at the facility and household levels and the indicators for child health (CATCH) to measure access to, and the quality of, maternal and child health services in the project areas at mid-term and end of project. Information on these indicators will be gathered using the KPC survey and the HFA.

Lower Level Result (LLR) 1.1

Original	Revision
LLR 1.1: *Improved knowledge and skills in IMCI of health providers at the village and sub district levels* **Indicators:** 1. % of village and sub district health providers who are able to correctly describe the use of IMCI algorithm	**LLR 1.1:** *Improved knowledge and skills in providing quality maternal and child health care services through an adapted and simplified IMCI approach by health providers at village and sub-district levels of project areas* **Indicators:** 1. % of health workers who perform assessment, treatment and counseling correctly in the management of the sick child 2. % of health providers (midwives and paramedics) in the project areas who have been trained in the management of childhood illnesses 3. % of midwives who have been trained on safe and clean delivery and care of premature/ low birth weight newborns and lactation management

The change in wording from "...in IMCI of health providers…" to "...in providing better maternal and child health services..." was made to be consistent with IR 1 and to reflect the fact that the project will address both maternal and child health to support the survival and development of children. The IMCI strategy will be implemented by the project to reduce death, illness and disease, and to promote growth and development among children under five years of age. This strategy includes preventive and curative elements that will be adopted by families and communities as well as by health facilities. Improving maternal health care services is critical to reduce maternal morbidity and mortality, and should be seen as an integrated part of the child survival program.

The priority indicators for IMCI at health facilities will be used by the project to measure improved skills and knowledge of health providers in maternal and child health services. Measurement of these indicators will be done through the HFA.

LLR 1.2

Original	Revision
LLR1.2 *Increased utilization of QA supervision methods in IMCI implementation at the village and sub-district levels* **Indicators:** 1. % of village and sub-district health facilities that have received QA supervision visits at least quarterly	**LLR1.2** *Networks/partnerships between community-based institutions and health facilities are established and functioning effectively* **Indicators:** 1. % of villages that have conducted regular community-health provider meetings (at least 2 times/year) as a mechanism for improving the quality of maternal and child health services 2. % *Posyandu* attended by one health provider at least once/month 3. % of registered TBAs who have been trained on neonatal care, lactation management, and appropriate home care of the sick child

Most of the people in the target area rely on the maternal and child health care services provided through community-based health facilities/institutions such as TBAs and *Posyandus*. The *Posyandu* is a community-based program that provides basic preventive health to support child survival and growth including growth monitoring, ante-natal and post-natal care, family planning, immunization and vitamin A supplementation. Due to the fact that most of the parents/caretakers do not seek care at health facilities, many sick children die without getting medical care. The project team has come to realize that improving the health facilities alone would not be very effective. To address the issue of the existing gap between health care services and their utilization, DIP workshop participants proposed the establishment of a network/partnership between community-based institutions and health facilities. The networking/partnership between community-based institutions and health facilities will function as the vehicle for both types of institutions to provide feed back and support to improve the quality of maternal and child health services. Another reason to change this LLR was that QA supervision is mainly related to the local government/DHO system, over which the project has limited influence. However, measures of quality supervision will be used by the project as an indicator of the quality of maternal and child health services provided by the health facilities.

LLR 1.3

Original	Revision
LLR1.3 *Increased prioritization of primary health interventions by local government* **Indicators:** 1. % of total approved district budget allocated to primary health care	**LLR 1.3** *Increased prioritization of maternal and child health program interventions by local government* **Indicators:** 1. # of village midwives/village birth huts run by midwives available in the project areas 2. # of villages in or outside sub-district project areas who have adopted the *Posyandu* TKA and PD/Hearth models, to promote child survival growth and development

One of the results expected during the project is that the local government will place more emphasis on maternal and child health care services in their health master plan. However, it is impossible to separate resources allocated for MCH services from all primary health care since budget allocation for health care is lumped together into one pot and mostly used for infrastructure and operational costs, such as salary for health providers, transportation for supervision, etc. The participants of the DIP workshop therefore suggested using the number of village midwives and village birth huts run by midwives (funded by local government) as the indicator for measuring local government's commitment to improve the health and nutrition status of women and children in Pandeglang district. In addition, the willingness of the local government to adopt the *Posyandu* TKA (see section D.6 - Operations Research) and PD/Hearth model introduced by PCI in or outside sub-district project areas can be seen as an indication that the local government has placed special attention on maternal and child health care. These indicators can be easily gathered from the HFA and DHO reports.

IR 2

Original	Revision
IR 2 *Improved health-seeking and care-giving behaviors among caretakers* **Indicators:** 1. % caretakers who practice all applicable priority emphasis behaviors	**IR 2** No change in the wording of IR 2. **Indicators:** 1. % of mothers who wash their hands before food preparation, before feeding the child, after defecation, and after attending to a child who has defecated 2. % of children aged 0-5 months who were fed only breast milk in the last 24 hours 3. Median duration of exclusive breastfeeding increased from 1.0 month to 1.7 months 4. % of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment 5. % of sick children aged 0-23 months who received increased fluids and continued feeding during the illness in the past two weeks 6. % of children aged 0-23 months in the 30 villages with diarrhea in the last 2 weeks who received ORS and/or recommended home fluids 7. % of children aged 0-23 months who were breastfed within the first hour after birth 8. % of children aged 0-23 months who were weighed in the last 4 months 9. % of identified severely malnourished children and the children who fail to thrive after participating in PD/Hearth sessions who are visited by *Kaders* (to identify TB contact persons, to inform mothers and contact persons about TB key messages and to encourage them to seek TB treatment). 10. % of suspected TB cases referred to *Puskesmas*

The only change here has been to list out the indicators for each of the specific emphasis behaviors the project will work to improve and to include the relevant child health indicators.

LLR 2.1

Original	Revision
LLR2.1 *Increased and sustainable capacity of community-based institutions to address collaboratively local health issues using C/HH-IMCI framework* **Indicators:** 1. % of villages that maintain village health teams with minimum number of active members 2. % of village health teams implementing C-IMCI programs according to established plans 3. % of village health teams that meet with local health providers at least quarterly to plan health development activities 4. % of villages generating community contributions to implementation of their health development programs, according to established plans	**LLR 2.1** No change in the wording of LLR 2.1. **Indicators:** 1. Ratio of active *Kaders/Posyandu* 2. # of *Kaders'* fora established in the project areas as a place for sharing experience and updating skills and knowledge 3. # of *Posyandus* providing integrated services (health, nutrition, and baby/child stimulation) in the project areas 4. # of Community Empowerment Institutions (CEI) that are able to generate and manage community contributions for the implementation of their health/nutrition development program

No change was made to the wording of LLR. 2.1. However, project staff decided to change three indicators to measure the achievement of this LLR. Lessons learned from PCI's CHANCE (Community Health and Nutrition through Community Empowerment) project reinforce the notion that working with existing village institutions increases the chances of sustainability of interventions. Therefore this project will put more emphasis on the existing system of *Posyandus* and *Kaders* (village health volunteers who run the *Posyandu*). In order to track the achievements of LLR 2.1, CHOICE will use the ratio of active *Kaders/Posyandu*, number of *Kaders* fora established in the project areas as a place for sharing experiences and updating skills and knowledge, and number of *Posyandus* providing integrated services (health, nutrition and stimulation, including baby massage, active feeding, and playing with the children to stimulate fine and gross motor skills and psycho-social development) in the project areas as the indicators. In addition, the project will strengthen the capacity of existing community-based institutions at village level in health/nutrition program planning, management, and monitoring/evaluation activities. The project staff will train *Kaders* in capacity building and will ensure that community-based institutions are functioning according to the guidelines. Some examples of these institutions are: Village Representative Board (VRB), *Posyandu Kaders'* Organizations, Community Empowerment Institution (CEI) and Family Welfare Organization (PKK). One indicator to be used for measuring sustainable capacity of community-based institutions to collaboratively address local health issues is the ability of this institution to generate and manage community contributions for implementation of the health program.

LLR 2.2

Original	Revision
LLR 2.2 *Increased knowledge and skills regarding emphasis behaviors among caretakers* **Indicators:** 1. % of caretakers who are able to mention their village priority emphasis behaviors and correctly explain why they are important for the health of their families	**LLR 2.2** *Increased knowledge and skills regarding key family practices critical for child survival, growth and development among caretakers* **Indicators:** 1. % of parents/caretakers having children aged 0-59 months in the project areas who actively participate in parent/caregiver education activities 2. # of education sessions for parents/caretakers facilitated by trained *Kaders* conducted regularly in the 30 villages 3. # of villages with high percentage of child's malnutrition (≥ 30 %) applying PD approach for improving the nutrition status of malnourished children 4. % of underweight children aged 6-59 months participating in PD/Hearth sessions who rehabilitated (achieve normal weight) and sustained their normal status at least 3 months after recuperation 5. % of mothers of children aged 0-23 months who are aware of at least 2 symptoms of TB 6. % of mothers of children aged 0-23 months who know that TB is a curable disease 7.

Changes in the wording of LLR2.2 were made to describe the desired result more specifically. Several additional realistic and measurable indicators have been selected by the project team to measure this LLR, which can be gathered through *Posyandu* records/monitoring reports. Two TB indicators were also added here.

LLR 2.3

Original	Revision
LLR 2.3 *Reduced obstacles to emphasis behavior adoption by caretakers* **Indicators:** 1. % of male partners who are reported by mothers/caretakers as being supportive of adoption of emphasis behaviors in their families 2. % of HHs with access to clean water and latrines 3. % of HHs with home vegetable gardens 4. % of villages in which traditional healers are members of the village health team	**LLR 2.3** No change in the wording of LLR 2.3. **Indicators:** 1. % of fathers/male caretakers of children aged 0-59 months actively involved in parent education/*Posyandu* activities 2. % of HHs in the 30 villages with safe drinking water from piped or covered well (available all year round) 3. % of HHs in the 30 villages with access to a functioning latrine/toilet

The project team has revised the indicators used to measure this LLR. The project team felt that it would be more realistic to measure the percentage of father/male caretakers who are actively

involved in parent education/*Posyandu* activities rather than the percentage of male partners who are reported by mothers/caretakers as being supportive of adoption of emphasis behaviors in their families. While important, the percentage of home vegetable gardens was dropped as an indicator as the project staff does not see this as an obstacle to the adoption of emphasis behaviors. However, please note that home gardening is one of the activities planned by the participants during the DIP workshop to support families who are participating in the PD/Hearth sessions.

IR 3

Original	Revision
IR 3 *Successful implementation of PCI's community-based health development model by their partner NGO* **Indicators:** 1. % of assigned villages in which partner NGOs have implemented activities according to PCI's community-based health development model 2. # of partner NGOs that have developed plans to expand their health program beyond the areas and period covered by the project 3. % of village health teams meeting at least monthly with NGO field staff to plan health development activities	**IR 3** No change in the wording of IR 3. **Indicators:** 1. % of assigned villages in which partner NGO has implemented activities according to PCI's community-based health/nutrition development model 2. % of community empowerment institutions meeting at least quarterly with NGO field staff to review and plan health development activities

No change has been made in the wording of IR 3. The project will only work with one partner NGO. Therefore, using the indicator of "# of partner NGOs that have developed plans…" will not be realistic. Changes were also made to the indicator "% of village health teams meeting at least monthly…" In the revised indicator, "% of community empowerment institutions" will be used, and quarterly meetings will be used because it is a more practical measurement than monthly meetings since there are already a large number of meetings planned at the village level involving the CEIs.

LLR 3.1

Original	Revision
LLR 3.1 *Increased knowledge and skills in the PCI model of community development and emphasis behavior adoption* **Indicators:** 1. % Increase in NGO staff member's knowledge and skills in the PCI model of community development and emphasis behavior adoption	**LLR 3.1** *Increased knowledge and skills of NGO's staff in project management* **Indicators:** 1. NGO partner has their own specialist for health, nutrition and training that will be included in their own organizational structure by the end of project year 3 2. All training at community level organized, managed and facilitated by NGO partner without supervision from PCI technical persons by the end of project year 3

The project team has changed the wording of LLR 3.1 to make it more specific and clear. The partner NGO should be capable of managing the CHOICE project at the village level, facilitating the community in the implementing community-based health development projects, including *Posyandu* TKA and PD/Hearth, as well as in resource mobilization. Increase in project management capacity can be measured by assessing the NGO staff's ability to facilitate all trainings at the community level without depending on PCI technical staff; and by assessing the willingness of the NGO to assign greater responsibilities to capable staff.

LLR 3.2

Original	Revision
LLR 3.2 *Increased institutional capacity of selected local NGOs* **Indicators:** 1. # of NGOs succeeding in obtaining donor funding for health development activities 2. # of partner NGOs with whom district government signs an MOU to continue collaborating on health development beyond the project period 3. % of NGO staff members who have received training in areas of identified need 4. % of NGO staff members increasing their scores on the institutional capacity assessment	**LLR 3.2** No change in the wording on LLR 3.2. **Indicators:** 1. # of proposals accepted for funding by other funding agencies to continue support to communities in or beyond the CHOICE project areas 2. Collaboration/partnership between partner NGO and district authority continued beyond the CHOICE project period 3. % of NGO staff members who have received training in areas of identified need

As mentioned above, PCI will only work with one NGO. Therefore the "# of NGOs" is no longer used in these indicators. The indicator of "% of NGO staff members increasing their score" has been dropped since the institutional capacity assessment will assess organizational level capacity and not individual capacity.

5. Decision to Work with One NGO

After completing a thorough pre-assessment of NGOs being considered as project partners, the PCI team determined that they would work with only one NGO due to the following reasons:

1. Results of the potential partner pre-assessments showed minimal financial capacity, limited initial capacity and potential for growth of local NGOs, which are important readiness criteria for PCI's work with local partners; and
2. Lessons learned from PCI's experiences in West Sumatra through the CHANCE program showed that intensive efforts working with one NGO resulted in greater capacity building gains than when working with more than one NGO.

During the NGO pre-assessment phase, PCI learned of YPSI's experiences partnering with other PVOs—such as Mercy Corps and Plan Indonesia—and their ability to obtain funding from international donors, such as the Danish International Development Agency (DANIDA) and the International Labor Organization (ILO). PCI was also impressed with their ownership of a surplus capital fund to face critical situations, and their organizational structure, which included

a woman as the Executive Director. In addition, PCI's positive experiences working side-by-side with YPSI staff (the two organizations share an office in Pandeglang) during the first 6 months of project start-up have confirmed the appropriateness of this decision, and the potential and willingness for growth of the partner organization. Already, the relationship that PCI and YPSI have built has succeeded in blending the two organizations into a smooth functioning team that is committed to maintaining an enriched organizational learning environment in which all members will continue to strengthen and complement one another's capacities, ultimately resulting in increased and more sustainable community benefits.

6. Operations Research (OR)

The 2002 Indonesian Family Life Survey shows a dramatic decline in the quality and utilization of *Posyandu* services over the last five years. For example, child growth monitoring dropped from 50% to 36%, and the availability of equipment and supplies declined (the availability of Road to health (KMS)-Growth Monitoring Cards dropped by 24%). An evaluation of *Posyandu* performance and client satisfaction conducted by UNICEF/UNHAS (Hasanudin University of Makassar) in West Sumatra, East Java, and South Sulawesi in 1999/2000 revealed a similar drop in utilization and quality of these services. Such findings suggest limited standardization and quality assurance in *Posyandu* training, often resulting in non-existent or inadequate counseling (only 11%-27% of mothers reported receiving any orientation from the *Kaders*) and poor task performance by *Posyandu Kaders*. These statistics confirm anecdotal reports of a significant decline in *Posyandu* quality and utilization over the last decade. Key reasons for the decline appear to be due to a shift in consumer preferences; fewer village residents who are willing to volunteer; and a general degradation in the quality of health services. On the other hand, the addition of health and family planning services has increased "medicalization" (i.e. *Puskesmas* staff/midwives used the *Posyandu* also as a place to deliver curative services), and this has created misunderstanding among the community about the ownership of the *Posyandu*. In addition, in villages where the number of existing *Kaders* is limited, the *Puskesmas* staff/midwives often act as the *Kaders*, helping them with their responsibilities, such as the weighing and recording of the weights in the registers. This situation creates a dependency on the *Puskesmas* and less ownership and control by the community. The *Puskesmas* is a first line government health facility at the sub-district level in rural areas, and at both sub-district and village levels in urban areas. The *Puskesmas* provide primary health care services, including maternal and child health services, nutrition, curative services, prevention and control of infectious diseases, health promotion, and water and sanitation. Beside the main *Puskesmas*, the government also provides auxiliary or mobile *Puskesmas*, especially in hard to reach areas. To increase the community's access to MCH services, the government places village midwives in isolated communities who are supposed to live in the village, but this is not the case in remote Pandeglang district.

CHOICE's baseline survey conducted in the 30 villages indicated that each *Posyandu* is only served by an average of two *Kaders*, and they are given insufficient guidance from the *Puskesmas* staff to ensure competent service provision. *Kaders* and village leaders who spoke with staff during the baseline survey also reported that many of the *Posyandus* in the project areas collapsed after being abandoned by *Puskesmas* staff, and that many mothers felt that baby weighing alone was not enough to maintain their interest in going to the *Posyandus*.

To address this deficiency, PCI proposes an OR study to determine if a *Posyandu* TKA (*Posyandu Tumbuh Kembang Anak - Posyandu* for survival, growth and development)—a multi-sectoral model for an enhanced *Posyandu*—can increase the utilization of the *Posyandu*, increase the competence of *Kaders*, and increase community ownership and sustainability. PCI has initiated discussions with the research institution, SEAMEO from the University of Indonesia, to collaboratively develop the research design in order to analyze the effectiveness of this model in increasing *Posyandu* utilization and quality. (See Annex 5.E for the terms of reference to be used as the basis for the study design.) In the following months, the project staff will conduct discussions with the *Kaders*, the village leaders, and representatives from other sectors—such as the religious, business, education, and environmental sectors—as well as parents/caretakers to explore their perception of the *Posyandu* program. During these discussions, project staff will seek to identify the major causes of decline in the *Posyandu*, and brainstorm community-based solutions for their improvement. CHOICE and YPSI staff will explore the possibility of a *Posyandu* with added incentives for community participation, such as a *Posyandu* that combines a micro-credit with education angle, or a *Posyandu* offering an adult literacy program. In order to determine the added benefits of a multi-sectoral approach, the OR study will also test the effectiveness of an improved *Posyandu* in villages where water and sanitation (W&S) interventions have been introduced to reduce barriers to hygiene (such as appropriate clean water systems and healthy toilets). As part of the study, the project staff together with *Kaders* will collect baseline data from each *Posyandu* on: target group attendance; the effectiveness of *Posyandu* sessions in improving child health and nutrition status (% of children gaining significant weight); and on trainings received by *Kaders* in the last year.

7. Budget Adjustments

The total amount of the sub-grant for NGO partners will not change. However, since only one NGO will be working with the project, the full amount designated for sub-grants will now go to this one organization. Further discussions with YPSI staff have indicated that NGO operating costs may be much higher than originally anticipated, thus further validating the need to provide the full amount to this one NGO.

In addition, there are several areas of need that will require additional supplemental (match) funding. For example, one intervention area not envisioned during proposal writing is iron supplementation for anemic children (Helen Keller International [HKI] Nutrition and Health Surveillance System [NSS] data shows a high prevalence of anemia among children under five) because the project design team had understood that the government could provide these supplements. Although anemia and worm infestation are prevalent among children, and will affect their survival, growth and development, the GOI program has been unable to address these problems. Additional funds to address these problems in the short term may be needed for this project and PCI is exploring ways to develop match funds for this component. The project will discuss with HKI to solicit their recommendations for addressing this issue. In addition, the project will conduct further qualitative research through FGDs to determine the reasons for anemia in children. To combat the prevalence of anemia in the community during the early phases of project implementation, iron supplements will be distributed to the affected mothers and children. As a long-term, low-cost and sustainable solution to this problem, the project will introduce a local food-based approach, based on the PD/Hearth methodology. An estimated amount of $14,700 is needed to purchase iron supplementation for the anemic children.

CHOICE will also need additional monies for printed materials, such as mothers' and children's health/vaccination books, growth monitoring cards (GMC) for parent/caregiver education, simple illustrated manuals for *Kaders* to conduct parent/caregiver education sessions, and other Behavior Change Communication (BCC) materials, including copies of existing print and audio/visual materials that will be used for starting discussions with parents/caretakers during education sessions. The estimated additional amount needed for this item is $25,000.

Supplemental funds will be needed to support water and sanitation interventions (water system and latrine construction) to help reduce barriers to practicing healthy behaviors, thus helping to prevent diarrhea and worm infestation in children and the community at large. As was discovered during the KPC and rapid W&S surveys, unclean water and poor sanitation are two of the most predominant problems in the CHOICE project area. PCI will support the construction or improvement of water and sanitation facilities surrounding 60 pilot *Posyandu* TKA. The total budget needed for this component is $58,911. PCI will work with communities to encourage them to mobilize their own resources such as labor, sand and other materials that are available in the villages. Based on previous experience with the CHANCE project, PCI anticipates that community resource mobilization may surpass $34,673, for the water and sanitation component.

In addition, PCI will help communities to identify their water and sanitation needs and mobilize their own resources to improve or build their own systems. PCI's International Office (IO) and field office, will work together with YPSI to take advantage of resource development opportunities and pursue a realistic strategy to secure supplemental funds to address the estimated remaining expenses of $25,000 for the water and sanitation component . This strategy includes the submission of proposals through YPSI to small grants programs, such as those funded by the Japanese Embassy, the Canada Fund, the New Zealand Embassy, and AusAID, the Australian development agency. PCI is confident that even in the unlikely event that none of these proposals receive funding, the organization will enjoy an estimated cash match of at least $50,000 from the sales offered through the Alternative Gifts International catalog (PCI/Indonesia is already an approved recipient) which brought in over $75,000 to Bolivia's country program in 2003 and over $40,000 to Zambia's country program in 2004. Finally, to provide additional resources for potential project expansion, PCI is currently exploring additional sources of funding from other U.S. government and non-governmental agencies. While PCI does not anticipate this happening, if for some reason, match funds are not forthcoming, based on the organization's recent experience in Ghana, administrative, financial, and management procedures have been put into place to ensure that budgets and program plans are adjusted downward to reflect USAID funds only; this would be done in close collaboration with the CSHGP.

8. Sustainability Framework

Through a competitive process, PCI was awarded technical assistance (TA) by CSTS to incorporate the sustainability framework more fully into its project planning, implementation, and evaluation processes. The TA will be provided via an on-going process that has already included beneficial guidance and processing exercises facilitated by two of the CSTS technical specialists, Dr. Eric Sarriot and Dr. Michel Pacqué, and the participation by the CHOICE project IO backstop in the orientation workshop held in Calverton, MD, in December 2003. Through

this assistance, project stakeholders and PCI staff at IO and in the field have gleaned a thorough understanding of the six steps involved in utilizing the sustainability framework (from planning to evaluation), and are now fully using the framework. During the DIP workshop, Dr. Pacqué explained the sustainability framework in great detail, and facilitated a useful exercise enabling participants from different sectors to determine how the results framework fits into the sustainability framework and why the framework would help the project measure sustainability. (See also Annex 5.D - DIP Workshop Report.) Several participants commented on how pleased they were to be involved in using this new framework from the beginning. Participants thus acquired knowledge and skills in applying the three dimensions of sustainability in their own planning processes, and not just those of the project. The remaining task now is for project staff to finalize the process of determining the appropriate baseline values in each of the dimensions. Once these values have been established (after capacity building assessments have been completed with the partners), project staff will plot the values on a diagram representing the three dimensions; this will represent the sustainability potential at baseline. The sustainability framework will continue to be completely integrated into the project's overall implementation, monitoring, evaluation and documentation processes. (See section E.3-Program Monitoring and Evaluation section for additional information on how sustainability measures will be taken and utilized at mid-term and end of project.)

E. DETAILED IMPLEMENTATION PLAN

1. Summary of Baseline and Other Assessments

In addition to numerous planning meetings, secondary data review, networking, and in-depth discussions with partners and collaborators, the CHOICE project has completed, or is in the process of conducting, the following quantitative and qualitative assessments. Results from these assessments have already been used as the basis for the design of program strategies detailed in this document; when it is completed, it will further help project staff and partners to refine the work, training, behavior change and communication, and monitoring and evaluation strategies and activities:

- Population-based survey (KPC)
- Health Facility Assessment (HFA)
- Rapid water and sanitation survey
- Institutional Capacity Assessments (IA)
- FGD/ Participatory Rapid Appraisal
- Doer/Non-doer analysis
- Sustainability Framework Assessment

1.a. Population Based Survey (KPC)

In December 2003, the KPC survey was conducted in the project site. The objectives of this survey were:

1. To identify maternal and child health problems in the project areas
2. To identify the capacity of health facilities to provide maternal and child health services
3. To help the project prioritize problems to be addressed and determine interventions to be developed, and
4. To gather baseline data for monitoring and evaluation purposes.

Data on the twelve Rapid CATCH indicators and from the majority of the indicators from the KPC modules were collected. As mentioned earlier, the module on HIV/AIDS was excluded because, after detailed discussions with partners, the project staff felt that the questions were too sensitive, and that some participants might feel offended and refuse to participate further in the study. These questions can be addressed during follow-up qualitative research, such as Focus Group Discussions.

The target population for the KPC survey was mothers of children aged 0-23 months, and the total number of mothers included in the sample was 450. Cluster sampling was used to select 30 villages and 15 respondents per village from the project's 4 sub-districts of Patia, Angsana, Pagelaran, and Saketi. In addition to the KPC survey itself, anthropometric measurements were taken for every participant.

Key results from the KPC Rapid CATCH indicated the following:

1. *Malnutrition and Child Feeding Practices*: 89% of children aged 6-9 months had received breast milk and complementary foods during the last 24 hours. On the other hand, only 48.5 % of children aged 0-5 months had been exclusively breastfed during the last 24 hours; and, not surprisingly, 23.5% of children aged 0-23 months are underweight.
2. *Birth Spacing:* 82.9 % of children aged 0-23 months were born at least 24 months after the previous surviving child.
3. *Births Attended by Skilled Health Personnel:* only 15.8 % of births of children aged 0-23 months were attended by skilled health personnel.
4. *Sanitation and Hygiene:* only 1.3 % of mothers with children aged 0-23 months report that they wash their hands with soap/ash before feeding children, after defecation, and after attending to a child who has defecated.
5. *Immunization Coverage:* 61.7 % of children aged 12-23 months received a measles vaccine, and 68.7 % of mothers with children aged 0-23 months received at least two tetanus toxoid injections before the birth of their youngest child. Only 51.1 % of children aged 12-23 months are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday.
6. *Malaria Prevention:* 0 % of children aged 0-23 months slept under an insecticide-treated net (ITN) during the previous night. (ITNs are not available in the project area due to its classification as a non-risk area for Malaria.)
7. *Management/Treatment of Childhood Illnesses:* while 73.4 % of sick children aged 0-23 months received increased fluids and continued feeding during illnesses in the past two weeks, only 28.7 % of mothers of children aged 0-23 months know at least two signs of childhood illness that indicate the need for treatment.

Fifteen trained students of the Serang Nursing Academy, under the close supervision of PCI and our NGO partner's staff, did the data collection. Thirty (30) clusters from the project's target area, with a total of 450 mothers of children age 0-23 months, were randomly sampled as respondents. A total of 456 children age 0-23 months and 584 children aged 24-59 months were examined for their weight and height, and a total of 539 mothers (consisting of 441 non-pregnant and 98 pregnant mothers) were examined for their mid-upper arm circumference (MUAC). (See Annex 2 - Report of Baseline Assessments, for methodology, guide, and results.)

Additional KPC results that have already been used as the basis for the design of project interventions include:

1. Module 1-A: Water and Household Sanitation
   - 54.9% of households with safe drinking water all year long
   - 27.7% households with access to a flush toilet

2. Module 4-C: Diarrhea
   - 11% of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids
   - 27.7% of mothers who can correctly prepare ORS
   - 34.9% of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness

3. Module 4-D: Acute Respiratory Infection
   - 56.7% of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to health facility, or received antibiotics from an alternative source

4. Module 5-A: Pre-Natal care
   - 3.7% of mothers had a maternal card for the youngest child less than 24 months of age
   - 66.6% of mothers had at least one prenatal visit to skilled personnel prior to the birth of her youngest child less than 24 months of age
   - 12.9% of mothers took ≥90 tablets of iron supplementation while pregnant with the youngest child less than 24 months of age

5. Module 5-B: Delivery and Immediate Newborn Care
   - 0.4% of children aged 0-23 months were immediately breastfed at birth
   - 63.1% of children aged 0-23 months were placed with mother immediately after birth
   - 80% of children aged 0-23 months were bathed immediately after birth

6. Module 5-C: Post-Partum Care
   - 58.9% of mothers had at least one post-partum check-up
   - 4.7% of mothers were able to report at least two known maternal danger signs during the post-partum period
   - 5.8% of mothers were able to report at least two known neo-natal danger signs
   - 10% of mothers received a vitamin A dose during the first two months after delivery

7. Module 6: Child Spacing
   - 52.4% of non-pregnant mothers who desire no more children in the next two years, or are not sure, are using a modern method of child spacing
   - 67.3% of non-pregnant mothers are using a modern method of child spacing

The maternal and child health status in the four target sub-districts is even worse than in Indonesia in general, as indicated by the IDHS 2002-2003. The following is a comparison of key findings between the IDHS results for Indonesia and Banten Province, and the KPC results:

Indicator	**Indonesia (IDHS 2002-03)**	**Banten (IDHS 2002-03)**	**Pandeglang (4 sub-districts *kecamatan*, KPC survey)**
▪ Median duration of any breastfeeding	22.3 months	24.8 months	10 months
▪ Median duration of exclusive breastfeeding	1.6 months	1.7 months	1 month
▪ Percentage of under five children who received vitamin A in the last 6 months	63.7%	56.6%	59.1%
▪ Percentage of children aged 12-23 months who are fully vaccinated (against five vaccine-preventable diseases).	51.5%	25.4%	57.5%
▪ Percentage of children aged 0-23 months whose births were attended by skilled health personnel	66.3%	62.9%	15.8%
▪ Percentage of mothers who took ≥90 tablets of iron supplementation while pregnant with the youngest child less than 24 months of age	29.1%	22.4%	12.9%
▪ Prevalence of modern contraceptive use	56.7%	57.5%	67.3%

Various socio-economic factors and poor quality of existing health facility services in the target areas are mainly responsible for these below national average statistics for the target areas. As indicated in the Banten Health Profile 2001, approximately 37% of the population aged 10 years and under never attended school or only attained ≤6 years of elementary school. The District Health Office report (2002) showed that 82 out of 104 still births were delivered by low-educated women. Population update data collected by the Population, Family Planning and Civil Registrar Office (2002) showed that approximately 49%—or between 26.1%-94.3%—of households in the CHOICE project areas are living under the government-defined poverty line.

1.b. Health Facility Assessment

Information about the health facilities and providers' performance were collected through the Health Facilities Assessment (HFA) conducted in November/December 2003. The HFA gathered information regarding providers' performance in assessment, treatment, counseling and referral, and management of the sick child. The HFA also gathered information on the supervision capacity of the DHO to ensure that the services are implemented according to IMCI clinical standards, the availability of essential drugs, equipment and supplies, and IMCI training coverage. The HFA utilized the USAID/BASICS (Basic Support for Institutionalizing Child Survival) Integrated Health Facility Assessment tools, and was conducted in order to obtain information on the availability and the quality of health services, especially child health services

related to the integrated management of childhood illnesses. The tools used in the HFA consisted of the following:

- Observation Checklist - Sick Child
- Exit Interview - Sick Child
- Health Worker Interview
- Equipment and Supply Checklist

Data collectors gathered information on: the availability of essential drugs, equipment, and supplies; providers' competency in supervision, counseling, and proper management of severe illnesses; the IMCI training coverage; and parent/caregiver's knowledge of home treatment. Twelve technical staff members of the DHO were involved in conducting the HFA as supervisors and surveyors. Since the CHOICE project has little control over the improvement of the district health system, the involvement of the DHO in the program from the beginning was proposed to build ownership in the project, to encourage the health sectors to become aware of where they are and where they want to go, and what supports are needed to provide better quality health services. The rationale behind this is that the DHO can use the HFA results to develop appropriate and effective plans for improving the quality of health services for the entire Pandeglang district.

Because only two of the DHO staff had been trained in IMCI, PCI decided to hire the existing survey team of DHOs who had nursing and midwifery education backgrounds. Training on how to conduct the HFA was facilitated by PCI staff that had already been trained in IMCI. Four (4) Public health centers, two (2) auxiliary *Puskesmas*, and eight (8) individual health facilities run by midwives were observed for the availability of drugs, equipment, and supplies. Interviews were conducted with three (3) midwives and one (1) nurse providing maternal and child health in *Puskesmas*, and eight (8) midwives and two (2) nurses who are providing MCH in the auxiliary *Puskesmas*. A total of 37 client-provider interactions were also observed during the HFA. The summary of HFA results is as follows:

Information on the Existing Health Facilities in the Four Sub-Districts

Sub-District	**No. of Villages**	**No. of Public Health Centers (*Puskesmas*)**	**No. of Auxiliary *Puskesmas* (*Pustu*)**	**No. of village Birth Huts**	**No. of villages visited by Mobile *Puskesmas* (min. once/wk)**
Saketi	14	1	2	0	4
Pagelaran	14	1	0	0	0
Patia/Perdana	19	1	4	1	14
Angsana	10	1	0	0	10
Total	**57**	**4**	**6**	**1**	**28**

Type of Health Workers

Sub-District	**No. of Midwives**	**No. of Paramedics (non-MWs)**	**No. of Health Assistants**	**No. of Nutritionists/ Assistants**	**No. of Medical Doctors**	**No. of Dentists**
Saketi	10	5	3	0	2	1
Pagelaran	5	7	2	1	2	1

Sub-District	No. of Midwives	No. of Paramedics (non-MWs)	No. of Health Assistants	No. of Nutritionists/ Assistants	No. of Medical Doctors	No. of Dentists
Patia/Perdana	8	7	2	1	2	1
Angsana	3	5	1	0	0	0
Total	**26**	**24**	**8**	**2**	**6**	**3**

Although the ratio of midwives to the number of villages should be 1:2, this is not the case for many of the target villages. The hard-to-reach villages are not frequently visited by the midwives or are visited only once a month during the *Posyandu* activities. Even though the government's policy is that midwives should live in the villages they serve, there is only one midwife living in one of the villages in the entire CHOICE project area.

Health Worker Skills

Assessment - A total of 37 client-provider interactions were observed as part of the HFA. In these interactions, none of the children were checked for three general danger signs—the presence of cough, diarrhea and fever. The vaccination status was checked for only eight children and the growth chart was checked for only seven children. None of the children were assessed for feeding. The index of integrated management, or mean of 10 assessment tasks performed per sick child, was 0.4. These results indicate that the competency of health workers in managing ill children is still low and needs to be improved.

Correct Treatment and Counseling - In the 37 interactions observed, none of the children were diagnosed with pneumonia, diarrhea with blood, acute ear infection, malaria, or anemia. Therefore, we cannot evaluate the appropriateness of antibiotics/anti-malaria treatment. It was also observed that only eight children were properly prescribed antibiotics. The remaining twenty-five children did not need antibiotics, but were incorrectly prescribed to take them.

The counseling skills of providers are still insufficient. Only 16 out of 37 mothers were advised to give extra fluids and continue feeding during illness. Immunizations were only given to one out of 18 children who needed to be vaccinated. The HFA survey also found that only 14 mothers/caretakers of children who were prescribed with ORS and/or oral antibiotics could describe how to give the treatment. This indicates that the competency of providers in counseling mothers on how to treat sick children needs to be improved.

Management of Severely Ill Children - The team also found that the health workers did not even recognize common signs of pneumonia in children, which are very easy to identify. Examples of such signs are the in-drawing of the lower chest wall and "stridor" in a calm child (a harsh sound made when the child inhales, indicating risk of respiratory tract obstruction). In one case, which was diagnosed by the team as severe pneumonia, the health worker did not refer the case to a higher level of health facility, although the seriousness of the case certainly warranted a referral. These findings also confirm the need to improve the management of sick children.

Health System Support for IMCI - There are two essential components that need to be strengthened to improve the quality of health services. These two components are the provider's compliance with MOH health service standards and procedures, and the availability of essential drugs, equipment, and supplies. The HFA findings show that only two out of 14 surveyed health

workers reported that they had received at least one supervision visit in the last six months. The quality of supervision is still questionable, as they reported that the supervision was mostly focused on administrative tasks and not on support to ensure that the two essential components for performance are in place.

Not all eight essential oral drugs for IMCI were available in each of the surveyed health facilities. As revealed from HFA results, only 4 out of 14 facilities had the 8 essential oral drugs (the index of availability of essential oral treatment is 0.79). The availability of injectible drugs for referral treatment was even worse, with only five facilities having one injectible drug (IMCI requires four drugs), giving an index of only 0.09. The HFA also found that all four of the vaccines were available in all Public Health Centers and in the five private health facilities run by midwives. In addition, of the four *Puskesmas* observed, only two *Puskesmas* have adequate facilities and maintenance of cold chain, one *Puskesmas* does not have a thermometer, and one *Puskesmas* did not regularly check the refrigerator's temperature.

1.c. Rapid Water and Sanitation Assessment

A rapid water and sanitation assessment was conducted in the project area in order to identify the baseline condition of water and sanitation, and to forecast the budget needed for the construction of potential water and sanitation facilities. The rapid assessment found that the availability of clean water varies in the 30 project villages. It ranges from 40-80% in the wet season to less than 40% in the dry season. Only 10–35% of households living in these areas use flush toilets. This data has confirmed the results of the KPC survey which showed that only 54.9% of households have access to clean water all year long. The most common sources of water are springs, groundwater, and rain. The community has also developed a simple technology for protecting and distributing water from the sources to houses or communal places, which has been very positive and needs to be supported with improved techniques.

1.d. Institutional Assessment

Institutional capacity will be assessed with the local partners—namely YPSI, the *Puskesmas*, the CEIs, and the Regional Development and Planning Board (RDPB). The assessment of the NGO partner, YPSI, is planned for May 2004. Considering that April is the election time for legislative members in Indonesia, and March is a heavy campaign month, informal institutional assessments with CEIs and the RDPB will be postponed until May 2004. The *Puskesmas* will also participate in an adapted capacity assessment session to determine key areas to be improved upon. Existing tools that PCI has utilized in several settings will be adapted and incorporated into a simple and participatory process that each of the local partners can replicate in future to assess improvements and to use in planning capacity building activities.

2. Program Description by Objective, Intervention and Activities

Program Objective and Interventions

The ultimate objective of the CHOICE project is to improve the health and nutrition status of the most vulnerable segments of the population - children under five, lactating and pregnant women. In addition, mothers/caretakers, including male caretakers, of children aged 0-59 months are also targets of this project for sustainable behavior change. This objective will be pursued through a participatory strategy which involves:

- Improving the capacity of health facilities to develop a sustainable and appropriate system to improve the quality of child health care by applying the IMCI approach
- Applying the three elements and multi-sectoral platform of the C-IMCI framework in strengthening the capacity of community-based institutions to identify health/nutrition problems, mobilize local resources, and plan, implement and manage sustainable community-based health/nutrition programs
- Strengthening networking mechanisms between community based institutions and health facilities in providing better quality maternal and child health services
- Building the capacity of families/communities for sustainable behavior change
- Establishing and strengthening village-based health planning and management institutions
- Capacity and partnership building with local NGOs
- Establishing close collaboration with district health authorities, *Puskesmas*, and District/Sub-District teams of Survival, Development and Protection of Children and Women.
- Outreach and awareness raising designed to educate communities about tuberculosis (TB) in order to reduce discrimination and encourage care-seeking and treatment compliance

The Results Framework

The overall program strategy of the CHOICE project is depicted in the results framework (see above, p.7), and includes the elements described in detail below. The project's Strategic Objective (SO) is: ***Improved health and nutrition status of children under five, pregnant and lactating women, and mothers of children under five in the selected project areas***. The achievement of this strategic objective will be measured by comparing baseline and final data on the percentage of children aged 0-23 months who are underweight; the percentage of stunted children aged 0-23 months; and the percentage of pregnant and lactating women with chronic energy deficiency**.** This strategic objective will be pursued through three Intermediate Results (IR), which are considered to be pre-conditions for its accomplishment.

The project's strategic objective, intermediate results, and lower level results will contribute towards the achievement of all three of CSHGP's IRs:

❖ Regarding CSHGP IR1: "*Increased quality of child and maternal health, and nutrition and infectious disease programs implemented by PVOs and their local partners.*" - CHOICE has incorporated essential aspects of quality programming in its design. The project includes a heavy emphasis on increasing the quality of MCH programs and services at all levels, from quality of care improvements in counseling and appropriate referrals at the *Posyandu* level, to increased quality of service provision to mothers and newborns by TBAs and midwives due to partnerships between these two, and increased accountability of management of improved health care services by the local government.

❖ Regarding CSHGP's IR2: "*Increased sustainability of child and maternal health and nutrition and infectious disease programs/interventions initiated by PVOs and their partners.*" - Two key aspects have been integrated into the CHOICE program:

1. Implementation of PCI's community development model in which organizational and technical capacity of the NGO partner is strengthened through training, technical

assistance, action plan implementation, monitoring, and joint problem-solving during community-based interventions; and

2. Community feedback mechanisms which facilitate the community's participation and ownership of the business of improving their own health.

Both of these approaches will further the potential of sustainable improvements in health, thus contributing to CSHGP's IR2.

- Regarding CSHGP's IR 3: "*Child and maternal health and nutrition and infectious disease program strategies, tools, and approaches developed/adapted, tested and applied.*" - The CHOICE project will work to ensure that lessons learned from the approaches and models developed and improved upon during the CHANCE project are being applied to enhance the outcomes of the communities in Pandeglang. PCI will also test a relatively new approach that has proven successful in other parts of Indonesia to rehabilitate malnourished children, reduce malnutrition, and prevent future malnutrition, of PD/Hearth. Finally, CHOICE will conduct an Operations Research study to determine if an enhanced model of the *Posyandu*—which includes involvement of multiple sectors in child health—has a substantial impact on increasing positive health outcomes.

IR 1: Improved Access to Quality Maternal and Child Health Care Services

Components one and two of the IMCI strategy (improving the skills of health workers and improving the health system), and element one of the C-IMCI framework (creating partnerships between health facilities and the communities they serve), will be implemented by the project to achieve this intermediate result. Based on the results of the baseline surveys and subsequent analysis during the DIP workshop, CHOICE staff have selected appropriate indicators to measure progress towards the achievement of this intermediate result (see the Work Plan, p.66). This intermediate result will be achieved through the accomplishment of the following lower level results (outputs).

LLR 1.1: Improved Knowledge and Skills in Providing Quality Maternal and Child Health Services through and Adapted and Simplified IMCI Approach at Village and Sub-District Levels of Project Areas

The project will work to strengthen the capacity of local health facilities, including the sub-district health centers and the village birth huts run by midwives. As indicated by the HFA results, the majority of midwives working in the project areas have not been trained in the essential skills and knowledge for child health care, such as integrated management of childhood illnesses, and only about 57% have been trained in maternal health care. This is consistent with their level of performance in managing sick children (please refer to section E.1.b. - HFA, and Annex 2 - KPC and HFA Reports). Learning from the baseline survey results, the project team also deduced that the midwives have not contributed positively to mothers' breastfeeding practices. Examples include not encouraging mothers to immediately breastfeed their babies, not counseling mothers on breast care, nor on how to correctly breastfeed. Given this situation, the project will assist the DHO in improving the skills and knowledge of the health providers by jointly facilitating a series of trainings and ensuring facilitative and supportive supervision and follow-up support to reinforce and ensure actual application of newly acquired knowledge and skills.

Trainings in the management of childhood illnesses, safe and clean delivery, care of premature/low birth weight newborns and neonatal care, including lactation management, will be a central part of the standard training package for the village midwives as well as health center staff. Competency-based training, utilizing participatory adult learning methods, will be used. Such training will also help to reinforce the status of the village midwife as a competent and trusted health provider, which will be particularly important in areas where traditional healers and birth attendants still remain the community's primary choice for curative and maternal service and delivery. The project will also provide training in a relatively new approach in nutrition rehabilitation, PD/Hearth, as well as an integrated approach for child survival, growth and development.

Key Activities:
Under this LLR, key activities will include:

- ✓ Training of health center staff and village midwives in safe and clean delivery for performance improvement
- ✓ Provision of a midwifery kit
- ✓ Training in lactation management, care for newborns and premature/low birth weight babies for midwives and nurses
- ✓ Training in PD/Hearth and essential nutrition action
- ✓ Training in an integrated approach for child survival, growth and development
- ✓ Training for midwives and health center staff
- ✓ Orientation on integrated *Posyandu* model for midwives and health center staff and training on facilitative and supportive supervision for DHO supervisory officials and *Puskesmas* midwives

LLR 1.2: Networks/Partnerships between Community-Based Institutions and Health Facilities are Established and Functioning Effectively

Improving the quality of the provision of services at the health facilities level alone will not ensure increased community access to health services since maternal health services are primarily provided by TBAs, while child health care—especially promotion and prevention activities—is mostly done by *Posyandu Kaders* in partnership with health providers. Thus, during the DIP workshop, participants suggested the establishment of networking/partnerships between community-based institutions and health facilities to gradually improve the quality of services provided by each type of health provider. The partnership/networking activities may include frequent providers' visits to provide services at the *Posyandus*, the joint provision of maternal and child health services, improving skills and knowledge of TBAs and *Kaders*, joint business ventures for the provision of contraceptives or common drugs, etc. The project will encourage regular meetings with CEIs, *Kaders*, TBAs, and the health providers to allow all sides (community and facility-based) to provide feedback on the activities they implement for the community, as well as to plan for emergency evacuation related to maternal and child health.

From Day 1 of the TBA training, the partnership between midwives and TBAs will be fostered and nurtured. Informal weekly training sessions will be conducted either in *Puskesmas* or village birth huts as agreed upon before the training sessions. The TBAs will be involved in antenatal care during the midwives' visits to the *Posyandu* or in the village birth huts run by midwives; in collaboratively assisting the midwives with deliveries; and in parents/caretakers education

sessions. This approach will help transform conventional training activities into true capacity building efforts. During the weekly sessions, midwives and TBAs will share their experiences in providing maternal and child health and will jointly resolve challenges, by sharing experiences and brainstorming specific measures for problem solving. These sessions will provide a regular forum in which midwives can continually assess and strengthen TBAs' skills. After completion of the entire training package, regular meetings on a monthly or bi-monthly basis will be scheduled to maintain close relationships between TBAs and midwives, ensure that the new skills and behaviors are still maintained by TBAs, update TBA's skills and knowledge, gather reports of service provision by TBAs, and discuss specific complicated cases and deaths, with a primary objective of developing follow up actions for quality improvement for better health outcomes.

While their roles and functions are slowly changing, as the government attempts to gradually phase out the TBAs, in many communities, the presence of the TBAs still remains dominant. This is due primarily to the widespread recognition that the government has failed to place midwives in the most needy villages. Today, TBAs are still largely acknowledged as the midwives' partners in providing maternal and child health services in remote areas. Their services are fundamental in areas where midwives are seldom located; thus, the project realizes that "pushing" the elimination of TBAs in the short term is not realistic. To further the effort to naturally phase out the TBAs, the OBGYN Specialist Association, in collaboration with the Women's Health Education Foundation and the Ford Foundation, offers scholarships in midwifery to the children/grandchildren and other close relatives of the TBA. Some DHOs, including the DHO of Pandeglang, also offer scholarships to local community members to study in midwifery school.

In the last few years, the Midwife Association has extensively promoted and encouraged the application of TBA-Midwives partnerships in provinces across Indonesia. This partnership model requires the division of roles and responsibilities between TBAs and midwives, e.g. the TBA will contact the Midwife for delivery assistance, accompany the mother, give support to the mother, and monitor for danger signs during the first stage of the delivery while waiting for the midwife's arrival; the TBA will also care for the newborn babies and care for the post-partum mother.

In line with the government policy, the CHOICE project will support the local government in providing trainings that will support the implementation of the TBA-midwives partnership program. The CHOICE project will provide trainings, including: neonatal care, lactation management, appropriate home care of the sick, and other related MCH/RH topics through on-site trainings, jointly working with midwives, jointly working with *Kader*s in parent/caregiver education sessions, and verbal and social autopsy/TBA-MW partnership meetings. All trainings for midwives will be provided during the 2nd year of the project period and will be immediately followed by the training of TBAs. The training activities will be the starting point of establishing the TBA-Midwife partnerships.

The partnership model has been initiated by the Midwives Association as an effort to decrease maternal death. Through these partnerships, skills and knowledge can be increased; midwives can easily supervise and monitor the TBAs; and separate roles and functions can be agreed upon

and clarified between TBAs and midwives (e.g. midwives will assist at delivery, while TBAs will care for the mothers and newborns after delivery).

Key Activities:
Under this LLR, key activities will include:

- ✓ Facilitation of verbal and social autopsies for maternal and child mortality
- ✓ Orientations/trainings for TBAs on neonatal care, lactation management, and home care of the sick child
- ✓ Midwives-TBA partnership meetings
- ✓ Regular attendance of health providers at the *Posyandu*
- ✓ Joint TBA/midwife deliveries
- ✓ Joint antenatal care by midwives and TBAs
- ✓ Joint parent/caregiver education sessions
- ✓ Regular meetings with midwives, TBAs, *Kaders*, CEIs, village heads, community representative boards, and religious community leaders as a feedback mechanism that will ensure the quality of services provided by health providers at the facility and community levels

LLR 1.3: Increased Prioritization of Maternal and Child Health Program Interventions by Local Government

As indicated by the HFA, the project area has an insufficient number of midwives. To address this deficiency, the CHOICE project will support the DHO in advocating for the local government to assign a higher priority to maternal and child health, especially for issues affecting service delivery in marginalized areas. CHOICE staff and partner NGOs will play a central role in advocating for the local government authorities to recruit additional midwives for the CHOICE project areas, and to allocate resources for the adoption of the community-based health/nutrition development model, PD/Hearth, implemented during the CHOICE project period in other areas outside of CHOICE's project areas. PCI/Indonesia has extensive experience as a leader in the field of PD/Hearth in Indonesia having not only successfully led the process to adapt and produce an Indonesian language version of the Child Survival Collaborations and Resource Group (CORE) PD/Hearth Resource Guide—considered the most useful training manual available for PVOs on the subject—but also having used an adapted version of the model during its CHANCE project, and compiled these lessons and those from other PVO partners to publish a bi-lingual English-Indonesian newsletter featuring lessons learned in applying the model in the field.

CHOICE will also help communities to assume a health advocacy role, through the leadership of the CEI members and with the involvement of local health facility staff. PCI and YPSI will educate the CEI members about district budgeting and policy-making processes, provide training in advocacy skills, create opportunities for direct contact with district/sub-district decision-makers, and advise on ways to cultivate public influence. This may take the form of formal visits to the DHO and district legislature (DPRD), hosted site visits to project villages for district officials, or other options proposed by the CEI. In addition, the CHOICE project will engage in selected low-cost capacity building activities with the local government, such as the Regional Development and Planning Board (RDPB), in such key areas as resource allocation and activities prioritization. In order to ensure a high level of motivation for participation in these activities,

CHOICE will offer government officials the opportunity to participate in day-long cross-visits to nearby districts to encourage these officials to: establish networking and mentoring relationships between districts; exchange ideas; discuss barriers and benefits; and, ultimately, jointly develop strategies for increasing maternal and child health sector resource allocation in local government budgets.

Key Activities:
Under this LLR, key activities will include:

- ✓ The DIP/sustainability workshop
- ✓ Seminars on maternal and child health at the district level
- ✓ Cross–visits to other districts to enhance learning, strategizing, and mutual support between districts
- ✓ Orientation on the *Posyandu* TKA and PD/Hearth models for district and sub-district members of the Survival, Development and Protection of Women and Children Teams
- ✓ Workshops on the mid-term and final evaluations

IR 2: Improved Health-Seeking and Care-Giving Behaviors Among Caretakers

In addition to improving partnerships between health facilities and the communities they serve (element one), the second element of the C-IMCI framework involves the increase of appropriate and accessible health care and information from community-based providers, while the third element of the framework refers to the integrated promotion and adoption of key family practices critical for child health and nutrition. The key family practices are grouped according to practices that:

1. Promote physical growth and mental development
2. Prevent disease
3. Facilitate appropriate home care, and
4. Facilitate care-seeking behaviors.

In accordance with the KPC and HFA results and as prioritized by the target communities during PRA exercises, the project will promote those key family practices that will have the greatest impact on increasing maternal and child health indicators in the project area. Factors that are barriers or benefits to behavior adoption will continue to be identified through participatory behavior change exercises (such as the BEHAVE framework, "Doer and Non–Doer" analysis) and key behaviors will then be designated for promotion and prioritized. Negotiated behaviors will be used to help families gradually gain confidence through smaller, incremental changes in behavior in order to better sustain these changes over the long-term. These negotiations will be facilitated by utilizing such approaches as Designing by Dialogue or Trials of Improved Practices (TIPs).

Based on the results of the baseline survey and subsequent analysis during the DIP workshop, CHOICE staff have selected the appropriate CATCH and other indicators related to breastfeeding and nutrition practices, disease prevention practices, home treatment of childhood illness, and care-seeking behaviors, to measure the progress towards the achievement of this intermediate result (see Work Plan, p.66). Under this IR, the project will focus on increasing the capacity of community-based institutions and caretakers to address childhood illnesses and

reduce obstacles to the adoption of key family practices. Specifically, this intermediate result will be achieved through the accomplishment of the following lower level results (outputs).

LLR 2.1: Increased and Sustainable Capacity of Community-Based Institutions to Address Collaboratively Local Health Issues using C/HH- IMCI Framework

Increasing the capacity of community-based institutions to address local health issues is a crucial pre-requisite to a community's improvement in health practices. The project will strengthen the existing and potential community-based institutions at the village level in health planning, management, resource mobilization, and monitoring/evaluation. These institutions will include: the Village Representative Board (VRB), *Posyandu Kaders* Organizations, Community Empowerment Institutions (CEI), and the Family Welfare Organization (PKK). This last organization is an independent women's organization at the village, sub-district, and district levels that is linked to the CEI under the overall coordination of the village head. The Family Welfare Organization (FWO) coordinates all *Posyandu* activities run by the *Kaders*. At the start of the project, CHOICE staff will focus on intensive capacity building of the *Kaders* and strengthening the *Posyandu Kaders* Organizations. The CEIs' responsibilities include community mobilization, planning and monitoring of village health, environment, sports, economic, religion, and security programs, and its members include community representatives, such as formal and non-formal leaders, religious leaders, youth, local professionals—such as teachers—and others considered to have significant influence in the community. While all members of this community-based institution are men, and thus will be targeted specifically to encourage their involvement in behavior change activities promoting women's and children's health, women have an equal voice/representation as the exclusive members of the Family Welfare Organization. CHOICE staff will help revive or strengthen the CEIs and FWOs, and will advocate for a participatory process in the selection of members, including the inclusion of women representatives on the CEIs.

The project will address gender issues and promote women's empowerment, including creating an enabling environment for women to make decisions about their health and that of their children, as well as adopt roles (group or individual) to contribute to their village's development, especially as they relate to decisions regarding village health. Parent education sessions for fathers/male caretakers and mothers/female caretakers will include the basic rights of the child and reproductive rights for women. In addition, the sessions will focus on skills-building to promote the survival, growth, and development of the child. The project will also provide orientation on the Convention on the Rights of the Child (CRC), and reproductive rights and gender awareness in development with regards to the CEIs, village heads, and community/religious leaders. CHOICE's NGO partner, YPSI, has extensive experience in these areas.

One of the initial activities of the CEIs will be leading their respective villages in a participatory process of identifying the key factors influencing the adoption of key family practices that contribute to a child's survival, growth, and development. For this purpose, CHOICE will assist the community-based institution members in conducting Focus Group Discussions, Participatory Rapid Appraisal techniques, "Doer/Non-Doer" analyses, and other participatory exercises. Once the information is gathered, each village will be facilitated in developing a long-term plan to promote key family practices, reduce obstacles, and sustain and enhance health improvements

beyond the project period. With a focus on community empowerment, CHOICE will also use adapted, simple capacity assessment tools to identify areas to be improved among the CEI members, and *Posyandu Kaders* to build self-confidence, and improve their capacity in managing community-based health services.

In villages where the *Posyandu* are weak or non-existent, CHOICE will work with the village head and apparatus, FWO, and CEI, as well as community leaders, to help revitalize these important community institutions. Concomitant with this will be the mobilization of village health volunteers (*Kaders*) in charge of the *Posyandu* sessions. At least five volunteers are required to run a complete *Posyandu*, which consists of integrated services to support child survival, growth and development. CHOICE will focus on strengthening the counseling and extension function of the *Posyandu.* Under the umbrella of the *Posyandu*, activities will be added to stimulate physical growth and mental development, rehabilitate malnourished children, and to enable parents/caretakers to learn from and be supported by their peers for sustainable behavior change. Lessons learned from PCI's CHANCE project in Jakarta and West Sumatra has proven that integrating services around the child survival, growth and development have increased the attendance of children and their mothers/caretakers at the *Posyandu*. An OR study is also planned to enhance learning on which types of enhanced, multi-sectoral *Posyandu* models are the most effective in increasing the *Posyandu* utilization, increasing *Kaders*' competence, and increasing community ownership (see Section D.5 – Operations Research).

The project will also facilitate the extension of the *Kaders'* role, including their role outside the formal *Posyandu* sessions. A community-based incentive system for volunteers will be established in order to motivate *Kaders* and increase the sustainability of the institution through continued community commitment. For example, in collaboration with the midwives/*Puskesmas* staff, the *Posyandu* will operate a small shop selling contraceptives, simple drugs recommended by *Puskesmas* staff, and/or iodized salt, etc. Quality control measures will be carefully followed to ensure that caretakers receive complete information regarding contra-indications, side-effects, and correct instructions for use. Other possible incentives may include establishing a reward point system for the crucial activities conducted by the *Kaders*, or encouraging the *Puskesmas* to give free medication cards to the *Kaders* and nuclear family members. CHOICE will also encourage CEIs to assume responsibility for community-based health program management and to advocate for its full support by the village leaders.

The project will encourage the formation of *Kaders* committees at the village level. The *Kaders* committee members will consist of the representatives of each *Posyandu* in the village area and will be led by a respected *Kader* elected by the members. *Kaders* committees will organize and coordinate regular *Kaders* forum meetings (monthly or bi-monthly) at which *Kaders* and *Puskesmas* staff/midwives will share experiences, discuss feed back on the services they have provided to the community, update their skills and knowledge, and establish and monitor an action plan for improving the quality of their services. At the sub-district level, under the coordination of the Survival, Development and Protection for Women and Children team, the representatives of the village *Kaders* committees will meet together at least three times each year to share the progress of program interventions and lessons learned, identify support needed from the sub-district or district levels, and plan actions for improvement. Through this forum, *Kaders* will feel that they have an important voice and that they are appreciated, and—most significant of all—that they are bound together as members of a special "*Kader* family".

Key Activities:
Under this LLR, key activities will include:

- ✓ Trainings for *Kaders* in specific intervention areas (maternal and neonatal care, immunization, nutrition and breastfeeding, control of diarrheal diseases and ARI)
- ✓ Other cross-cutting topics will be a central part of the *Kaders* standard training package, such as physical growth, intellectual development, and baby/child stimulation (including baby massage, active feeding and playing together to stimulate gross motor skills and psycho-social development), facilitation skills, and institutional management (including financial/resource management)

The project will also provide trainings for the CEI members to improve their capacity in program planning, management, and resource mobilization. Also included under this LLR will be the formation of *Kaders* committees, and facilitation of feedback meetings at the sub-district level. Regular meetings between *Kaders*, CEI members, and village leaders will be conducted to review the process and achievements, and develop action plans to improve results.

LLR 2.2: Increased Knowledge and Skills regarding Key Family Practices Critical for Child Survival, Growth and Development among Caretakers

As mentioned under IR2, key family practices critical for child survival, growth and development will be prioritized by the community. To influence parent/caregiver behaviors, CHOICE plans to use community-based and participatory behavioral change strategies designed, planned and implemented by community members and facilitated by the local NGO field staff. Through an adapted BEHAVE model and "Doer/Non-Doer" Analyses, participating communities will identify obstacles to key family practices adoption and formulate plans and activities for overcoming them. Behavior change will be promoted and supported through regular monthly parent/caregiver education sessions led by well-trained *Kaders* under the umbrella of the *Posyandu* program. During these sessions, the Appreciative Inquiry and Positive Deviance approaches will be used to focus on positive behaviors and how to replicate them. Where possible, the project will utilize existing traditional and/or low-literate materials, such as flip charts, counseling cards, sketches, and videos. During PD/Hearth and nutrition sessions, examples of nutritious local foods will be used to stimulate discussion during parent/caregiver education sessions. Low-cost educational incentives will be given as tokens of appreciation to all mothers/caretakers whose infants have maintained significant weight gain for at least three consecutive months, and for the TBAs who have been actively involved in the *Posyandus* or parent/caregiver education sessions. The type of educational incentive will be defined later by the project staff and *Kaders* with the intention that the community will assume responsibility for providing this incentive so as not to create a dependence on the project.

CHOICE will work with the TBAs, traditional healers, and other opinion leaders at both household and village levels to help educate and influence their family members and fellow villagers/neighborhood caretakers of children under five. Religious leaders in the *majelis taklim*, or religious learning forums organized for women and men, will also be recruited for this purpose. The project will also strategically incorporate use of the *arisan* or "merry-go-round" savings group, which is common and well placed for promoting health messages. As mentioned under IR 2, Designing by Dialogue or the TIPs behavior change approaches will be used to work with households to negotiate behaviors that are feasible middle steps to build confidence in

caretakers' abilities to make major behavior changes. Based on its successful *Posyandu* School Education approach in the Maluku Islands in the 1990s, PCI and its NGO partner will work with the primary education sector and through the schools to develop a complementary child-to-child approach (this could also include child-to-younger child, child-to-older child, and child-to-adult) for sustainable behavior change—for example, to increase the target group's attendance at the *Posyandu.* Also, PCI will work at the village level with the well-known youth organization called "Karang Taruna". Interested and qualified members of *Karang Taruna* will be trained as health promotion volunteers and to help with *Posyandu* activities—CHOICE staff will determine criteria for selection in collaboration with the communities.

As mentioned in section D.5 – (Operations Research) and above under LLR 2.2, an OR study will be designed and conducted to determine what differences an integrated and multi-sector *Posyandu* TKA model can make on the quality, utilization, and community ownership of the *Posyandu*. The PD approach will also be employed, especially for behaviors related to feeding, health care, and health-seeking practices.

The integration of TB interventions into CHOICE's Child Survival Project will be introduced in stages as *Puskesmas* become equipped and trained to competently manage TB in their sub-districts. This means that in the first year of project implementation (starting October 2004), the CHOICE project will prioritize its outreach and awareness-raising interventions in the 10 villages of Pagelaran sub-district where the existing *Puskesmas* has already been strengthened through capacity building and through the provision of laboratory equipment and supplies by the KNCV project. This *Puskesmas* is currently functioning as a "self-help DOTS strategy implementer", called a *Puskesmas Pelaksana Mandiri* (the *Puskesmas* that can analyze sputum smears for diagnoses). Malnourished children and adult TB patients who are living in the same house or living in surrounding areas near the children's houses are the main target groups of the TB intervention in the CHOICE project area. The project will treat every identified malnourished child or a child who failed to thrive as potentially having had contact with an adult TB patient. Home visits will be made by trained *Kaders* to detect contact persons and to disseminate information on TB symptoms, transmission and appropriate care-seeking. Once a contact person has been identified, *Kaders* will report their findings to the *Puskesmas* staff for follow-up action. The National TB Program has developed guidelines for pediatric and adult TB diagnosis and treatment that are now being used by *Puskesmas*.

In the second year of project implementation, outreach and awareness-raising interventions will be expanded to the 10 villages of Saketi sub-district, where the health providers of the existing *Puskesmas* have been trained on diagnostic technique, and where the *Puskesmas* has been provided with laboratory equipment and supplies, but is not yet able to do laboratory diagnostics due to a lack of availability of laboratory staff. PCI understands that the local government has identified a budget and is in the process of recruiting the needed laboratory staff.

During the second year of the project implementation, the interventions will also be expanded to the 5 villages in Patia Subdistrict and 5 villages in Angsana Subdistrict. As identified during the "*Puskesmas* Capacity Assessment" workshop conducted in May 2004, these two *Puskesmas'* staff have also completed training as health providers. These persons have already been trained to identify suspected TB in adults and children, to properly process and refer sputum fixation and

smears, and to manage TB cases as a satellite to the fully-staffed and equipped MR (Microscopic Reference) *Puskesmas* in Pandeglang District. Funded by the KNCV project, training was provided by the provincial trainer team which had been established and participants trained for improving the quality of TB services.

TB Component Objectives and Indicators

The CHOICE TB component falls primarily within the project's IR 2: Improved health seeking and care giving behavior among care takers, and LLR 2.2: Increased knowledge and skills regarding key family practices critical for child survival, growth and development among caretakers. Indicators to be used to measure intermediate results related to TB include:

- At least 80 % of identified severely malnourished children and the children who fail to thrive after participating in PD/Hearth sessions are visited by *Kader*s (to identify TB contact persons, to inform mothers and contact persons about key TB messages and to encourage them to seek TB treatment).
- Percentage of suspected TB cases referred to *Puskesmas* increased by 40 %

To measure the Lower Level Result 2.2, the project will use the following indicators:

- Proportion of target population (mothers of children aged 0-23 months) who are aware of at least 2 symptoms of TB
- Proportion of target population (mothers of children aged 0-23 months) who know that TB is a curable disease

In addition, the project will measure progress through several process indicators that relate directly to the activities outlined below. These include:

- Number of *Kaders* and other health care workers trained on topics related to TB
- Number of home visits made
- Number of IEC materials developed and/or adapted
- Number of DOTS observers identified
- Number of village-level TB campaigns organized

CHOICE TB activities will include the following:

- ♦ Training for selected *Posyandu Kaders* (100), midwives (20 - if the government assigns them all), and TBAs (40) on the transmission of TB, the symptoms of TB in adults and children, the correlation of severe malnutrition with TB in children. Prevention, care-seeking and advocacy skills will be enhanced, in collaboration with the DHO and *Puskesmas*.
- ♦ Trained *Kader*s will be encouraged to visit (400) families with severely malnourished children that they identify during *Posyandu* activities or through PD/Hearth sessions. Home visits will be made in order to identify TB contact persons, disseminate key messages by using an illustrated card (developed by KNCV), and encourage adult (suspected to have TB) s to check their health status at the *Puskesmas*. The results of home visits will be reported by the *Kaders* to the *Puskesmas* staff for follow-up action.
- ♦ Locally acceptable IEC materials will be developed and/or adapted (in coordination with KNCV) for TB campaigns and health education sessions, and will be incorporated into the parent/caregiver education module. Key messages will include the fact that TB is not a genetic disease, that TB drugs are provided by *Puskesmas* free of charge, and that TB can be

cured. Information on disease transmission mode, treatment schedules and steps, and the importance of drug observers to ensure patients' compliance with TB treatment will also be provided. CHOICE staff will work together with the KNCV, *Puskesmas*, *Kaders*, the Family Welfare Organization (PKK) and CEI members to develop locally accepted orientation materials for a TB campaign.

- 120 appropriate and reliable treatment observers will be identified. During home visits to children's families, the *Kaders* or CEI members will interact with the patient, mothers of malnourished children, and family members and respected/responsible neighbors, and select one person who is willing to help monitor the TB patient, including escorting the patient to the *Puskesmas* for a health check-up. This observer will: receive orientation about TB (together with the patient) at the *Puskesmas*; conduct regular visits to the patient to ensure compliancewith the TB drug regimen and to remind the patient about sputum rechecking at the *Puskesmas*. For TB in children, the mother will be the primary treatment observer.
- *Kaders*, PKK, CEI and village leaders will be facilitated in organizing (40) TB campaigns. PCI will coordinate advocacy and awareness building campaigns designed to minimize stigma and maximize appropriate behaviors. PCI will coordinate with the PPTI (Indonesian Tuberculosis Control Association) and others, building on their experiences and adapting materials for use in the target sub-districts.

(Please see Annex 5.F for an illustrative "Decision-Tree").

Key Activities:
Under this LLR, key activities will include:

- ✓ Use of the BEHAVE framework and "Doer/Non-Doer" Analyses
- ✓ Application of Designing by Dialogue
- ✓ Implementation of a child-to-child approach
- ✓ Informal training and recruitment of youth volunteers to help with *Posyandu* activities
- ✓ Monthly parent/caretaker education sessions
- ✓ TB training for selected *Posyandu Kaders* and midwives
- ✓ Facilitation of TB home visits for families with severe malnourished children
- ✓ Development and/or adaptation of TB IEC materials for campaigns and health education sessions
- ✓ Identification of appropriate and reliable TB treatment observers
- ✓ Organization of TB campaigns

ROLE OF SECTORS INVOLVED IN TB COMPONENT

Major Activities	Sector' s Responsibility		
	PCI	KNCV	DHO/PHO
A. Training			
1. Training for selected *Posyandu Kader*	Technical assistance (TA), training cost and facilitators	Training module	TA, facilitators, training cost
2. Training for midwives	TA, training cost & facilitators	Training module	TA, facilitators
3. Training for TBAs	TA, training cost & facilitators	Training module	TA, facilitators, monitoring

B. Case identification			
4. Home visits by *kaders* to families with malnourished children or children who fail to thrive	TA, training, monitoring	Monitoring, TA	Drugs, TA, facilities for sputum check
5. Develop locally acceptable IEC materials	TA, training, printing cost	Printing cost, existing materials	TA, existing materials
6. Orientation for treatment observers	Facilitation, TA, monitoring	Orientation module, TA	Orientation cost, facilitators, TA, monitoring
7. TB campaign	Materials for campaign, TA	Existing materials, TA	TA, monitoring, materials for campaign

(Please see Annex 5.G for a proposed change in strategy in the TB component of CHOICE)

LLR 2.3: Reduced Obstacles to Adopt Recommended Key Family Practices to Support the Survival, Growth, and Development of Children

Increased knowledge alone will not automatically lead to changes in behavior. Behavioral changes are more likely to occur and be maintained when social and cultural contexts are modified to support a positive climate for behavior change. Besides a "lack of knowledge" the baseline survey showed that a "lack of facilities" is another obstacle for communities' adoption of key family practices. The KPC results revealed that community access to safe drinking water all year long is still low (54.9 %), while the rest of the population is using water from unsafe sources such as open wells, surface water, and open rainwater reservoirs for their daily use. Only 27.7% of households had access to a functioning toilet, and the vast majority of those responding indicated that their households defecated in open places contributing to transmission of infectious diseases. This situation is magnified by the fact that almost half of villages in two of CHOICE's sub-districts are vulnerable to flooding—not surprisingly, about 24% of children aged 0-23 months had an episode of diarrhea in the two weeks before the KPC survey. Limited access to a clean water supply is also contributing to the extremely low percentage of mothers who wash their hands properly at recommended times (only 1.3%).

To address these problems, CHOICE will help communities to mobilize their local human, natural and monetary resources, and whenever needed, small amounts of aid will be provided in the form of materials, such as cement and pipes (with PCI's non-CSHGP resources), as well as technical assistance. Based on its extensive experience in W&S through CHANCE and other projects, PCI will join YPSI staff to build the capacity of the community members under CEI coordination on simple techniques of W&S facilities construction, maintenance, and management, and will work with the CEIs to mobilize community self-financing for the long-term maintenance of these facilities. In addition, PCI and our partner will explore the incorporation of SODIS (Solar Disinfection of Water), an extremely low-tech, low cost method of purifying water for drinking, into outreach, education, and behavior change activities, as appropriate.

In Pandeglang, as in many other areas of Indonesia, male partners are the predominant decision-makers in their families, while "wise" persons—such as male religious leaders—also play an

important role in influencing the community members to make decisions. This dependency of women on male partners and "wise" persons who control decision-making regarding their health and that of their children has traditionally contributed to an often fatal delay in seeking appropriate treatment at the health center. CHOICE will engage men in promotional activities through man-to-man sensitization efforts, small workshops, group discussion and outreach strategies. Men's active involvement will be sought from the beginning of the project. Fathers and other male caretakers—such as grand-fathers, uncles, etc.—will be encouraged to participate in parent/caregiver education sessions and to bring under-five children to receive services at the *Posyandu*. Other obstacles are expected to be identified during additional participatory assessment exercises, and will be addressed in collaboration with community members, as appropriate,

The project will adapt existing BCC materials for the training of *Kaders*, and parent/caregiver education. In addition, information on TB prevention will be integrated into parent/care giver education programs. The information to be promoted will include the symptoms and disease transmission mode, the danger of not complying with the recommended TB cure, the importance of protecting children from TB infection with Bacille Calmette-Guerin (BCG) immunization, and the importance of improving environmental sanitation.

Key Activities:
Under this LLR, key activities will include:

- ✓ Water system and latrine construction and SODIS
- ✓ Engage men in promotional activities as influential catalysts for change (parent/caregiver education sessions, man- to-man sensitization, small workshops, outreach)
- ✓ Adapt and utilize BCC materials for behavior change.

IR 3: Successful Implementation of PCI's Community-Based Health Development Model by their Partner NGO

After completing a thorough pre-assessment of NGOs being considered as project partners, the project team decided to work with only one NGO, namely the Social Concern Foundation of Indonesia (YPSI). PCI and YPSI will participate in local NGO networks in Banten Province and Pandeglang district, in which they will seek to engage other sectors in a child health round table.

LLR 3.1: Increased Knowledge and Skills of NGO's Staff in Project Management
PCI and YPSI have already established excellent working relations through a number of joint project start-up activities, including project preparation, baseline survey, relationship-building with other sectors at the district level, organizing the DIP workshop along with government officials, conducting institutional capacity assessment with health center partners (*Puskesmas*), and organizing meetings with sub-district authorities and village community leaders. In early June 2004, YPSI will sign a second MOU with PCI (the first facilitated the two organizations' collaborative work on project start-up activities) to start mobilizing and recruiting full-time project staff. Once staff are in place—including 15 new field facilitators, four field supervisors (whose current contract will most likely be renewed), a full-time project coordinator, and one full-time finance officer—a detailed orientation of the project, including its strategy, approach and interventions, will be provided. Technical trainings necessary to support YPSI's staff in

working with the community will be conducted prior to full project implementation. The technical trainings needed by YPSI staff, as identified during the DIP workshop, include:

- Training on how to conduct Participatory Rapid Appraisals (PRA)
- Community mobilization
- Maternal and child health (including project intervention areas)
- Water and sanitation
- Facilitation skills/adult learning methods
- C-IMCI
- *Posyandu* TKA
- PD/Hearth
- Monitoring and data management

All technical training is expected to be completed by the end of year 2. Periodic refresher trainings will be provided to the NGO field staff to refresh and update their knowledge and skills and continually improve their competence in working with the community. It is expected that by the end of project year 3, all trainings at the community level will be managed and facilitated by the YPSI staff without assistance from PCI technical staff, other than technical advice as needed, and supportive supervision and monitoring to ensure quality.

To ensure proper implementation by NGO project staff, PCI's technical staff members will provide technical assistance, guidance and supervision, avoiding direct involvement in most of the community-level activities. This supervision is intended to assist the partner NGO in joint problem-solving, and help ensure focus on the agreed-upon results and approaches.

Key Activities:
Under this LLR, key activities will include:

- ✓ Training of YPSI staff in project management and other key areas
- ✓ Technical assistance
- ✓ On-going on-the-job refresher training
- ✓ Facilitative and supportive supervision by PCI of YPSI's activities.

LLR 3.2: Increased Institutional Capacity of Selected NGO Partner

Key to the successful functioning of the partner NGO will be their development into a stable, effectively managed institution, capable of sustaining community-based health programming beyond the life of the CHOICE project. To help accomplish this objective, PCI will assist YPSI in conducting an institutional capacity self-assessment process prior to project implementation. The purpose of the self-assessment is to identify capacity building needs of the institutions, and to help target training and technical assistance interventions. As mentioned previously, the SCAT methodology will be used for the assessing institutional capacity. Once NGO capacity building needs are clearly identified and prioritized, based on the assessment results and on the topics identified during the DIP workshop, PCI will source training expertise from its own staff or from external consultants or organizations, as needed. Potential areas of NGO capacity building include strategic planning, project design, and resource development. These capacity building efforts (through workshops, on-the-job training, mentoring, exchange visits, etc.) will be conducted in parallel with each project implementation phase.

With the increased management and programmatic capacity developed through the CHOICE project—and with the potential to share that improved knowledge, skills and expertise with others—YPSI will be in a better position to gain donor confidence when applying for grants, thus improving their capacity to sustain health interventions over the long term. Fortuitously, the Banten Provincial Health Office is also seeking to develop local NGO capacity and skills in health programming. Thus, the provincial government, and potentially the district as well, are likely to release funds for collaboration with local health sector NGOs, thus presenting an additional opportunity for YPSI to diversify its resource base. In addition to liaising with local government, PCI will also help YPSI to develop contacts with a range of donors and other international PVOs who may be potential collaborating and funding partners in the future.

Key Activities:
Under this LLR, key activities will include:

- ✓ Capacity assessment
- ✓ Prioritization of capacity building topics in collaboration with and for YPSI
- ✓ Capacity building activities
- ✓ Liaising with local government
- ✓ Assisting YPSI in developing contacts with donors and potential collaborators

Intervention-Specific Approaches

Overall BCC Strategy
While analysis of KPC and HFA results and planning sessions during the DIP workshop have enabled project staff to identify and prioritize potential behaviors to be promoted, CHOICE staff will use the BEHAVE framework to further refine their intervention strategy, including:

1. Confirming the selection of key target audiences,
2. Identifying which behaviors should be targeted for change within each target audience
3. Determining the factors (barriers and benefits) that influence the behavior, and
4. Developing an appropriate set of BCC interventions.

Due to their significant influence on pregnant women and mothers in Indonesia, CHOICE plans to target five primary groups for BCC interventions:

I. The government health staff (DHOs, *Puskesmas* staff, and midwives)
II. TBAs and volunteer *Kaders*
III. Mothers and mothers-in-law
IV. Key opinion leaders
V. Husbands and other male caretakers

In order to develop step 3 of the BEHAVE framework in each intervention area (determine the enabling factors and key barriers to behavior change), CHOICE will conduct additional qualitative research through Focus Group Discussions, selected in-depth interviews, and "Doer/non-Doer" Analyses with the target groups—for example, the project will attempt to determine what factors might contribute to a change in harmful practices, such as the introduction of pre-lacteal fluids/foods during the first three days. Once the research has been analyzed, it will contribute to the finalization of an appropriate behavior change strategy. Based

on previous experience in other areas of the country, project staff anticipates that the focus of the multi-media strategy will be on low-cost, traditional and folk media, such as local songs, dramas, and popular contests (most nutritious recipes, cooking contests, best TBAs, etc.). For *Kaders* and TBAs, in addition, interpersonal communication/counseling techniques focusing on improving the quality of care from the client's perspective, and using existing materials for low-literate audiences, will be an important component of the BCC program. Negotiated behaviors will be used to help families gradually gain confidence through smaller, incremental changes in behavior in order to better sustain these changes over the long-term; these negotiations will be facilitated by utilizing such approaches as Designing by Dialogue or TIPs.

In preparation for refinement of the BCC strategy, PCI staff will train their partner, YPSI, in the BEHAVE framework (including "Doer/Non-Doer" Analysis); qualitative research methods (including Focus Group Discussions and Participatory Rapid Appraisals); BCC materials adaptation and use (including message design based on formative research, developing traditional, low-cost media); and negotiation methods, such as Designing by Dialogue or TIPs. By training YPSI staff as trainers, and empowering them to facilitate workshops and other capacity building processes on the above topics for the community, the project will build individual capacity and confidence while contributing towards the institutional strengthening of the NGO. This increased capacity in BCC methodologies/strategies will enable YPSI to increase their marketability in the future should they solicit additional opportunities to partner with other PVOs or receive funding for similar types of activities.

Overall Approach to Quality

Project staff recognizes that conventional training alone is not likely to result in changed behaviors. Therefore, strengthening the supervision system—involving TBAs in verbal and social autopsies at the village level, providing competency based trainings (see BCC section), establishing TBA-midwife partnerships, and elevating the status of TBAs by involving them in the promotion of key family practices—will be the focus of these quality assurance efforts for sustainable behavior change for all target groups, including the mothers/fathers/caretakers, TBAs, midwives, and *Kaders*.

CHOICE staff will build the capacity of CEI members/*Kaders* to facilitate verbal and social autopsy meetings to identify social aspects that contribute to the deaths of mothers and children. These meetings will allow the community to collaboratively identify solutions to prevent these deaths, such as a delay in identifying pregnancy danger signs/complications, delays in decision-making, referring to the appropriate health facility, and in receiving appropriate health services. Through the partnerships between the midwives and the TBAs, and by engaging all sectors of community development (religion, education, environment, etc.) through a multi-sectoral approach, the community will become competent and motivated to conduct these autopsies, which will contribute to a reduction of maternal and child mortality over the long term. Also, building increased capacity of TBAs and midwives in improving health indicators in all intervention areas will contribute to the sustainability of behavior changes in the community, even after the LOP.

The project will contribute to the strengthening of the monitoring and supervision capacity of health officials to ensure that first-level health facilities are correctly implementing the MOH

(IMCI) standards of maternal and child service procedures, and their problems and obstacles are effectively addressed. As a quality improvement (QI) monitoring and supervision system already exists in the District Health Office (but has not yet been implemented appropriately), the project will work with the DHO to conduct regular QI supervisory visits, and to integrate this into the district's existing quarterly reporting and supervision scheme.

District health staff will use the HFA questionnaire modified into a Quality Improvement Verification Checklist (QIVC) tool, as well as the standardized Indonesia checklists used during project monitoring and supervision visits, to ensure that the services offered by midwives are compliant with national and international standards (MOH/IMCI). For this, CHOICE staff will provide training to supervisory health officials in the application of HFA/QIVC tools, and on how to conduct facilitative supervision as well as the use of the data for management and planning. Special emphasis will be placed on the practical use of the information, to enable the supervisory staff to see the value of the system for improving health service delivery. PCI will also provide refresher training and assistance with problem-solving as needed. For the TBAs and *Kaders*, the project, in collaboration with the DHO, will develop simple checklists to be used by the midwives in supporting the TBAs and *Kaders* in improving and maintaining the quality of services offered in the community.

As most of the DHO staff have already been trained in QI supervision, the project will improve their knowledge and skills on how to do facilitative supervision (the training module will be adapted from American Voluntary Service Corps' (AVSC) facilitative supervision module). This supervision method will eliminate the "power gap" between supervisor and supervisee—it will enable them to discuss the results of supervision visits freely through a participatory process. This method will also allow the health providers and *Puskesmas* managers to take immediate actions for improvement since the feedback from supervisors will be received on the same day. Regular monitoring and supervision visits conducted by the DHO, in partnership with the project staff, at one- and six-month post-training intervals will also help ensure that the midwives are constantly applying new skills and maintaining and improving their competency levels.

The CHOICE staff will conduct frequent and regular visits to provide coaching and informal training to the *Kaders* at the village level to ensure that new skills are improved upon and reinforced. Through the midwife/TBA partnerships, the quality of services provided by TBAs will be improved through self-assessments, joint problem identification, and resolution processes followed during regular meetings at which TBAs will present the results from their checklists, discuss what challenges they have had in performance improvement—and, jointly with the midwives, strategize ways to resolve problems and continue to improve skills, such as through on-the-job training, coaching, mentoring, and prioritizing future topics for refresher training. CHOICE staff will work with midwives and TBAs to assist them in developing an on-going process for assessing quality of care from the client's perspective, and connecting client satisfaction to decision-making by service providers.

The project will also contribute to the quality of reporting in this area by working with the DHO, midwives, and *Kaders* to increase the distribution and consistent use of the health cards for mothers and children. TBAs will also be responsible for monthly record keeping using a simple

illustrated tool/checklist that will be brought to each meeting with the midwives (see section E.3 - Performance Monitoring and Evaluation, below).

E.2.1. Maternal and Newborn Care

Behavior Change Communication

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
Few deliveries attended by skilled personnel (15.8%) Few midwives have been trained in safe and clean deliveries (15/26 in project area)	TBAs are less expensive, and provide extra services (massaging the mothers, preparing herbal teas to return the uterus to normal position, washing clothes, washing and planting the placenta, bathing the baby until 7 days postnatal)	Regional/local government officials Key opinion leaders TBAs and midwives	**Policy Level:** With DHO, advocate for increased placement of midwives in project area
Babies are bathed immediately after birth (80.7%)	Baby needs bathing immediately after birth - not necessary to unite the baby and mother immediately after birth		**Community Level:** Train midwives and TBAs in safe and clean deliveries Social & verbal autopsies Improve monthly record-keeping through illustrated checklists Partnerships between midwives and TBAs to increase skills and mutual support Improve supervision of TBAs by midwives & midwives by DHO (community feedback mechanism) Train midwives/TBAs

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
		Mothers/mothers-in-law/grandmothers Fathers/male caretakers	and *Kaders* in client-centered counseling/IPC **Individual Level:** *Strategies*: Support groups for parents/caretakers *Interventions/Media Channels*: Message dissemination and awareness-building (via songs, dramas, contests, counseling cards, video); Behavior negotiation; Peer education, support, and reinforcement Improve reporting by parents (health cards)
Key Messages: Use skilled health providers trained to ensure safe and clean deliveries; do not bathe babies post-partum (may cause hypothermia); babies need to be placed immediately and directly on the mother's chest for early bonding, early latch on, immediate breastfeeding, and for mothers' warmth			
Limited antenatal care and lack of knowledge of pregnancy-related danger signs (only 37.5% of mothers with cards had had at least four antenatal visits; only 8.7% of mothers knew at least two pregnancy danger signs)	Pregnancy is seen as common and mothers do not receive information on danger signs	*Kaders*, TBAs, midwives Mothers/mother-in-laws/grand-mothers Fathers/male caretakers	**Community Level:** Include info. on danger signs in *Kaders*, TBAs, and midwife trainings **Individual Level:** Stress importance of danger signs and antenatal visits during support group education sessions

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
Key Messages Know pregnancy danger signs; prepare for emergency evacuations in case of danger signs			
Low coverage of tetanus toxoid (TT)*	Barriers on supply and access sides	DHO Midwives	**Policy Level:** Advocate for provision of TT by DHO to prevent interrupted stocks **Community Level:** Collaborate with DHO to influence midwives to take vaccines to villages with each visit (learn about barriers)
Limited post-partum care for the baby and mother (50.9% of mothers report having had a post-partum check-up)	Mothers do not go to the health center because they believe the TBA can put the uterus back into its original position, and that massages provided by TBA will make them healthy and recover quickly	TBAs and midwives Mothers/mothers-in-law/grand-mothers/fathers/male caretakers	See above activities re: "few deliveries attended by skilled personnel"
Key Messages: Go to the *Posyandu* or *Puskesmas* and demand your right to a tetanus toxoid (TT) vaccination during pregnancy. After birth, go back to the *Posyandu/Puskesmas* and learn how post-partum check-ups ensure the health of mothers and babies and can even save lives			

**While the Rapid CATCH shows a relatively high percentage of mothers with at least 2 TT vaccines (68.7%), this data is misleading because it represents only those women with mothers' health cards, which in fact was only 3.7% of the total mothers interviewed.*

Training and Supervision

Following the C-IMCI framework, CHOICE will address each element and utilize the multi-sectoral platform to strengthen and sustain its efforts. As part of element 1, emphasis will be on creating, supporting, and strengthening partnerships between midwives and TBAs, increasing their skills and improving referral systems. Recognizing that in reality TBAs are the number one choice for mothers who deliver in the project area, while at the same time supporting the MOH policy to encourage births by skilled health personnel, CHOICE's strategy will be to concurrently improve the skills of TBAs while encouraging the TBAs to work with the midwives to increase the number of women who deliver with the midwives. Anecdotal reports have

indicated that in some areas where partnerships between midwives and TBAs have been formed, not only has the quality of maternal and neonatal services improved, but the number of births assisted by skilled personnel has also increased.

For element 2—improving the quality and access to information through community-based providers—PCI will provide first-level health providers (midwives) with training in safe and clean delivery to: avoid traumatic delivery and emergency cases; avoid infection; provide appropriate immediate care, such as warming and drying (including "kangaroo" care for small or premature infants); stimulation of crying and ensuring that the baby's airway is clear; demonstration of cord care; and promotion of pre-natal care to treat sexually transmitted illnesses. Midwives, *Posyandu Kaders* and TBAs will also be trained to encourage early initiation of breastfeeding, educate mothers and key family members (husbands, mothers-in-law and grandmothers) about danger signs in newborns, lactation management, baby massage, and neonatal care (see section on LLR 1.2, above, for description of training strategy for TBAs and midwives).

The project will work with the Provincial Training Center (PTC) for Reproductive Health and the Association of Indonesian Perinatologists (*Perinasia*) to train midwives in safe and clean delivery, as well as how to conduct social and verbal autopsies. The PTC is using the MOH standardized materials for training developed with support from JHPIEGO's Maternal and Neonatal Health (MNH) project. To promote exclusive breastfeeding during the parent/caregiver education sessions, the project plans to utilize approaches and training materials from the National Breastfeeding Center, a video developed by Dr. Utami Rusli, an Indonesian breastfeeding specialist, and a training manual developed and tested by PCI during the CHANCE project. Because of their role as key decision-makers in health, and the fact that the current Indonesian socio-cultural environment is very conducive to their involvement, an emphasis will be placed on encouraging fathers and male caretakers to participate in exclusive breastfeeding promotion.

Posyandu Kaders will in turn be trained by the project, in collaboration with the midwives, in lactation management and baby massage. CHOICE staff see the training and support of TBAs and *Kaders* in these areas as essential to ensuring the sustainability of changed behaviors since they will be able to support the mothers in adopting and maintaining positive behaviors in these areas. One of the lessons learned by project staff working in Jakarta and Papua was that mothers became enthusiastic about bringing their babies to the *Posyandu* sessions when the sessions included other activities besides just the weighing and counseling. Several studies have shown that baby massage can have positive effects on improving growth and development for babies from birth through their first year (to stimulate hunger, weight gain and physical growth, improve immunity, increase mother-child bonding and interaction, improve sleep, and even increase the production of milk, because babies feel hungrier and mothers' milk production responds accordingly). Since increasing the technical information is not sufficient in and of itself, message delivery must be accompanied with effective counseling/interpersonal communication skills that focus on a client-centered approach: therefore midwives, TBAs, and *Kaders* will all be trained in these skills.

"Support groups" (consisting of mothers, mothers-in-law, grandmothers, and male caretakers, all of whom exert significant influence on pregnant women) designed to assist pregnant women have been used in other areas of Indonesia, and represent a potentially highly successful approach to helping women to adopt positive behaviors regarding their maternal health and healthcare of the newborns. These groups are seen by project staff as key to ensuring sustainability of project efforts: therefore, all activities under the CHOICE project related to working with these groups will focus on setting up systems for their continued functioning after the LOP. For element 3 of the C-IMCI framework, the project will consider using these groups to encourage mothers to make at least four antenatal visits, to understand their rights and be empowered to ask for the level of quality of care they are entitled to, including sufficient iron folate supplements (at least 90 tablets during the last trimester - see Nutrition and Breastfeeding Interventions), two tetanus toxoid (TT) vaccinations, recognize danger signs during pregnancy, receive nutritional counseling during antenatal visits, and complete child immunizations on a timely basis. These groups will also provide the impetus for encouraging mothers and community members to develop emergency evacuation plans, including savings to help mothers support the costs of delivery/emergency cases.

The project staff will build the capacity of CEIs members/*Kaders* to conduct small workshops/discussion with fathers/caretakers of children aged 0-5 years, husbands of pregnant women, and male religious community leaders to promote the role of the husband in seeking quality maternal and child care, and preparing for and being present during the birth in case unanticipated emergencies arise. The men's groups will also be oriented with the information related to women's and children's nutrition; the rights of the child regarding survival, protection and development; danger signs of pregnancy, delivery and postpartum; danger signs of newborns and sick children; and other reproductive health issues, such as family planning and STIs/HIV/AIDS. In addition, the men's groups will also discuss ways to help mothers and children in an emergency situation, or whenever they need to be referred to the more advanced health facilities/hospital, which includes organizing transportation and mobilizing resources. Project staff will learn about the concept of local revolving health funds that have been implemented in some areas in Indonesia for the Making Pregnancy Safer Initiative, and, if possible, adapt and introduce this concept to the target communities.

Quality
(See section E.2 above - Overall Approach to Quality Improvement.)

Access
Maternal and child health (MCH) books, TT vaccines, midwife kits, and cool boxes are essential commodities for the successful implementation of activities related to this intervention area. Initially, the project will purchase these commodities (with the exception of TT vaccines which are provided by the DHO) to ensure that they are in adequate supply when project activities in this intervention area begin. The project will implement low cost sustainability measures, such as printing substantial quantities of existing maternal and child health books, proper maintenance of cool boxes and midwife kits to ensure their long term availability, and carrying out advocacy measures for continued provision of the TT vaccines by the DHO to help alleviate barriers to uninterrupted supply stocks. In addition, these advocacy measures will include working with the government to include prioritization for essential maternal and child health commodities in their

strategic planning during years 3 and 4, and after the LOP. A major constraint to achieving this vision of long term sustainability is limited budget allocation; the project will explore how other districts have resolved this issue and adapt appropriate measures. Maternal and child health books serve multiple benefits for the children and family, and contain information on the mother's blood type, pregnancy danger signs, delivery and post-partum, maternal and child nutrition including breastfeeding, immunization, antenatal check-up results, home treatment of sick children, and a growth monitoring chart. This book will be provided to all pregnant women in the project area and used for monitoring the children's growth until aged 5. It can also be used by *Kaders* to initiate discussion with parents/caretakers at education sessions. During these sessions, *Kaders* will focus on information regarding home treatment for sick children, enabling mothers/caretakers to give first aid and potentially save their children's lives, and the recognition of danger signs that indicate the need to take the child to a health facility.

Simple inventory/supply stock, safe use, disposal, and storage checklists will also be developed and applied by *Kaders* to monitor safety, availability, quality and distribution of supplies. Since ample supplies, including TT vaccinations, are available at the central *Puskesmas*/health center levels, but complete doses of these supplies seldom seem to reach pregnant women in an appropriate timeframe, the project will work with the DHO/*Puskesmas* to determine key factors influencing behaviors of midwives regarding regular administration of vaccinations during village visits, and to determine what factors need to be in place to ensure that all pregnant women receive the complete cycle of two TT vaccinations. Some of the potential inhibiting factors may be that midwives do not have cool boxes or they may feel that it is not cost effective to open a vial for one or two mothers since one vial can vaccinate eight mothers. If the presence of cool boxes is one of the main causes of limited access to vaccines, the project will support the midwives/*Puskesmas* in the provision of cool boxes, and train them in their maintenance to ensure long term use. The proper distribution and use of cool boxes, and subsequent quality of their contents, will be monitored through QI supervision.

E.2.2 Nutrition and Breastfeeding

Behavior Change Communication

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
Lack of early initiation of breastfeeding (only 12.4 % of children aged 0-23 months were breastfed within the first hour after birth)	TBAs and others don't understand the necessity of uniting the newborn with the mother immediately after birth because they do not realize that babies have a natural reflex to suckle and an innate instinct for immediate latch-on if		**Policy Level:** Ensure awareness of national norms for exclusive breastfeeding; support the BFHI and BKPPASI efforts to sensitize health workers and communities to the existing policies,

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
	placed on the mother's chest		norms, and international standards related to optimal infant feeding practices;
Limited exclusive breastfeeding during six months (70.8 % of children 0-23 months were fed with pre-lacteal fluids/foods during 3 days after birth - and the maintenance of breastfeeding of children aged 18-23 months was 66.2%	TBAs, mothers, grandmothers, mothers-in-law believe that newborn needs to have honey, banana or papaya, water, or other food/liquids in order to survive, especially when the mother may have difficulties with milk production during the first 3 days after birth. If the baby cries it means they are thirsty and hungry.	TBAs/*Kaders* Mothers/mothers-in-law/grandmothers/ fathers/male caretakers Key opinion leaders	coordinate with national level for the adoption of Essential Nutrition Action approach for improving the nutrition of women and children (7 proven actions and 6 critical contact points) Advocate for greater involvement of men **Community Level**: *Strategies*: Parents/caretakers' Support groups - Fathers' participation in encouraging EBF
Malnourished infants (23.5% of children 0-23 months are underweight; only 52.2 % of children 0-23 months have a growth monitoring card; and 25.4% of children 24-59 months are stunted); children aged 6-23 months only eat an average of 3 food groups	Low use of high nutrient, iron rich foods & frequent use of non-nutritive snack foods Limited breastfeeding practices	*Kaders*, parents/caretakers	*Interventions/Media Channels*: Message dissemination and awareness-building (through songs, dramas, contests, counseling cards, video)
Only 37.78 % of children aged 6-23 months ate animal source foods in the last 24 hours and	Children will be infested with worms if they eat fish or meat because their stomachs are small.	Parents/caretakers (including, grandmothers and male caretakers), TBAs, *Kaders*	**Individual Level:** Behavior negotiation; Peer education, support, and reinforcement; PD/Hearth

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
only 16.3% of children aged 6-23 months ate at least the minimum recommended number of times in the last 24 hours	Children aged 6-23 months do not need to eat frequently		implemented in 16 priority villages
32 % of pregnant women have MUAC < 23.5 cm (cut off point used in Indonesia)	Eating more than usual will result in a big baby (& a difficult delivery)	Pregnant women, youth, *Kaders*, grandmothers, husbands	
Key messages: Initiate exclusive breastfeeding (EBF) immediately, continue EBF to 6 months, introduce proper complementary foods at 6 months, and continue BF for 2 years, EBF during illness (for babies under 6 months) and continue providing additional food/fluid and breast milk for children older than 6 months; give complementary foods at least 2 times a day for children aged 6-8 months and 3 times a day for children aged 9 - 23 months; give animal source food at least 3 times a week to children; children aged 6-8 months should eat 2 times or more and children aged 9-23 months should eat 3 times or more solid, semi-solid or soft foods other than liquid; children should eat a variety of foods; take iron/folic acid (at least 90 tablets during pregnancy); increasing foods during pregnancy and lactation will make you strong and healthy; eating eggs or other animal source foods and tempe or tofu every day will make you and your child healthy and clever; eating more dark leafy greens every day will make you strong and healthy; it is healthy to gain weight during your pregnancy; for husbands: prioritize your foods to your wife during pregnancy and lactation, etc.			

KPC results show that nutrition, breastfeeding and complementary feeding practices need to be addressed early-on in the project. This is both because of the severity of the health status in this intervention area, and because of the potential strategic impact improvements in these practices could have on other poor child health indicators, such as diarrhea diseases and ARI.

Through training of the TBAs and during support group sessions (see above section E.2.1 on Maternal and Newborn Care), the project will promote and disseminate messages on the healthy cycle of breastfeeding (immediate and exclusive breastfeeding to stimulate milk production, provide complete nutrition and the baby's first immunizations, stimulate contraction of the uterus, promote bonding between mother and baby, lengthening the duration of exclusive breastfeeding to six months, and continuing to breastfeed while introducing other complementary foods until the age of two years), and continuing to breastfeed exclusively when a child under 6 months is sick, or offering additional fluids, food, and breast milk for a child

over 6 months old. Mothers, mothers-in-law, and grandmothers will be the focus of the project's efforts to empower women to learn more about how their body reacts and the natural instinct of the baby to suckle.

During support group/parent education sessions, facilitated by well-trained *Kaders*, topics such as good nutrition for the baby and the mother, including the importance of locally available nutritious foods that are high in vitamin A and iron, and/or good sources of protein, as well as the importance, the proper use, and storage of iodized salt will be included. Parents/caretakers will also learn how to record and monitor their children's weight using Growth Monitoring Cards and increase their awareness of the importance of taking the children to the *Posyandu* for regular weighing and to receive other services. As previously mentioned, in collaboration with *Puskesmas*/village midwives, the project will provide intensive training for *Kaders* to enable them to effectively facilitate support group/parent education sessions.

CHOICE will consult widely-utilized and reputable resources and help *Kaders* adapt these participatory methods of negotiation in their approach to behavior change during parent/education sessions. Potential methods include Designing by Dialogue and the TIPs approach. In this way, *Kaders* will learn to negotiate acceptable behaviors that mothers feel they can implement; confidence in making small changes in behavioral patterns will grow; *Kaders* will reinforce the positive benefits through one-on-one counseling sessions; and gradually, mothers will be able to incorporate and maintain the positive health behaviors.

To address relatively high rates of malnutrition, the project will select villages with the largest percentage of underweight children under five (≥30 %)—especially children aged 6-36 months—to participate in the community-based nutrition education and rehabilitation sessions applying the PD/Hearth approach. Prior to the implementation of the PD/Hearth methodology, the CHOICE project staff will orient the *Puskesmas* staff on the PD/Hearth approach for nutrition programs, and train *Kaders* on how to conduct FGDs and PD inquiries and to facilitate mothers/caretakers during PD/Hearth sessions. During FGDs, the *Kaders* will learn more about common family practices, including the quality, quantity, and type of complementary foods given, at what times, how feeding is done, and why some individuals stop exclusive breastfeeding at one month, and why many mothers do not continue breastfeeding until the recommended two years.

After FGD results have been analyzed, the project will:

1. Orient community leaders to the problem using a PRA technique
2. Strategize potential approaches to addressing the problem, including the PD/Hearth method
3. Discuss the methodology and anticipated results
4. Identify positive deviants and negative deviants
5. Coordinate and train community volunteers
6. Conduct PD inquiries
7. Socialize the mothers to the issue and proposed method
8. Conduct PD/Hearth sessions
9. Monitor and evaluate the approach.

Amongst others, key messages will include: active feeding techniques, reinforcing positive complementary feeding practices, and encouraging women and other caretakers to continue breastfeeding and giving other foods and liquids (if the child is over 6 months). Using support groups and PD/Hearth sessions together will help reinforce messages, and further contribute to the adoption and sustainability of key health practices.

At the beginning, PCI will start to apply this approach in the 16 villages where malnutrition prevalence (moderate and severe malnutrition) is highest or ≥ 30 %. PCI will use the *Posyandu*'s anthropometry data as the base for expanding the implementation of the PD/Hearth approach and will include children aged 6- 59 months who fall under mild, moderately and severely under-nourished levels in the PD/Hearth sessions. One or two (may be more) small groups consisting of 10-12 children and parents/caregivers in every *Posyandu* area, will be formed and will conduct their activities in one of the community member' s homes to learn and practice new behaviors in child care and feeding practices. Twelve consecutive days are needed to learn and practice new behaviors during parent gathering sessions; this period is followed by the internalization of the new behaviors at their home setting. Meetings with parents/caregivers are needed prior to the session to discuss the schedule, place for gathering, parent/caregiver contributions during the sessions, division of tasks, etc.

Home visits (aimed at identifying reasons for irregular attendance at PD/Hearth sessions; reinforcing feeding and child caring practices; and identifying TB contact persons, such as adults with coughing ≥ 3 weeks) will be conducted by trained *Kaders* to homes of children and parents/caregivers who are:

- not regularly attending the PD/Hearth session
- show non -significant weight gain (weight gain ≤ 200 gr/2 weeks)

The CHOICE project staff will work closely with the *Puskesmas* and will facilitate the process to identify the causes of CED among pregnant and lactating mothers through the application of BEHAVE framework and Doer/non-Doer analyses. Based on the results of the analyses, the project staff will also encourage the *Puskesmas* staff (midwives and nutritionist) to integrate PD/Hearth into their supplementation program for malnourished pregnant women (CED). During the sessions, pregnant women can learn about good nutrition for their health and that of their babies; women will be encouraged to eat greater quantities of protein-rich foods and to increase their weight during the last trimester of their pregnancy. These messages will be reinforced by incorporating them into parent/caregiver education and husband/man group's activities.

As mentioned earlier, HKI NSS data shows a high prevalence of anemia among children under five. FGDs will be conducted to determine the reasons for anemia in children through questions regarding food intake and food taboos during pregnancy, and influencing factors, such as tea drinking after meals which reduces the absorption of iron. To combat the prevalence of anemia in the community during the early phases of project implementation, iron supplements will be distributed to the affected mothers and children. As a long-term, low-cost and sustainable solution to this problem, the project will introduce a local food-based approach for the prevention of anemia, utilizing the PD/Hearth approach.

Quality
(See section E.2 above - Overall Approach to Quality Improvement.)

Both the QIVC checklists for supervision to be used by the DHOs to supervise the midwives and those checklists to be used by the midwives to support the work of the *Kaders* and the TBAs will include questions regarding the expiration date, stock levels, and storage conditions of Vitamin A and iron supplements. These checklists will also include questions to help monitor the distribution of Vitamin A (illustrated checklists for low-literate audiences will be used to facilitate this activity with the TBAs). In addition, as earlier mentioned, the partnerships that will be forged between the TBAs and midwives (and the resulting community feedback mechanism) will contribute to ensuring the quality of these activities (see section E.2 - LLR 2.1, above).

The PD/Hearth methodology has an inherent emphasis on quality improvement as the methodology, by definition, is designed to improve the quality of complementary feeding practices, and the quality of nutrition status for target children. CHOICE staff will work to ensure that the methodology is implemented properly through thorough orientation and training on the methodology before implementation, and through ongoing supportive supervision and monitoring of PD/Hearth implementers.

Access
The HFA results show the limited number of midwives in the project area. On average, each midwife theoretically covers 2-3 villages, 50% of which are geographically hard to reach areas. The project will support the DHO in advocating with the local government for the recruitment and placement of additional midwives in the project areas. According to the HFA results, Vitamin A is available at health facilities; however, the KPC results show that Vitamin A distribution remains relatively low (only 59.1% of children aged 6-23 months received Vitamin A). This is largely due to the fact that Vitamin A is only distributed twice a year (in February and August), and thus the children who are not taken to the *Posyandu* during these months lose the opportunity to receive the vitamin. Therefore, the project will advocate with the *Puskesmas* (who keep the supply of Vitamin A) to decentralize the Vitamin A stocks to the *Posyandu* level, enabling the *Kaders* to be responsible for the storage and monthly distribution of Vitamin A during *Posyandu* sessions, and also allowing TBAs to distribute Vitamin A to pregnant women or post-partum mothers during the first eight weeks, thus increasing coverage. *Kaders* will also be encouraged to carry Vitamin A capsules when they make home visits for other reasons, thus enabling them to reach the children that are never brought to a *Posyandu* session.

Iron tablets for pregnant women are also widely available through the midwives at the *Puskesmas* level. While KPC results show that the total proportion of women receiving iron tablets during their last pregnancy is relatively high at 77.8%, nevertheless only 12.9% of women report having taken the tablets during the recommended 90 days or more. In addition to limited distribution, a lack of compliance in taking a full cycle of 90 days may be due to a lack of understanding of the importance of taking the full cycle, side effects, unpleasant taste of the tablets, and/or limited attendance at antenatal care sessions (where iron tablets are distributed). The project's approach to addressing this issue will be to:

1. Better understand the reasons that iron tablets are not distributed for the full 90 day cycle
2. Understand further issues of compliance/constraints by mothers
3. Understand the reasons why the midwives do not engage the TBAs in distributing and promoting compliance, and
4. Develop appropriate measures to reduce barriers to access and encourage use amongst pregnant women.

Regarding iodized salt, during the KPC project staff identified certain brands of salt that contain recommended levels of iodine—therefore, during support groups, and in PD/Hearth sessions, these brands will be promoted. The project will also advocate with the local government to explore ways to enforce regulations that all salt produced in Pandeglang (especially through home production methods) will be iodized. Village *Kaders* will also play a major role in advocating shopkeepers to only sell iodized brands of salt.

Interviews with *Kaders* and parents indicated the unavailability of Growth Monitoring Cards (GMC) at *Posyandus*. This was also reflected in the KPC results, which showed the low percentage (52.2%) of children aged 0-23 months possessing GMCs. Considering the importance of these cards in helping parents to monitor their children's growth/health, including the monitoring of the vaccinations received by the children, the project will provide GMCs for under-fives and MCH books for pregnant women during the early years of the project period, and will encourage and advocate for the DHO to prioritize these expenses in their budgets while exploring other sources for the future. The MCH book will continue to be used for monitoring the child's health.

PD/Hearth and *Posyandu* activities may require additional supporting materials or supplies, such as mattresses, baby weigh scales, other food ingredients to demonstrate preparation of nutritious recipes during parent/caregiver support groups, and small gifts as incentives for the mothers of children who have been successful in reaching a good nutritional status and/or are showing a significant weight increase during the PD/Hearth session, and for the mothers of children who have been fully immunized before the age of 12 months.

E.2.3. Immunizations

Behavior Change Communication

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
Low percentage of children fully vaccinated (51% of children aged 12-23 months were fully vaccinated against the five vaccine-preventable diseases and 61.7% of children aged 12-23	Due to low card use, actual coverage is probably much lower Lack of attendance at *Posyandu* sessions means that large percentage of children are not being vaccinated	Key opinion leaders *Posyandu Kaders*/	**Policy Level:** Advocate for vaccine accountability (ensure that midwives understand that village vaccinations are their responsibility) **Community Level**:

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
months were vaccinated against measles).* Full cycle of DPT not followed (17.2 % of children drop out between DPT 1 and DPT 3.) Few health center staff giving vaccinations to children who need them (*Puskesmas* staff gave vaccinations to only 1/18 children who needed them)	Midwives are not taking vaccines to villages during visits Mothers/caretakers believe that children will get sick with fever if they are immunized	TBAs/Midwives	Hold District Immunization Days Work with DHO/*Puskesmas* to increase accountability of midwives regarding vaccinations Work with *Posyandus* to increase the importance of maintaining accurate vaccinations records on mothers' and children's cards Key influential leaders work with *Posyandu Kaders* to make house visits During *Posyandu* sessions, counseling on importance of fully vaccinating children
		Mothers/mothers-in-law/grandmothers fathers/male caretakers	**Individual Level**: *Strategies*: Parents'/caretakers' Support groups - fathers' participation in encouraging complete vaccinations *Interventions/Media Channels*: Message dissemination and

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
			awareness-building (through songs, dramas, contests, counseling cards, video); Behavior negotiation; Peer education, support, and reinforcement
Key messages: Fully vaccinate your child before one year; return for doses 2 and 3 of DPT; important to complete the immunization cycle; colostrum is your baby's "first immunization"; prevention of illness is important and possible; importance of maintaining health cards for mother and child; in most cases, immunization will not make your child sick, but not getting immunized can make your child extremely ill.			

**As mentioned above, while the Rapid CATCH shows a relatively high percentage of mothers with at least 2 TT vaccines (68.7%), the above data does not accurately reflect the reality (coverage is probably much lower) because it represents only those children/women with Growth Monitoring Cards (GMC)/Mothers' Health Cards, which in fact was only 52.2% of children included in the study, and 3.7% of the total mothers interviewed. One reason for the discrepancies between numbers of mothers and children with health cards is that the Mothers' Cards are distributed by the midwives who are not consistent in these efforts, while the child's GMC is distributed by the Kaders who use them regularly during the weighing sessions.*

CHOICE will work with the DHO/*Puskesmas* to determine key factors influencing behaviors of midwives regarding regular administration of the vaccination during village visits and/or during child's visit to health facility, and to determine what is the best mechanism for ensuring that all pregnant women and children receive the recommended doses of all vaccinations. Focus group discussions with mothers/caretakers will be conducted by the project staff together with *Puskesmas* staff/midwives at the beginning of the project intervention to identify factors preventing children from being vaccinated. Results will be used to develop messages and strategies for behavior change.

Quality
(See section E.2 above - Overall Approach to Quality Improvement.)

The project will also contribute to the quality of reporting in this area by working with the DHO to increase the distribution and consistent use of the Mothers' Cards. CHOICE staff, in collaboration with *Puskesmas*/Midwives, will work with the *Posyandu* volunteers to convey the importance of checking the possession and up-to-date status of GMCs during the *Posyandu*

sessions and counseling mothers to overcome barriers and focus on the benefits of 100% fully vaccinated children. Since a high percentage of babies are not taken to the *Posyandu* for weighing (KPC results show that only 45.3% of children aged 0-23 months were weighed in the last 4 months), the project will assist the *Puskesmas* staff in coordinating District Immunization Days approximately 3 times per year in each sub-district. With assistance provided by project staff, the schedule and coordinating mechanisms will be determined by community leaders and *Puskesmas* staff. For the children not covered by the Immunization Days or the *Posyandu* visits, the village *Kaders* will be supported by community leaders to make home visits to ensure full coverage.

Access
(See above section E.2.1 - Maternal and Newborn Care, as it also applies to vaccinations, in general).

E.2.4. Diarrhea Disease (DD) Control

Behavior Change Communication

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
High rates of diarrhea (24.2% of mothers of children aged 0-23 months reported that their children had suffered diarrheal episodes within the last two weeks) Poor hygiene practices (only 1.3 % of mothers with children 0-23 months reported that they wash their hands with soap/ash before feeding children, after defecation, and after attending to a child who has defecated)	Mothers/caretakers believe that more fluid/food intake will make the child defecate even more frequently Community members have indigenous belief that boiled guava leaf water can stop diarrhea	Key opinion leaders TBAs and midwives *Puskesmas* staff *Kaders*	**Policy Level:** *Puskesmas* to advocate for decentralization of ORS at *Posyandu* level **Community Level:** Improve supervision of *Puskesmas* staff by DHO PD/Hearth sessions to incorporate messages on proper hand washing and ORS use ORS demonstrations during parent care taker support groups Child-to-child approach through schools to promote proper hand washing

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
Mothers lack knowledge on how to properly treat a child with diarrhea (only 34.9 % of children aged 0-23 months who had suffered diarrhea in the last two weeks were offered more fluids during the illness, and only 11% of them received Oral Rehydration Solution [ORS] and/or recommended home fluids)		Mothers/mothers-in-law/grandmothers/fathers /male caretakers	*Posyandu* counseling on ways to reduce DD **Individual:** *Strategies*: Parents'/caretakers' Support groups - Fathers' participation in encouraging *DD* prevention and treatment *Interventions/Media Channels*: Message dissemination and awareness-building (through songs, dramas, contests, counseling cards, video); Behavior negotiation; Peer education, support, and reinforcement (*Note*: See also activities above related to breastfeeding)
Key messages: EBF has multiple benefits including reduction of DD; proper hand washing reduces DD; give extra breast milk to babies < 6 months; continue providing additional food/fluid and breast milk for >6 months; ORS preparation instructions must be followed carefully & administered to address dehydration; in case of danger signs, take child to the health center			

To address these issues, the project will work with the *Puskesmas and Kaders* to determine reasons (including traditional beliefs) why women/caretakers do not wash their hands. Project staff feels that an increase in access to safe and clean drinking water will have a substantial

influence on mothers/caretakers' behaviors; however, messages will still be needed to accompany these actions in order to reinforce the need to change behaviors. CHOICE staff will also learn why caretakers do not give ORS and more fluids/food to the children during the episode of diarrhea, and investigate positive and negative indigenous practices which have been commonly adopted by the community in managing diarrhea/sick children. A general approach to reaching health targets will include an integrated promotion of key family practices through parent/caregiver education sessions (see BCC in section E.2.1 - Maternal and Newborn Care, above). The NGO partner will provide continuous capacity building in skills and related knowledge needed for facilitating parent/caregiver education sessions through formal and informal trainings. For villages with PD/Hearth, mothers/caretakers will learn proper and timely hand washing, feces disposal, ORS preparation/use, and the importance of continued breastfeeding. For others, staff will reinforce these behaviors through the *Posyandu* counseling sessions and child-to-child approaches.

Quality
(See section E.2 above - Overall Approach to Quality Improvement, and section on Quality related to Breastfeeding and Nutrition.)

Project staff learned from CHANCE's experience in West Sumatra that the training duration was too long (12 days); training was very expensive; and follow-up after training was very limited. All these factors contribute to a dearth of competent health providers, with only a fraction having undergone expensive and extensive training—at one year post-training, only one of 40 participants was able to do assessments properly, provide correct treatment, and counsel the mothers with regards to the illnesses of their children. The project will work closely with the DHO in adapting the WHO IMCI curriculum to make it more interactive and emphasize practical exercises, with the overarching intent that the benefits will be seen by the DHOs who will then train their *Puskesmas* health workers. The adapted version will concentrate on: why it is important to recognize danger signs and on improving the skills of health providers in assessment, treatment, counseling and management of severely ill children. Together with DHO trained staff, the health and nutrition specialist for the CHOICE project—who has been trained as an IMCI trainer—will be responsible for the adaptation of the training module and will facilitate the competency-based training. The project will use the existing *Puskesmas*/DHO information sharing mechanism to update health provider's knowledge and skills related to IMCI and other maternal and child health issues. The health providers will use the existing checklists developed by the MOH to be used when they examine a sick child. By using these checklists, the health providers will be guided on how to correctly assess and treat sick children, provide appropriate counseling to mothers/caretakers, and on how to manage severely children.

As planned by the DHO during the DIP workshop, regular facilitative and supportive supervision visits will be conducted in order to maintain the skills of health providers post-training, and to ensure that all trained providers comply with the IMCI standard procedures of treatment and referral.

Access
One of the barriers to accessing ORS is that the midwives currently possess the sachets, and they are not widely available at the *Posyandu* level. CHOICE will work with the DHO to first

determine what official regulations dictate regarding the distribution and stocking of ORS. If necessary, the project will work with the *Puskesmas* to advocate for the decentralization of the ORS sachets for distribution by the village *Kaders*. The project will encourage *Kaders* to do simple inventorying of all supplies (ORS, vitamin A, GMCs, etc.) distributed by *Kaders* by adapting and distributing a simple, illustrated tool. Inventory records will help *Puskesmas* staff/midwives to check the stock of all supplies and ensure that all ORS sachets are still in good condition and have not expired. See also section on access above under Maternal and Newborn Care.

E.2.5. Acute Respiratory Infections (ARI)

Behavior Change Communication

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
Few mothers know danger signs of childhood illnesses (28.7% knew the danger signs of childhood illness that indicate the need for treatment) Only half of children were taken to a health facility when they presented danger signs (51.6% of children with cough and fast/difficult breathing were taken to a health facility) Limited competence of health center staff (Only 8 of 37 children were treated correctly in terms of antibiotics and one	Parents/caretakers do not know that fast or difficult breathing is a danger sign of coughing; they think that coughing is a common illness for children	Key opinion leaders/ DHO/*Puskesmas*/decision-makers TBAs/*Kaders* Mothers/mothers-in-law/grandmothers fathers/male caretakers	**Policy Level:** Adapting IMCI protocol for proper case management and referral **Community Level:** Promote need to recognize and respond to danger signs **Individual Level:** *Strategies*: Parents'/caretakers' Support groups - Fathers' participation in encouraging complete ARI prevention and treatment *Interventions/Media Channels*: Message dissemination and awareness-building (through songs, dramas, contests, counseling cards, video);

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
child with severe pneumonia went undiagnosed and without referral) Health workers do not recognize easily identifiable danger signs such as chest in-drawing in the calm child			Behavior negotiation; Peer education, support, and reinforcement (*Note*: See also activities above related to breastfeeding)
Key messages: EBF has multiple benefits including reduction of ARI; care-seeking at onset of danger signs; correct use of antibiotics and referral to higher level facilities			

CHOICE staff will work with the DHOs/*Puskesmas*/midwives/TBAs/*Kaders* to ensure that an integrated promotion of key family practices to ensure the survival of the children will be implemented through parent/caregiver education and the involvement of trained TBAs in the promotion of ARI prevention and treatment. (Please also refer to Breastfeeding and Nutrition, Immunizations, and Diarrhea Disease Control sections, above.)

Quality
(See section E.2 above - Overall Approach to Quality Improvement.)

The adapted IMCI protocol will ensure that quality is built into the training, and the project will take appropriate measures to ensure continuous quality improvement after the training. At the initial stage, or immediately after the adapted IMCI training, CHOICE will provide checklists to be used by trained providers when they examine the sick child. (Please also refer to the Diarrheal Disease Control section above on Quality.)

Access
The HFA revealed that not all eight essential oral drugs for IMCI are available in the health facilities (only 4 of the 14 health facilities surveyed had the complete stock of 8 essential oral drugs). The availability of injectible drugs for referral treatment was even worse (only 5 facilities had one injectible drug—IMCI protocol requires 4 drugs). The project expects that the IMCI training will not only improve the knowledge and skills of the providers in managing sick children but will also contribute to the increase of health providers'/DHO decision-makers' awareness and commitment to make all essential drugs available in each health facility. Project staff will collaborate with the DHO/*Puskesmas* decision-makers to ensure the proper use of checklists to monitor and mange supplies of antibiotics and other medications.

E.2.6. Tuberculosis (TB)

Behavior Change Communication

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
High percentage of underweight children (23.5 % among children aged 0-23 months, and 34.1 % of children aged 24-59 months) About 6.6 % of children aged 0-23 months and 7.5 % of children aged 24-59 months are severely malnourished	Being thin and stunted is inherited from the parents and is not related to TB. Frequent fevers are common in children. Prolonged coughing and difficulty breathing are mostly caused by asthma and are inherited from parents and grandparents.	Regional/local government officials	**Policy Level:** With DHO, advocate for functioning district *Gerdunas* (national integrated movement for TB program) for equipping/facilitating *Puskesmas*, and for the recruitment of laboratory staff for the implementation of DOTS strategy. Train *Puskesmas* staff on TB management.
Relatively low percentage of people who are aware of at least 2 symptoms of TB. Relatively low percentage of people who know that TB is a curable disease.	Bleeding with cough is usually caused by *magic*. TB is an embarrassing disease	Key opinion leaders	**Community Level:** Orient CEIs, PKKs, village/community/ school teachers/ religious leaders youth groups/ children's groups on TB control.
		Kaders	Train *Kaders* on TB control and IP/counseling skills. Conduct home visits to the families of severely malnourished children and of children who failed to thrive for TB contact person checking, care-seeking motivation and TB information dissemination.

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
		TBAs	Integrate TB content into TBA training module and encourage TBA to motivate suspected TB cases for care-seeking.
		Parents/care-givers	**Individual Level:** *Strategies:* Integrate TB content into parent/education module. Identify and orient mothers/ fathers/older siblings/other family members as "drug observers" for children.
		Drug observers	Orient drug observers on TB prevention and treatment. *Interventions/Media Channels:* Message dissemination and awareness-building (through TB information cards, video, etc); Behavior negotiation; Peer education, support, and reinforcement.
Key Messages: Everybody can get TB; TB is curable and is not inherited from parents or grandparents; adults with TB are the main source of TB infection in a community; TB can be transmitted from adults to children, especially if the child is weak and malnourished, so save their lives by checking your health at the *Puskesmas* if you have productive cough for 3 weeks or more, or if you have bleeding with cough; TB drugs are available at the *Puskesmas* free of charge; TB can			

KPC/HFA Results	Traditional Beliefs/Influencing Factors	Key Target Groups	Activities at Policy, Community & Individual Levels
be cured if you comply with the treatment schedule; TB can make your children very sick; TB can infect the child's lungs, brain, lymph nodes, bones, and other parts of their body; bring your child to the *Puskesmas* if she/he has a cough for more than 3 weeks, frequent or prolonged fever without a clear cause, is losing weight without clear cause, and is not gaining weight for one month or more.			

Quality
(See section E.2 above - Overall Approach to Quality Improvement.)

Access
TB services are available at selected *Puskesmas* and TB drugs are provided by these *Puskesmas* free of charge. Access in the target villages is less of an issue of availability and more an issue of education, outreach and awareness about the disease and how it is transmitted. Stigma and the fear of discrimination also plays a role in keeping potential TB cases from seeking diagnosis and treatment, and from fully complying with treatment regimens. The entire CHOICE TB component has been designed specifically to address these barriers to access and has been developed in coordination with KNCV and the local GOI to complement and strengthen existing services and ensure that they are being adequately utilized.

3. Program Monitoring and Evaluation Plan
The CHOICE project will measure progress toward the achievement of its objectives with a variety of indicators, as detailed in the Work Plan (p.66, below). Indicators have been defined and further refined for the strategic objective, intermediate results, and lower level results, and will be used to track progress in the areas of improved access to quality maternal and child health services, improved parents'/caretakers' behavior in optimal child feeding and care, and NGO capacity and implementation. End of project targets have been established based on the results of the baseline assessments.

Current Information Systems
Throughout Indonesia, the DHO is the designated repository of health information pertaining to each respective district. Beginning at the village level, the volunteers serving at the monthly *Posyandu* are tasked with collecting information on children seen and services provided, which is to be reported to the local health center having jurisdiction for the area. At the sub-district health center, information will be compiled from each *Posyandu* in the area and reported to the district health office, along with data on services provided by the health center itself. Similarly, the village midwife in each village is responsible for recording information on the patients she sees, and reporting this data to the health center, which subsequently compiles the information and submits it to the district health office. The DHO is responsible for maintaining this data, and publishing an annual district health profile, which presents key health status and health service indicators.

However, reliable data on health service provision and health status are lacking in many areas of Indonesia, and decentralization and the economic crisis have exacerbated the situation. In

collaboration with USAID and the MOH, Management Sciences for Health (MSH) is attempting to develop improved systems for basic health data collection at the district level which can be applied throughout Indonesia. In Pandeglang district, PCI intends to complement this effort by working with communities and the government to facilitate the introduction of these improved systems, and identify ways to simplify existing systems for health data collection and analysis. PCI will coordinate closely with MSH, as well as HKI, UNICEF, WHO, and other organizations working with the DHOs in order to improve health data collection and analysis avoid duplication of effort.

Collection, Analysis and Utilization of Data

The measurement methods are listed in the Work Plan and described in more detail as follows:

Posyandu and TBA Records

The Government has developed recording and reporting system for *Posyandu* , but unfortunately, *Kaders* have not always been able to provide information on the services they provide, which might be due to the complexity of the recording form. All records regarding the number of under-five children, the number of children weighed and having GMCs or receiving immunization are not available at the *Posyandus* and are mostly held by midwives. The project will devote special attention to improving the ability of *Kaders* in records keeping. Although *Puskesmas* staff requires *Kaders* to use the existing MOH record keeping and reporting system, the project will, as necessary, organize and facilitate meetings with *Kaders* and *Puskesmas* staff to jointly develop a simple system and tools to be used at the *Posyandu* level. The information to be gathered will include the attendance of target groups at *Posyandu* sessions, number of children/mothers that need special attention (e.g. malnourished child, high risk pregnancy), the progress of children participating in nutrition rehabilitation sessions, the number of *Kaders* providing services at the *Posyandu* and the provision of immunizations and micronutrient supplementation. In addition, the project staff will review the existing government's tools and as necessary, in collaboration with *Puskesmas*/DHO, will develop a simple illustrated tool to be used by TBAs to record the services they provide to mothers and newborns. The TBA—the key persons who have extensive relationship with the villagers—are also expected to be resource persons for information regarding pregnancy, births and deaths. These verbal information will be gathered during TBA–Midwife partnership meetings, informal meetings between TBAs and midwives /*Puskesmas* staff and or during *Posyandu* sessions. The *Puskesmas* staff and the NGO field staff will record and analyze this information on a monthly basis which will be used as reference materials during *Kaders'* meetings and/or in social audit meetings. Appropriate health staff, such as the midwives, will be oriented and trained in the use of social/verbal autopsies as a way of analyzing and understanding the factors contributing to each death in the target area. In addition, performance monitoring and improvement will be an important aspect of all supervisory visits and processes.

CEI Monitoring Records

The CEIs will be encouraged to monitor the village achievements or performance relative to the activity plans that they have developed. They will also monitor the performance of the team itself, as to whether all members are active, whether *Posyandu* volunteers are active, etc. For development of their own plans, the CEIs will be facilitated to define the appropriate indicators, which may or may not always be the same as the project's indicators. Village self-help

contributions to the project will be recorded by the CEIs using forms that will be developed together with the NGO staff. The CEIs will also be assisted in conducting quarterly participatory monitoring meetings—involving the *Kaders*, TBAs, the head of neighborhoods and hamlets, village PKK committee members, and religious leaders—to determine whether activities are conducted as planned, identify the key factors that inhibit or positively contribute to the progress of the project, and plan actions for improvement. In addition, the CEIs' representatives from each village will meet quarterly within each sub-district to present their achievements and share lessons learned. This may develop into a health services advocacy forum.

PCI and NGO Records and Reports

Tools for monitoring actual versus expected process/activities, and for measuring project performance, will also be developed collaboratively by PCI and YPSI staff. For example, a simple process and tool will be developed to track the BCC components of the project, including target audience reached, indications of message retention, and implications for actual behavior change. The NGO is expected to conduct monthly performance monitoring and submit a summary of the results quarterly to PCI. The performance monitoring report will be used by PCI and our partner NGO to determine how well the project is being implemented at different levels, and to develop plans for improvement—or, if necessary, changes in strategy. Quarterly meetings between PCI and partner staff will be held throughout the life of the project. PCI and YPSI will jointly produce quarterly programmatic reports containing the results of the monitoring and evaluation meetings, as well as other pertinent project status information to share with other key stakeholders such as the DHO and USAID. In addition, NGO and PCI will prepare monthly financial reports of project expenditures.

PCI staff will be responsible for planning and managing the launch of monitoring and evaluation processes during the end of first year and into the second year of the project. Also during this period, PCI will provide training to YPSI staff, to build their capacity in monitoring and evaluation systems, and enable them to assume responsibility for managing this component beginning in the third year. At that time, PCI will assume a less direct role, providing guidance, technical assistance and oversight to the implementing NGO. PCI will also assist the NGO in providing training in data collection and interpretation to the VHT members, *Posyandu* volunteers, district health staff, and other stakeholders who will participate in the community-based monitoring and evaluation process.

IMCI Quality Assurance Monitoring and Supervision Records

As described previously, PCI will encourage the DHO to use HFA tools that have been used at baseline to gather information on the performance of health facilities and providers. The tools will not only help monitor whether the IMCI standards in managing childhood illness are being properly adhered to by the health providers, but also verify that providers are focusing on a client-centered approach to quality of care. Training on how to do supervisory visits and use of the tools will be provided by the project early-on. The one-month-after-training and semi-annual tabulations of data provided by this system will contribute substantially to the overall picture of how IMCI and quality of care processes are being implemented in the project area.

Household and Community Level: Quantitative and Qualitative Data
The KPC Rapid Catch survey to measure key indicators will be conducted at mid-term, and will be followed up by qualitative data gathering through focus group discussion and in-depth interviews with parents/caretakers and key persons to determine whether the project has made progress in changing family behaviors, what the barriers are to adopting key family practices, and what the factors are that inhibit *Puskesmas* staff from performing their responsibilities in providing health services at *Posyandu*/community level (e.g. immunizations and antenatal care). The project staff will facilitate the process of capacity self-assessment for CEI members and *Kaders* in the middle and at the end of project implementation. The results of the mid-term evaluation will be used by the project and stakeholders to develop a plan of action for the second half of the project. The mid-term evaluation will also generate lessons learned which can be used to promote PCI's model of community-based health development to local government and/or other development agencies.

The KPC 2000+ survey will also be conducted again at the end of project period to measure selected indicators that have been defined by the project team based on the baseline KPC results. The survey will employ the 30-cluster sampling methodology, and respondents will be mothers of children aged 0-23 months. The latest DHS results and/or National Socio-Economic survey will also provide important health information at district level, and will be used to compare the health status at district and province/national levels at baseline and at the end of the project. The intensive intervention in the four sub-districts which covers 30 villages is expected to contribute to changes at the district level.

Participatory Rapid Appraisal (PRA)
PCI will train the partner NGO in the PRA methodology (focused on MCH, nutrition, W&S) and assist them in conducting the exercise in each of the project villages, at the beginning of project implementation. The PRA, through FGDs and key informant interviews, will identify practices and beliefs about child care/rearing that are commonly adopted by communities. Other techniques, such as mapping and a seasonal calendar will be applied to identify the population concentration, natural resources, water sources, flooding period, and seasons that are related to episodes of illness. The PRA results and other qualitative and quantitative survey results will be used as a reference to draw up detailed action plans with the communities. FGDs and in-depth interviews with key informants will be applied during midterm and end-of-project evaluations to identify changes and challenges in child care/rearing practices and beliefs.

Institutional Capacity Assessments
PCI will facilitate the partner NGO through a process of organizational self-assessment utilizing an adapted capacity assessment tool and process as described previously. Subsequently, the NGO will be facilitated to develop a strategic plan that reflects what changes they aspire to see in their organization, especially those related to successful project implementation. The institutional capacity assessment will be repeated with the NGO at mid-term and project end to determine progress in relation to their strategic plan, how capacity has increased, and to identify areas in need of further attention. In addition, PCI and YPSI staff will assist *Puskesmas* staff in applying a similar self-assessment process, using an adapted, simple tool and participatory process. The *Puskesmas* will discuss the results with the DHO for proposing supports they need in improving their institutional performance. The project will provide support that falls within the scope of the project.

The project team has learned that although CEIs are not functioning yet in most villages, this existing formal entity has the potential to be strengthened. The project team will therefore facilitate a self-assessment process with the CEIs prior to full project implementation, which will be repeated at mid-term and project end. A simple assessment tool will be adapted from various tools commonly used by the NGOs in Indonesia for this purpose.

Child Survival Sustainability Assessment (CSSA)
At baseline, mid-term, and again at the final evaluation, the project will measure and identify values for indicators and indices in each of the three CSSA dimensions to determine progress made in those dimensions. Several of the already conducted and planned assessments mentioned above (e.g. the KPC, HFA, Institutional Capacity Assessment) will feed into the ongoing process of developing these indicators and indices. By mapping these values (including the priority indicators of child health using the rapid CATCH indicators), PCI and its NGO and government partners will be able to show the potential sustainability of the improved health outcomes in the CHOICE project areas for partners and potential partners at various levels, including USAID, the MOH, and other potential donors. CHOICE will continue to seek out and take full advantage of technical support available through CSTS to ensure that the CSSAs are optimally carried out. Project staff will apply lessons learned by others in using this framework for monitoring and evaluating progress towards sustainable health.

Mid-Term Review
Midway through the project, with assistance from an experienced local consultant, PCI will organize a thorough review of the project's progress to date to determine lessons learned and ensure that the project is on track toward achieving its intended results. Data from the various monitoring and evaluation methods listed above will be compiled and organized in summary form. PCI and partner NGOs will organize a workshop in which the data will be presented and used as the basis for discussing project progress and making recommendations for continued implementation. PCI will invite VHT members, other key community stakeholders, local health providers, district, provincial and national health officials, Indonesian and international NGOs and PVOs, USAID, and other interested parties to participate in the workshop and contribute to the discussion and formation of recommendations.

Final Evaluation
Upon completion of the final KPC survey, PCI will conduct a comprehensive evaluation of CHOICE, to assess the impact of the project. A team of evaluators will be assembled for this purpose, which may include representatives of the District or Provincial Health Offices, the Survival, Development and Protection for Children and Women Team, the national MOH, and the PCI International Office. The team will be led by an external consultant experienced in maternal and child health programming in Indonesia, and will likely involve review of cumulative monitoring data, examination of final survey results, interviews with PCI and NGO staff, and a range of project stakeholders at the community, district and provincial levels. A report of the evaluation results will be widely distributed to the public health community in Indonesia and internationally.

Operations Research

As a result of decentralization, Indonesian villages have been given greater latitude in governing their affairs. With this has come the authority to mobilize their own resources, potentially in support of public health activities. Given the importance of the *Posyandu* to the delivery of village-level integrated health and nutrition services, PCI will work with a research institution such as SEAMEO (South East Asian Ministers of Education Organization), universities and/or a private consultant to conduct an Operations Research study on the implementation of the *Posyandu* TKA model. The primary research question will be: *How does the Posyandu TKA model compare to the usual Posyandu in increasing the utilization of Posyandu services, increasing Kaders' competence in providing services and increasing community ownership?* PCI will further assess the feasibility of this OR concept in the initial months of the project's implementation phase, in collaboration with YPSI and village leaders. (See also section D.6 above, and Annex 5.E for additional information on this proposed study.)

4. Work Plan

Please see following pages.

WORKPLAN

PCI CHOICE PROJECT
Pandeglang Province - Indonesia

Key /List of Acronyms

A	Access
BC	Behavior Change
CD/TS	Community Development/Training Specialist
CEI	Community Empowerment Institution
HNS	Health and Nutrition Specialist
HH	Household
KPC	Knowledge Practices and Coverage
LBW	Low Birth Weight
MW	Midwife
MUAC	Mid-Upper Arm Circumference
PD	Positive Deviance
PM	Project Manager
PRA	Participatory Rapid Appraisal
PY	*Posyandu*
QA	Quality Assurance
SPDWC	Survival Protection and Development for Women and Children Team
TBA	Traditional Birth Attendant
TKA	*Tubuh Kembang Anak* (*Posyandu* for Survival, Growth and Development)

Strategic Objective (SO): ***To improve the health and nutrition status of children under five, pregnant and lactating women, and mothers of children under five in the selected project areas.***

Indicators (with Measurement Method) for SO:

1. Percentage of under weight (weight/age <-2 SD) children aged 0-23 months in the 30 villages decreased from 23.5% to 12%. (Anthropometric Measures–Baseline, Midterm and Final Evaluations)

2. Percentage of mothers with chronic energy deficiency (MUAC of <22.5 cm) decreased from 18.2% to 10%. (Anthropometrics Measures–Baseline, Midterm and Final Evaluations)

3. Percentage of children aged 0-23 months with stunted growth (height/age < -2 SD), in the 30 villages decreases from 24.4% to 14%. (Anthropometric Measures–Baseline, Midterm and Final Evaluations)

IR.1: Improved access to quality maternal and child health care services.

Indicators(with Measurement Methods) for IR.1:

1. Percentage of health workers in the project areas receiving at least one supervisory visit that included observation of case management in the last six or 12 months will be increased from 7% to 80%. (HFA - baseline, midterm and final evaluation; QA supervision reports - one month after training and every six months).
2. Index of availability of essential oral treatment will be increased from 0.79 to 1 (HFA - baseline, midterm and final evaluation; QA supervision reports - one month after training and every six months).
3. Percentage of mothers with children aged 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest children will be increased from 68.7% to 80 % (HFA -baseline, midterm and final evaluation; QA supervision reports - one month after training and every six months).
4. Percentage of children aged 0-23 months whose delivery is attended by skilled health personnel will be increased from 15.8% to 56%. (KPC survey-baseline and final evaluation; KPC-Rapid CATCH survey- midterm).
5. Percentage of children aged 12- 23 months who are fully vaccinated against the five vaccine-preventable diseases before their first birthday will be increased from 51.1% to 75 %. (KPC survey - baseline and final evaluation; KPC-Rapid CATCH survey - midterm).
6. Percentage of children aged 12- 23 months who received a measles vaccine will be increased from 61.7% to 85%. (KPC survey - baseline and final evaluation; KPC-Rapid CATCH survey - midterm).
7. Percentage of children aged 12-23 months who received vitamin A (KPC survey - baseline and final evaluation).

LLR1.1: Improved knowledge and skills in providing quality maternal and child health care services through and adapted and simplified IMCI approach by health providers at village and sub-district levels of project areas

Indicators (with Measurement Methods) for LLR 1.1:

1. Percentage of health workers who perform assessment, treatment and counseling correctly while managing a sick child will be increased from 0% to 60%. (HFA—baseline, midterm and final evaluation; QA supervisory reports, every six-months).
2. Percentage of health providers (midwives and paramedics) in the project areas who have been trained in the management of child hood illness will be increased to 80% (HFA—midterm and final evaluation; QA supervisory reports, every six-months).
3. Percentage of midwives who have been trained on safe and clean delivery and care of premature/ low birth weight newborns and lactation management will be increased to 80 % (HFA—midterm and final evaluation; QA supervisory reports, every six-months).

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
Health Facility and District:				
1. Training in the management of childhood illness for MWs and nurses.	BC	Q 2 of year 2	HNS	30 MWs and Nurses
2. Training in facilitative supervision for DHO supervisory officials and *Puskesmas* midwives.	QA	Q 2 of year 2	HNS	8 DHO & *Puskesmas* staff
3. Training in safe and clean delivery for MWs.	BC	Q 3 of year 2	HNS	11 MWs
4. Training in neonatal/premature/LBW care for MWs.	BC	Q 3 of year 2	HNS	26 MWs
5. Training in lactation management for MWs, nurses and nutritionists.	BC	Q3 of year 2	HNS	32 persons
6. Orientation on PD/Hearth approach for nutrition baselined programs and essential nutrition education for MWs, nurses and nutritionists.	BC	Q4 of year 2	CD/TS	32 persons
7. Orientation on integrated *Posyandu* model for MWs, nurses and nutritionists.	BC	Q4 of year 2	CD/TS	32 persons
8. Training on TB topics for Midwives, TBAs and *Kaders*	BC	Q 4 of yr 2 and Q1 of yr 3	HNS/DHO *Puskesmas*	20 MWs 40 TBAs 100 PY *Kaders*

LLR 1.2: Networks/partnerships between community-based institutions and health facilities are established and functioning effectively

Indicators with (Measurement Methods) for LLR 1.2:

1. Percentage of villages which conducted regular community-health provider meetings (at least 2 times/year) as a mechanism for improving the quality of maternal and child health services will be 80%. (Capacity assessment - baseline, midterm and final evaluation).
2. Percentage of *Posyandu* attended by one health provider at least once/month will be increased to 80%. (PY records/monitoring reports).
3. Percentage of registered TBAs trained on neonatal care, lactation management and appropriate home care of sick child will be increased to 80%. (HFA -midterm and final evaluation; QA supervisory reports, every six-months).

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
Community:				
1. TBA trainings in neonatal care and lactation management.	BC	Q 3 - 4 of yr 2	MWs	88 TBAs
2. TBA trainings on appropriate home care of sick child and essential nutrition.	BC	Q3-4 of yr2	MWs	88 TBAs
3. VRB/CEI/village head/*Kader*/TBA community - health provider meetings.	QA	Started by Q3 of yr 2	CEIs	4 times/year
4. Verbal and social autopsy meetings.	QA	Started by Q3 of yr 2	CEIs	4 times/year
5. TBA – midwife partnership meetings.	QA	Started by Q3 of yr 2	MWs	12 times/year
6. Joint parents/caretakers education sessions.	BC	Started by Q3 of yr 2	*Kaders*	At least once a month
7. Monitor the attendance of health providers at the PY and provide feedback to the *Puskesmas* and DHO	A and QA	Started by Q3 of yr 2	CEIs and *Kaders*	At least once a month
LLR 1.3: Increased prioritization of maternal and child health program interventions by local government				
Indicators (with Measurement Methods) for LLR 1.3: 1. Number of village midwives/village birth huts run by midwives, available in the project areas will be increased from one to at least ten. (HFA - baseline, midterm and final evaluation). 2. Number of villages inside or outside sub-district project areas that have adopted integrated PY and PD/Hearth models to promote child survival, growth and development will be at least three. (Final evaluation; DHO annual reports).				

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
District and sub-district:				
1. Workshop on the results of baseline survey/sustainability; mid-term evaluation and final evaluation.	BC & QA	Feb. '04, Feb. '06, Sep. '07	PM	3 times during project period
2. Orientation on PD/Hearth approach for nutrition based programs and essential nutrition for the SPDWC team members at district and sub-district level.	BC	Q4 of year 2	PM & CD/TS	1 workshop with 20 people in 1 district; 1 workshop with 20 people in 4 sub-districts
3. Orientation on *Posyandu* TKA model for the SPDWC team members at district and sub-district level.	BC	Q3 of year 2	PM/HNS	1 workshop with 20 people in one district & sub-district
4. Seminars on maternal and child health at district level.	BC	Q1 of year 3 & Q1 of yr 4	PM/HNS	40 persons/ seminar and 2 seminars in one district
5. Cross–visits to other districts to enhance learning, strategizing, and mutual support between districts.	BC	Q1 of year 3	SPDWC Team leader	1 time during the project period
6. Train CEI members in advocacy skills and facilitate the formation of a CEI network as an advocacy forum.	BC	Q 1 of year 3	YPSI staff	40 CEI members; 1 district forum formatted and functioning

IR 2: Improved health-seeking and care-giving behavior among caretakers.

Indicators (with Measurement Methods) for IR 2:

1. Percentage of mothers who wash their hands before food preparation, before feeding child, after defecation, and after attending to a child who has defecated will be increased from1.3% to 55%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
2. Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours will be increased from 48.5% to 75%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
3. Median duration of exclusive breastfeeding will be increased from 1.0 month to 1.7 months. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
4. Percentage of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment will be increased from 28.7% to 75%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)

5. Percentage of sick children aged 0-23 months who received more fluids and continued feeding during the illness in the past two weeks will be increased from 73.4% to 85%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
6. Percentage of children aged 0-23 months in the 30 villages with diarrhea in the last 2 weeks who received ORS and/or recommended home fluids increased from 11% to 60%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
7. Percentage of children aged 0-23 months who were breastfed within the first hour after birth increased from 12.4% to 55%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
8. Percentage of children aged 0-23 months who were weighed in the last 4 months increased from 45.3% to 75%. (KPC – baseline, midterm (Rapid CATCH) and final evaluation)
9. At least 80% of identified severely malnourished children and the children who fail to thrive after participating PD/Hearth session who are visited by *Kaders* (to identify TB contact persons, to inform mothers and contact persons on TB key messages and to encourage them to seek TB treatment (*Posyandu* records).
10. Percentage of suspect TB cases referred to *Puskesmas* increased by 40 % (*Puskesmas* records)

LLR 2.1: Increased and sustainable capacity of community-based institutions to collaboratively address local health issues using C- IMCI framework.

Indicators (with Measurement Methods) for LLR 2.1:

1. Ratio of active *Kader/Posyandu* will be improved from 1:2 to 1:5 (PY records, monthly monitoring reports and annual NGO partner reports)
2. Number of *Kaders'* forums established in the project areas, as a place for sharing experience and updating skills and knowledge will be increased to 4 *Kaders*' forums at sub-district level and 30 at village level. (PY records, monthly monitoring reports and annual NGO partner reports)
3. Number of *Posyandus* providing integrated services (health, nutrition and stimulation) in the project areas will be increased to 60 in 30 villages. (PY records, monthly monitoring reports and annual NGO partner reports)
4. Proportion of mothers of children aged 0-23 months who are aware of at least 2 symptoms of TB (FGD, mid term (Rapid Catch) and final evaluation
5. Proportion of mothers of children aged 0-23 months who know that TB is a curable disease (FGD, mid term (Rapid Catch) and final evaluation

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
Community:				
1. *Kaders*' training in integrated management of childhood illness at households and community levels.	BC	Q1-Q2 of yr 2	HNS/YPSI staff	600 *Kaders* (120 PY x 5 ps)
2. *Kaders'* forum meetings.	QA	Started by Q2 of yr 2	*Kaders*	1080 mtgs. (36 times x 30 vill.) and 40 times at sub-district.
3. *Kaders*' training on growth monitoring, essential nutrition and child stimulation.	BC	Q1-Q4 of yr2	HNS/YPSI staff	600 *Kaders* (120 PY x 5 ps)
4. *Kaders*' training in PD/Hearth approach in nutrition rehabilitation and education program.	BC	Q2-Q4 of yr2	CD/TS&YPSI staff	160 *Kaders* (16 villages x 2 posts x 5 *Kaders*)
5. Trainings for the CEI members to improve their capacity in program planning and management and resource mobilization.	BC & QA	Q1 of yr 3	CD/TS&YPSI staff	60 persons (30 villages x 2 persons)
6. Training in *Posyandu* management.	BC	Q1-Q4 of yr 2	CD/TS&YPSI staff	240 persons (120 PYx2 persons)
7. Training of selected PY *Kaders* in TB control and prevention.	BC	Q1-Q4 of yr 2 in one sub-district; Q1-Q4 of yr 3 in 2nd sub-district	CD/TS&YPSI staff	100 K*aders*
8. CEI, *Kader* and village leader meetings.	QA	Started by Q 2 of yr 2	CEIs	330 meetings (30 CEIs x 11 times)

LLR 2.2: Increased knowledge and skills regarding key family practices critical for child survival, growth, and development

Indicators (with Measurement Methods) for LLR 2.2:

1. Percentage of parents/caretakers having children aged 0-59 months, in the project areas, who actively participate in parent/ caregiver education activities will be increased to 60%. (PY and monthly monitoring records)
2. Number of parent/caretakers education session facilitated by trained *Kaders* conducted regularly in the 30 villages will be held at least twice a month. (PY and monthly monitoring records)
3. Number of villages with high percentage of child's malnutrition (≥ 30 %) applied PD/Hearth approach for

improving the nutrition status of malnourished children will be 16. (Monthly monitoring and annual NGO partner reports)

4. Number of underweight children aged 6-59 months who participated in PD/Hearth sessions, achieved normal weight and sustain their normal status at least 3 months after recuperation will be increased to 75%. (PY and monthly monitoring records)
5. Percentage of target population (mothers of children aged 0-23 months) who are aware of at least 2 symptoms of TB (KPC – baseline and final evaluation)
6. Percentage of target population (mothers of children aged 0-23 months) who know that TB is a curable disease(KPC – baseline and final evaluation)

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
Households:				
1. Parent/caretakers education sessions.	BC	Started by Q1 of yr 2	*Kaders*	6240 sessions (120 PY x 52 times)
2. Provision of seeds for home gardening.	A	Q2-Q4 of yr 2	YPSI staff	120 PY x 5 HHs
3. Home visits to malnourished children's family to identify TB contact persons, disseminate TB information and to motivate for TB care seeking	BC	Started by Q 2 of year 2	*Kaders* and CEIs	400 HHs
Community:				
1. Support *Posyandu* activities.	A	Started by Q1 of yr 2	*Kaders*	120 PYs
2. Provision of materials and equipment for *Posyandus*.	A	Started by Q1 of yr 2	YPSI staff	120 PYs
3. Group discussions with children.	BC	Started by Q2 of yr2	CEIs/ *Kaders* & YPSI *Kaders*	TBD
4. Center-based and home-based PD/Hearth sessions.	A and BC	Started by Q2 of yr2	*Kaders*/CEI	32 posts
5. Identification of appropriate and reliable treatment observers.	A and BC	Started by Q2 of yr2	CD/TS in collaboration with YPSI, KNCV, etc.	120 observers
6. Facilitation of *Kaders*, PKK, CEI and village leaders in organizing TB campaigns.	A and BC	Started by Q2 of yr2	CD/TS in collaboration with YPSI, KNCV, etc.	40 campaigns
7. Development and/or adaptation of locally acceptable IEC materials for TB	A and BC	Q4 of yr 1		TBD

LLR 2.3: Reduced obstacles to adopt recommended key family practices to support the survival, growth and development of children

Indicators (with Measurement Methods) for LLR 2.3:

1. Percentage of fathers/male caretakers of children aged 0-59 months actively involved in parent education/*Posyandu* activities will be increased to 10%. (PY and monthly monitoring records)
2. Percentage of HHs in the 30 villages with safe drinking water from piped or covered well (available all year long) will be increased from 54.9% to 70%. (KPC survey – baseline, midterm, and final evaluation).
3. Percentage of HHs in the 30 villages with access to flush toilet will be increased from 27.7 to 40%. KPC survey – baseline, midterm, and final evaluation).

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
Community:				
1. Small workshops/group discussions with religious and community leaders and fathers/male caretakers on maternal and child health.	BC	Started by Q4 of yr 1	YPSI staff	120 PY x 30 times x 20 ps
2. Training in toilet construction and maintenance for village health teams.	BC & QA	Q 1 of yr 3	YPSI staff	24 staff (60 pilot areas x 4 ps)
3. Construction of water (including washing hand area) and toilet facilities in the pilot *Posyandu* areas.	A	Q1-Q2 of yr3	YPSI staff	60 PY
4. Adaptation of BCC materials for behavior change.	BC	Q4 of year 1	PCI and YPSI staff	6 BCC materials
5. Facilitate and help community to identify W&S needs and develop strategy to address the needs.	QA	Q1-Q2 of year 3	YPSI	W&S needs identified and strategy implemented

IR 3: Successful implementation of PCI's community based health development model by their partner NGO.

Indicators (with Measurement Methods) for IR 3:

1. Percentage of assigned villages in which partner NGO has implemented activities according to PCI's community based health/nutrition development model will be 100%. (Monthly monitoring records and annual NGO partners report).
2. Percentage of community empowerment institutions meeting at least quarterly with NGO field staff to review and plan health development activities will be 80% or 24 CEIs. (Monthly monitoring records and annual NGO partners report).

LLR 3.1: Increased skills and knowledge of NGO's staff in project management

Indicators (with (Measurement Methods) for LLR 3.1:

1. NGO partner will have their own specialist for health, nutrition and training that will be included in their own organizational structure by the end of year three. (Institutional Capacity Assessment – baseline, midterm and final evaluation)
2. Training at community level will be organized, managed and facilitated by the NGO partner without supervision from PCI technical persons by the end of year three. (Institutional Capacity Assessment – baseline, midterm and final evaluation)

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
NGO Partner:				
1. Training in KPC survey and rapid survey on technical potential for W/S.	BC	Q1 of yr 1	PCI staff	4 supervisors
2. Training in Qualitative Research Methods (FGD, In-depth Interviews, and PRA); in BEHAVE framework ("Doer/Non-Doer" Analysis); in Negotiation Methods (TIPS (Designing by Dialogue); in BCC Materials Adaptation.	BC	Q3 of yr 1	PCI staff	20 persons
3. Training in community development and resource mobilization.	BC	Q3 of yr 1	PCI staff	20 persons
4. Training on facilitation/ adult learning methods.	BC	Q4 of yr 1	PCI staff	20 persons
5. On- going, on- the job refresher training in integrated management of childhood illness at household/ community levels.	BC	Q4 of yr 1 Q3 of yr 2	PCI staff	20 persons
6. Training in growth monitoring and child stimulation/*Posyandu* TKA.	BC	Q4 of yr 1	PCI staff	20 persons
7. Refresher training in essential nutrition and PD/Hearth approach for nutrition and health programs.	BC	Q1 of yr 2, Q4 of yr 2	PCI staff	20 persons
8. Training in monitoring and data management system and advocacy skills.	BC	Q1 of year 2,	PCI staff	20 persons
9. Facilitative and supportive supervision of YPSI's activities by PCI.	BC	Q2 of year 2	PCI staff	20 persons

LLR 3.2: Increased institutional capacity of selected local NGOs

Indicators (with Measurement Methods) for LLR 3.2:

1. Number of proposals accepted for funding by other funding agencies to continue support to communities in the CHOICE project areas or beyond the areas will be at least two. (Annual NGO partner's reports; approval notifications)
2. Collaboration/partnership between partner NGO and district authorities continued beyond the CHOICE project period as indicated by a MOU signed by the end of project period. (Final NGO partner's report; signed agreement)
3. Percentage of NGO staff members who have received training in areas of identified need increased to 90% (Annual NGO partner's reports)

Major Activities	Activity Focus	Time Frame	Responsible Person	Benchmark/ Target
NGO Partner:				
1. Training in strategic planning/ institutional development.	QA	Q 1 of year 3	PCI staff	20 persons
2. Workshops on project design/ development.	QA	Q2 of year 3	PCI staff	20 persons
3. YPSI assisted in developing contacts with donors and potential collaborators.	QA	Q2 of year 3	PCI Staff	Contact with 3 key donors & potential collaborators
4. YPSI assisted in establishing strong relationship with government	QA	Q1 of yr 2	PCI staff	At least one community project activity is jointly funded by local government.

Annex 1A

Response to Application Debriefing

Response to Application Debriefing Summary Sheet FY 2003
(See Score Sheet and Technical Reviewers' Comments attached)

Comments Regarding TB Interventions (pp. 3-6)

PCI agrees that the TB aspects of the proposal were relatively weak and needed to be strengthened based on a more thorough assessment and closer coordination with the local groups most intimately involved with TB efforts in Indonesia. Since developing the proposal, PCI and its NGO partner YPSI have learned a great deal regarding the TB situation in Pandeglang, KNCV's activities, and the government's policies regarding TB. CHOICE staff are much better informed about TB activities and what key officials are recommending for the CHOICE project regarding TB interventions. PCI staff have gained additional knowledge regarding resources available and appropriate strategies, especially thanks to its experience in developing a proposal for submission to FIDELIS.

The original design of the CHOICE TB component involved the use of midwives. However, because midwives are already overloaded, the government is not supportive of the idea of midwives taking up additional responsibilities related to TB. PCI has also discovered that midwives are not present in most of the villages where the CHOICE project is to be implemented. Thus the original concept of using midwives as a major part of the strategy for community-based TB interventions has been modified. While increasing midwife knowledge about TB is still a worthwhile pursuit since they do play a major role in community-based health education and service delivery, this will not be a major part of the project's TB strategy. The project will also work with government and communities to advocate for midwives to be recruited and placed in villages where none are currently present.

After consultations with Dr. Benson Hausman, National Project Director for KNCV, Dr. Lukman Siregar, the KNCV representative responsible for TB in Banten Province, Dr. Komarudin, the head of Disease Prevention and Environmental Sanitation of Banten Provincial Health Office, Pak Yudi, the TB Program Supervisor of the Pandeglang DHO (District Health Office), Dr. Sri Boediharjo, of the USAID mission in Jakarta, among others at the mission, PCI has revised its TB component to emphasize complementarity with KNCV/government activities in Pandeglang District. It is important to note that PCI's approach is specifically designed to avoid creating a demand for TB services that are not yet available. CHOICE TB interventions will be introduced in stages as Puskesmas become equipped and trained to competently manage TB in their subdistricts. In addition, PCI's approach will involve working to ensure the support and involvement of both local and central government officials, as well as compliance with all relevant GOI policies and strategies.

Comments Regarding Delayed First Birth (p. 4)

Reviewers point out that the proposal does not mention promotion of delayed first birth and this should be considered due to its relationship with the improvement of mother's and babies' survival. While the KPC results showed high percentage (92.9%) of children aged 0-23 months who were born at least 24 months after the previous surviving child, this data does not indicate the number of previous miscarriages nor neo-natal deaths prior to the birth of this last

child. Also, unmet need for family planning is high in the project site (46% according to the KPC) and discussions with village health volunteers during the KPC also confirmed a relatively high number of births for one village within a one-month period (14). To address this problem, the project will work with the Survival Development and Protection for Women and Children team at the district and sub-district levels, in addition to working with the village health *kaders*/team. In collaboration with these groups, the project will include messages and behavior reinforcement through peer discussions (of Positive Deviants) during Mother's Support Group activities. In addition, factors affecting this behavior change will be determined through informal Doer/Non-doer Analysis and during FGDs. This information will provide the basis for messages and BCC support interventions regarding birth spacing and encouraging delay of first birth during TBA and Kaders training and parent education sessions. The project sees the discussion of delayed births as an opportunity to connect the benefits of longer periods of exclusive breastfeeding (6 months) with periods of delayed fertility (LAM, for example) and does not envision this as a separate component, but sees these messages as complementary to other child survival messages. The project will also include messages and supportive behavior change strategies on delaying first birth in its child-to-child, and youth-to-youth approaches at the community level.

Comments Regarding Supervision (pp. 4-5)

Reviewers mention that supervision/mentoring may be needed to ensure midwives can use acquired knowledge & skills and that difficulties commonly stated for not conducting visits is a lack of funding where health systems are severely under-funded. While PCI agrees that supervision and monitoring is essential, in the project site, the issue regarding supervision is not connected to a lack of funding to conduct these visits. The project staff, through the HFA, has confirmed that while supervision does take place, (and funding seems to be available for these visits), the real issue is the quality and organization of these visits. During visits, the DHOs only focus on administrative aspects (#s of prenatal visits) and do not assist with problem solving nor brainstorming ways to increase staff competencies. CHOICE sees the building of capacity in supervision/mentoring skills amongst the DHOs to be essential in ensuring sustainable positive health outcomes after the project's ends, and therefore, plans to make this a high priority of the project. Project staff will work with the DHOs to develop improved supervision mechanisms focusing on facilitative and supportive supervision techniques (the project manager will draw upon her previous experience in this area in working with other DHOs) and developing supervision calendars and goals to regularize these visits and monitor progress.

Comments Regarding Involving Men (p. 5)

PCI agrees that men should be proactively involved in all aspects of planning and implementation, and from the beginning, rather than being viewed as "obstacles". In the DIP, the project mentions that men will be one of the primary target groups for BCC activities; the project sees their role as pivotal in supporting positive household behaviors. From the beginning stages of formative research, such as FGDs and individual in-depth interviews, men's viewpoints will contribute to the identification and design of appropriate strategies, such as involving them as peer educators during parent education sessions and in convincing their

peers of the benefits of taking their children to regular posyandu sessions. The project will involve men as key stakeholders and will focus specific project activities, such as capacity building and promotion of key family practices for child and maternal health, with the male-dominated Community Empowerment Institutions.

Comments Regarding the Increased Role of the Midwife (p. 5)

CHOICE staff agree with the reviewer that the midwife plays a pivotal role in posyandu sessions. However, it is important to note that it is actually the village health volunteers/kaders who run the posyandu. Midwives have a very key role to play but, unfortunately, according to HFA results, they are not currently living up to expectations and are not fulfilling their roles as specified in their job descriptions (infrequent visits to the villages, providing counseling to the caregivers regarding proper home management of the illness and recognition of danger signs when the child is brought to the health center, etc.). To address this situation, CHOICE will promote a community feedback mechanism through regular community meetings with representatives from the health facilities, including the midwives, TBAs, community-based institution members, religious leaders, and village heads. At various levels, CHOICE will work with the midwives and communities to determine what would motivate them and what community contributions could be made to encourage them to take pride in carrying out the responsibilities of their job. Also, the project feels that in the initial stages of the program, training will serve as a motivating factor and to support their improved competencies, the DHOs with their improved supervision structure will also serve as mentors and help to motivate the midwives. The project's short history already has reflected the positive impact of project interventions (shortly after the KPC, the midwife who had rarely visited a certain village, made a visit to that village).

Comments on Capacity for Performance Monitoring and Evaluation (p. 7)

The budget for data collection has been reviewed and has been deemed sufficient by CHOICE personnel. Currently, the CHOICE project is fully staffed. Both the Health and Nutrition Specialist and Community Development/Training Specialist have been trained in data collection, and have experience in training staff and collecting data during the KPC and the HFA. CHOICE staff are adapting capacity assessment tools for use with their NGO partner whose data collection will have no additional expenses, other than staff time, consisting of approximately 2 days of assessments and 1 day of data analysis (for 1-2 facilitators). The CHOICE team has been trained in administration and data collection of the Institutional Capacity Assessment tools, including I-STAR, PCI's Integrated System for Transformation and Results) and others. Thus, PCI feels that it does have sufficient budget as well as the capacity to collect the required data, including the capacity assessment data, particularly given the low cost nature of the data collection methods being utilized.

PCI agrees that assessment of health status, using Rapid CATCH indicators, should be included in the M & E Plan and has therefore updated the plan accordingly (see Work Plan).

Comments Regarding Discussion with Mission (p. 8)

During the original project design and proposal development processes, PCI/Indonesia staff met with Mission representatives at least three times to discuss the project site, objectives, and potential strategies. In addition, during the start-up phase, CHOICE staff has been working very closely with Mission representatives, notably, Dr. Sri Durjati Boediharjo, via email, face-to-face meetings, and via telephone (the Mission actually recommended the consultant that the project decided to use for the KPC). Dr. Boediharjo was also invited to the DIP workshop but due to other obligations was unable to attend. Debriefing of the KPC results and DIP workshop outcomes was also held between Lynn Krueger Adrian, Team Leader for PHN and Dr. Boediharjo, Health and Nutrition Advisor & the CHOICED Project Manager. Finally, feedback on this DIP document was solicited from the Mission and incorporated into the final draft. Some recommendations included: suggesting the project provide training in cold chain management for health providers and self esteem and interpersonal communication/counseling for midwives (to improve the self confidence of the midwives in working with the community). Dr. Boediharjo also suggested that PCI could be the lead organization for an essential nutrition action network/forum.

Annex 1B

Debriefing Summary Sheet and Reviewers' Comments

(Hard Copy Only)

Annex 2

Report of Baseline Assessments (KPC/HFA Reports)

DRAFT REPORT OF BASELINE ASSESSMENTS (KPC/HFA)

I. EXECUTIVE SUMMARY

Background

Since October 1999, PCI has been implementing the Community Health and Nutrition through Community Empowerment (CHANCE) project in 3 areas of Indonesia. Benefiting from lessons learned from a 30 year history of maternal and child health programming in the country, PCI has developed a program model which includes the participatory assessment of community health needs, the establishment of community-based institutions for planning and management of interventions, the strengthening of local NGOs to support the community development process, and the training of health personnel to provide improved services in the health centers and at the village level. At the core of the CHANCE project is the IMCI model, including both clinical training of health workers and Household Community-based Integrated Management of Childhood Illness (HH/C IMCI). PCI is intending to build on the experience of previous child survival projects and adapt relevant lessons from the CHANCE project for this survival project.

CHOICE project is being implemented in Pandeglang District of Banten Province. The direct beneficiary population in Pandeglang, includes children under five, pregnant and lactating women and mothers of children aged 0-59 months. The project's strategic objective is **"improved health and nutritional status among children under 5 and women of child bearing age in the selected project areas".** There are three intermediate results which are considered to be pre-condition for its accomplishment i.e. (1) Improved access to better quality of maternal and child health services, (2) Improved health seeking and care giving behaviors among caretakers, and (3) Successful implementation of PCI's community-based health development model by partner NGO.

The design of the study is the One–Group Pretest-Posttest Design, which does not require control group. This study is divided into 3 stages of implementation. The first step is the baseline survey, the next will be the intervention phase, and at the end of the project will be the evaluation phase. In the middle of the intervention phase a midpoint evaluation will be done too.

The objectives of the baseline survey are: 1) to identify maternal and child health problems need to be addressed in the project areas; 2) to identify the capacity of health facilities in providing maternal and child health; 3) to help the project to prioritize problems to be

addressed for intervention or areas to be improved; and 4) health facility assessment. Twelve indicators of Rapid CATCH (Core Assessment Tool on Child Health) and several indicators according to each module were collected using KPC (Knowledge, Practice and Coverage) survey. Module HIV/AIDS was omitted from this survey because project felt that the questions in the module are too sensitive to be raised to respondents in that areas. Beside KPC survey, Health Facility Assessment survey was also done which covered information about health personnel's performances such as ability to conduct integrated management of sick children (which include assessment, treatment, counseling and referral management), supervision, the availability of essential drugs, equipment and supplies, and IMCI training coverage.

Methods

Eleven modules of the KPC 2000+ were used to understand the knowledge and practice of the community and coverage of maternal and child health programs. Those modules were: Household Water and Sanitation, Breastfeeding and Infant/Child Nutrition, Growth Monitoring and Maternal/Child Anthropometry, Childhood Immunization, Sick Child, Diarrhea, Acute Respiratory Illness, Malaria, Prenatal Care, Delivery and Immediate Newborn Care, Postpartum Care, and Child Spacing. Since the HIV/AIDS module was omitted, special FGD will be done to get information on HIV/AIDS.

Study indicators for KPC survey consisted of 12 Rapid CATCH indicators and other KPC indicators suitable to the chosen modules. The 12 Rapid Catch indicators were: 1) Percentage of children aged 0-23 months who are underweight, 2) Percentage of children aged 0-23 months who were born at least 24 months after the previous surviving child, 3) Percentage of children aged 0-23 months whose births were attended by skilled health personnel, 4) Percentage of mothers with children aged 0-23 months who received at least at least two tetanus toxoid injections before the birth of their youngest child, 5) Percentage of children aged 0-5 months who were exclusively breastfed during the last 24 hours, 6) Percentage of children aged 6-9 months who received breast milk and complementary food during the last 24 hours, 7) Percentage of children aged 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday, 8) Percentage of children aged 12-23 months who receive measles vaccine, 9) Percentage of children aged 0-23 months who slept under good condition bed net (in malaria risk area) the previous night, 10) Percentage of mothers with

children aged 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated, 11) Percentage of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment, 12) Percentage of sick children aged 0-23 months who received more fluids and continued feeding during an illness in the past two weeks. The survey of Health Facility Assessment included 1) Observation of sick child, 2) Health personnel interview, and 3) Equipment/supplies check and 4).Exit interview of sick child mothers. The study indicators of HFA included health personnel's skills (assessment, treatment, counseling and correct management of severely ill children), the availability of drugs, equipment and supplies, and the IMCI training coverage. Also supervisions by the Local Health District to each health facility became an indicator of HFA.

Out of twenty-two sub-districts which consist of 322 villages, four sub-districts were chosen as the project areas, namely Saketi, Pagelaran, Patia and Angsana. As many as thirty villages out of 57 villages in those sub-districts were taken as cluster samples.

The target population of KPC survey was mothers of children aged 0-23 months, and the number of sample was 450. In each village, 15 respondents were drawn randomly from the population in the community. The process of respondents selection was done by using "spin the bottle" technique to identify the starting point within a sample area. An addition to the respondents, purposive pregnant mothers and children aged 0-59 months were included to be weighed and measured for the purpose of anthropometric survey.

The number of health facilities in Pandeglang was limited. They were 4 health centers (PUSKESMAS), 6 auxiliary health centers (PUSTU), 1 village delivery hut (POLINDES), and 28 mobile health center activities per month. The number of health personnel in Pandeglang was also limited, only 6 physicians, 3 dentists, 23 midwives, 24 nurses, and 8 health assistants. All health centers, 8 private midwives, and 2 auxiliary health centers were taken as samples. Health personnel who were chosen as sample were midwives or nurses who delivered services for under five and mothers. The health personnel were 3 midwives from health center, 8 midwives who have private practice, 1 nurse from health center and 2 nurses from auxiliary health center. The choosing of the sample was decided by considering the site plan of CHOICE project implementation.

For KPC data collection, 5 supervisors and 15 data collectors were recruited and trained. Training of supervisors was done in Jakarta for 2 days and the training for the data collectors was done in Pandeglang, for 3 days. KPC data collectors were divided in 5 teams, where each team was led by one supervisor and consisted of 3 data collectors. Each data collector was responsible for KPC data collection in 2 villages, but the data collection in each village was done together by 3 data collectors in each team, led by the supervisor. Soon the data was collected in 1 village, the team moved to the next village. In fact the whole data collection lasted for 14 days. HFA data collection was done by 12 Local Health District staffs. The training for HFA data collectors was done in 2 days. HFA data collection was done by conducting direct observations and interviews.

Data entry and processing was done by using the SPSS Program Version 11.0. For KPC, data entry and data cleaning was done by 3 supervisors and the consultant team. HFA data entry and data cleaning was done by one PCI staff who was also performed as the trainer of the HFA training. Data processing of both KPC and HFA survey was done by the consultant team and PCI staffs.

Results and Discussion

The nutritional status of children aged 0-23 months in Pandeglang shows high severity problem of underweight. That condition was related to several factors. One of them was acute illnesses, which was shown by the high prevalence of diarrhea, acute respiratory infection, and other respiratory diseases accompanied by fever and/or cough. The high prevalence of infectious diseases could produce high infant and child mortality rate, if not properly managed. The management and treatment of sick children in Pandeglang is still inadequate, only around one-fourth of mothers could mention at least 2 child danger signs. Mothers' knowledge and practice towards the management of child with diarrhea was still insufficient. Preparation of ORS was only known by less than 30% mothers. The quality of health services in Pandeglang was also not satisfying nor supporting which was shown by health personnel's disability to examine or treat sick children and give relevant information to caretakers according to IMCI guidance, and the limited availability of drugs especially the injectables. The percentage of infants under 12 months who got complete immunization also showed the weakness of health services. Measles is a common disease which lead to malnutrition condition, but in fact the coverage of measles vaccination was below the national figure.

One of the underlying causes of those infectious diseases is poverty, in Pandeglang was shown by the income per capita and level of education of the community. Only half of sick children were brought to health facility/personnel, because families did not have money, or the health facilities and personnel were far away from their house. Health insurance was still not popular for the community, while the Social Safety Net for Health Program has not been developed well. Poverty would also influence the condition of environment which could contribute the prevalence of infectious diseases. The possible proxy variables which influence the prevalence of infectious diseases in Pandeglang were high use of unsafe drinking water, limited access to healthy toilet and bad habits in maternal hand washing before or after doing several important tasks related to disease transmission. Coverage of Vitamin A distribution which is a crucial immediate intervention that can break the malnutrition-infection complex was low too.

The nutritional status of children aged 0-23 months in Pandeglang could also resulted from low maternal nutritional status. Low maternal nutritional status provokes low birth weight babies. Poverty also influences the quantity and quality of food intake because mothers could not buy enough food for the whole family. Food distribution in the family in Pandeglang is still in question; while facts in other regions in Indonesia show that fathers got the first priority. Mothers did not go to health facility for antenatal, delivery or postnatal care because they did not have enough money for fee and transportation, or lived far away from health facilities/personnel. The transportation system was still bad, especially inter-villages and intra-village. This condition affected mothers health seeking behavior, they relied on the TBAs for maternal and child care. The TBAs who resided in their community still have a big role in maternal or even child care, and as the consequences this would influences the prevalence of tetanus neonatorum among newborn babies. However the prevention of tetanus neonatorum was not sufficient which was proved by the low coverage of TT.

Other important factor influences malnutrition among children under two is the practice of breastfeeding, such as early weaning, or early introduction of food. In Pandeglang early introduction of food was existed in a relatively high percentage, and started at the very early month of life. The median of exclusive breastfeeding was very low. A part of infants did not received complementary feeding as it should be. Mothers' ignorance maybe was the root of these wrong practices.

Birth interval between two youngest children in Pandeglang was satisfying in terms of time spent by mother to rear the older child; but still in question whether there were no deaths between those 2 youngest children, because the degree of unmet need for family planning was still high.

Looking at the data on the indicators of health facility support, it can be concluded that comprehensive improvement is very much needed, especially changes in the delivery of immunization. Interviews with health personnel revealed that they have not trained in the IMCI. This resulted a poor management of sick children as shown by very low achievement of several indicators of IMCI. In fact there was minimal supervisions which done by the Local Health District.

Conclusions and Recommendations

It can be concluded that factors that influenced low nutritional status of children under two, high childhood morbidity, low coverage of antenatal, delivery and postpartum care by health personnel; among others are poverty, low level of education, lack of access to health facility/personnel, low standard of health facilities and health personnel, lack of mothers' knowledge and practice towards breastfeeding, complementary feeding, hand washing, and child care. Bad transportation system which hampers referral system had contributed the maternal and child morbidity and mortality rates.

In general there are 4 major interventions need to be done to increase the nutritional and health status among mothers and children in Pandeglang: 1) the improvement of the quality of health services includes increasing the number of health facilities and health personnel which distributed evenly in the area, completing inputs in health facilities/health personnel such as training IMCI for health personnel and training for TBAs, adding needed equipments and vaccines/drugs, assuring qualified health delivery and supervisions; 2) health education for the community which involved NGO partners; 3) improvement of environment, such as transportation system, safe drinking water, and excreta disposal; 4) develop health insurance scheme based on the national health insurance system by utilizing Social Safety Net for Health, provided by the government. To accomplish satisfying result, before the intervention several activities need to be done to elucidate the problem such as focus group discussion, thorough investigation problem, and in-depth interview. The topics to be studied among others are

breastfeeding knowledge, beliefs and practices, vitamin A distribution, the role and previous training of TBAs, and the implementation of Social Safety Net for Health Program.

II. BACKGROUND

2.1. Project location

Distric of Pandeglang covers 2.747 km2 or 29.98% of Banten Province, or 6% of West Java Province. Pandeglang consists of 22 sub-districts, and 322 villages. City of Pandeglang which is the capital city is located about 23 km from Serang, the capital of Banten Province and 111 km from Jakarta. The distance of Pandeglang from Bandung is 298 km. The region which is located in the west part of Banten Province has administrative border as follow:

- North : District of Serang
- South : Indian Ocean
- West : Sunda Straits
- East : Regency of Lebak

KPC data was obtained from a survey conducted in 4 sub-districts, precisely in 30 villages, namely Pagelaran Sub-district (Kartasana, Margagiri Bama, Margasana, Tegalpapak, Montor, Sindang Jaya, Sukadame, Sendangsari dan Pagelaran); Saketi Sub-district (Saketi, Ciandur, Medalsari, Sukalangu, Langensari, Parigi, Girijaya, Sodong, Mekarwangi, Sindanghayu); Patia Sub-district (Sidamukti, Cibungur, Rahayu, Karyasari, Babakankeusik); and Angsana Sub-district (Padaherang, Karangsari, Cikayas, Cipinang and Kramatmanik).

District of Pandeglang, in the middle and South areas generally lowland with relatively low mountains height, namely Mount Payung (480 m), Mount Honje (623 m), Mount Tilu (582 m) dand Mount Raksa (320 m). The width of this region is about 85,07% of district's width. The North area is about 14,93%, and is an upland, because it has mountains such as: Mount Karang (1.778 m), Mount Pulosari (1.346 m) and Mount Aseupan (1.174 m). This area has relatively plenty amount of water as can be seen by many river flows.

2.2. Characteristics of the Target Beneficiary Population

Total population of Pandeglang in the year of 2001 was 1,028,000 inhabitants with the composition of male population 524,680 and female population 504,300. So that the sex ratio was 104. The distribution of the population is relatively uneven. The sub-district with the least

population density was Sumur Sub-district with the average of 72 people / km2. While the most dense sub-district is Pandeglang with 1,990 people / km2.

The population growth based on registration in the period of 2000-2001 was 0,99%. Total population of younger age (< 15 years old) was 392,556 (38%) while the total population of productive age was 579,625 people (56%). Total population of aging (above 64 years) was 56,801(5.5%). The most predominant ethnic is Banten, only some of the population are Javanese. Generally they can speak Bahasa Indonesia. The Banten people are famous for their "jawara" or "warriors" who make use of supernatural power reflecting the Banten people's nature, beliefs and strong adherence to traditional values and practices, including those related to health and child rearing. More than in other areas of Indonesia, most traditional healers and birth attendants (particularly the older ones) are believed to have and use supernatural power. In rural Pandeglang District, the percentage of children between 0-5 years is 7%. Women aged 15-44 comprise nearly 25% of the province's population. It is estimated that the total number of project beneficiaries for Child Survival intervention will be 32,520; this includes 12,780 children 0-5. and 19,740 women of reproductive age (WRA). The direct beneficiary population in Pandeglang, includes children under five, pregnant and lactating women and mothers of children aged 0-59 months.

2.3. Health, Social, and Economic Conditions within the Project area

In Pandeglang District, 62% of the total number households fall into the "pre-welfare" and "welfare level one" categories; this is among the highest percentages in the province. While Indonesia's national adult literacy rate is 90% and average figures are slightly lower for the rural areas (86.36%), the project areas lag far behind. Also, this high national percentage does not reflect the quality of the primary school education, the graduates' knowledge/skills, or the educational reality in Banten province. In 2000-nearly 37% of its population never attended or finished primary education. In terms of the influence of gender roles on health seeking behavior, fathers have the final decision as to whether a sick pregnant mother or a sick child should be taken to a health facility or traditional healer/traditional birth attendants (TBAs); their late decisions may cause fatalities in serious cases of childhood illnesses and in obstetrical emergencies.

Level of Education of Population of Regency Pandeglang in 2001 can be seen in the following table:

Table 2.1. Level of Education the Population of Pandeglang, 2001

Level of Education	**Percentage**
University	0.7%.
Academy	1.1%
Senior High School	9.2%
Junior High School	9.2%
Elementary	41%
Not yet or not finish elementary	33%
No schooling	5.5%

Total budget of income and expenses (APBD) of Pandeglang Distric in 2001 was Rp. 252,254,451,921,-.Total health expenses was Rp. 9,401,510,791,- or 3.37% from APBD.

Banten's Provincial Health Profile 2002 reports IMR at 101 per 1,000 live births. The health and nutrition situation in Banten is poorer than in the West Java province. HKI's Nutrition and Health Surveillance Systems (NSS) indicates that the proportion of fully immunized 12 to 17-month-old children in rural Banten is very low (<50%), and far from the minimum coverage target of 80%.

Table 2.2. Selected Demographic, Social, Health Status and Health Facility Data for Banten Province and Pandeglang District

No	Description	Banten Province	Pandeglang District
1	Population	8,052,312	1,010,741
2	Households	1,847,108	231,811
3	Families in "pre-welfare" or "welfare level one" groups	751,443 (40.7%)	144,368 (62.3%)
4	Women aged 15-44 yrs	1,970,122	220,556
5	Infants < 1 year of age	103,464	13,140
6	Children 1-5 years of age	398,036	59,730
7	% of women married before 16 years	38.18%	43.59%
8	Infant Mortality rate (IMR)	66.15	65.46
9	Health Centers (HC) and Ratio per 100,000 population	160/13.8	25/2.6
10	Health provider assisted delivery	58%	49%
11	Auxiliary HC/Mobile HC	257/97	66/14
12	Village Midwives	1,060	292
13	POSYANDU	8,042	1,335

The Banten Provincial Health Profile 2000 reported 162 cases of diphtheria; 2,841 of pertussis; 1,781 of tetanus; 241 of tetanus neonatorum; 1 of Polio; 26,233 of measles and 1,562 of hepatitis. The highest case fatality rate, at 35.7%, was held by diphtheria.

In April 2002, among the three provinces of East, West and Central Java, West Java (including Banten) was categorized as nutritionally the worst among infant aged 3-5 month. In Banten's proposed sites, the prevalence of child anemia among children 12-23 months old is high (20%). The majority of these cases are due to iron deficiencies. The most common foods provided to infants in Banten's rural areas are banana, mashed rice, or rice porridge (rarely with vegetables or protein source food) and at times, biscuits. The practice of prioritizing fathers or males for food distribution in the family, both in terms of quantity and quality, is also still very common, depriving infants and young children from the nutrients they need. Table 2.3 shows how the economic crisis has impacted the nutritional status of women and children and how the effects on Banten have been particularly severe.

Table 2.3. Nutritional Health Status and Posyandu Attendance among Children and Mothers in Banten

No	Respondent	Wasting	Stunting	Under weight	Anemia	Vit A Coverage	Posyandu Attendance	Diarrhea
1	Children	11,6%	41%	42%	57%	59%	69%	15.3%
2,	Non-pregnant mothers	14%	N/A	N/A	23.3%	10.7%	N/A	1.8%

**Data presented above represent average survey results from Apr 00 through Jul 01. Wasting, Stunting, Underweight, Anemia and Diarrhea are for 12-23 month olds; VAC is for 6-59 month olds; Posyandu Attendance is for 0-35 month olds.*
Source: Crisis Bulletin, Year 4, Issue 11, Helen Keller International Indonesia, January 2002

2.4. Overview of the project: goals, objectives, intervention activities, objectives of the KPC survey and HFA

The project's strategic objective is **"improved health and nutritional status children under 5 and women of child bearing age in the selected project areas".** There are three intermediate results which are considered to be pre-condition for its accomplishment i.e. (1) Improved access to better quality of maternal and child health services, (2) Improved health seeking and caregiving behaviors among caretaker, and (3) Successful implementation of PCI's community-based health development model by partner NGO

Those objectives will be pursued through a participatory strategy which involves improving the quality and accessibility of facility and community-based health services; increasing community knowledge and skills and encouraging the adoption of key health-promoting behaviors; the establishment and strengthening of village-based health planning and management institutions; capacity building and partnership with local NGO; and close collaboration with district health authorities.

The design of the study is the One–Group Pretest-Posttest Design, which does not require control group. This study is divided into 3 stages of implementation. The first step is the baseline survey, the next will be the intervention phase, and at the end of the project will be the evaluation phase. In the middle of the intervention phase a midpoint evaluation will be done too.

The objectives of the baseline survey are: 1) to identify maternal and child health problems need to be addressed in the project areas; 2) to identify the capacity of health facilities in providing maternal and child health; 3) to help the project to prioritize problems to be addressed for intervention or areas to be improved; and 4) health facility assessment. Twelve

indicators of Rapid CATCH (Core Assessment Tool on Child Health) and several indicators according to each module were collected using KPC (Knowledge, Practice and Coverage) survey. Module HIV/AIDS was omitted from this survey because the project felt that the questions in the module are too sensitive to be raised to respondents in that areas. Beside KPC survey, Health Facility Assessment survey was also done which covered information about health personnel's performances such as ability to conduct integrated management of sick children (which include assessment, treatment, counseling and referral management), supervision, the availability of essential drugs, equipment and supplies, and IMCI training coverage.

III. PROCESS AND PARTNERSHIP BUILDING

PCI and officials at the Pandeglang District Health Office and the Banten Province Regional Health Office have discussed specific needs, resources, and targets for the project area and their observations have helped shape the results framework and subsequent planned activities. These keys public health officials are supportive of the project and have offered their full collaboration. PCI had also decided to collaborate with an NGO called Social Concern Foundation of Indonesia (YPSI), that currently implement program in health, women and child 's right, and income generating in Banten Province. YPSI will play a central role in advocating for local government, particularly in pressing for prioritizing maternal and child health program. PCI will also work closely with YPSI to capacitate community-based institutions and encourage communities to adopt key family practices. The KPC survey was developed by the PCI staff, YPSI staff and the consultant team. KPC survey involved the local resources as enumerators. The results of KPC and HFA were presented and discussed in a special meeting, to analyze and decide the action to be conducted. The meeting involved the local government staffs both administrative and health, also other health related sectors.

IV. METHODS

4.1. Questionnaires

The Knowledge, Practice, Coverage (KPC) and Health Facility Assessment (HFA) questionnaires were translated into Bahasa Indonesia by PCI staff, and discussed by PCI staffs, YPSI staffs and the consultant team for the adaptation. Also the supervisors were included in the team. Several items were adapted in accordance with the local situation. After the pretest, some improvement need to be done, especially the wording and the classification of several data. The process of KPC questionnaires development took around 2 weeks to be ready for the survey. Eleven modules of the KPC 2000+ were used to understand the knowledge and practice of the community and coverage of maternal and child health programs. Those modules were: Household Water and Sanitation, Breastfeeding and Infant/Child Nutrition, Growth Monitoring and Maternal/Child Anthropometry, Childhood Immunization, Sick Child, Diarrhea, Acute Respiratory Illness, Malaria, Prenatal Care, Delivery and Immediate Newborn Care, Postpartum Care, and Child Spacing. HIV/AIDS module was omitted from this survey because the project staff felt that the questions in the module were too sensitive to be raised to respondents in that area.

Beside KPC survey, Health Facility Assessment survey was also done which covered information about health personnel's performances such as ability to conduct integrated management of sick children (which include assessment, treatment, counseling and referral management), supervision, the availability of essential drugs, equipment and supplies, and IMCI training coverage.

4.2. Study indicators

Study indicators for KPC survey consisted of 12 Rapid CATCH indicators and other KPC indicators suitable to the chosen modules. The 12 Rapid Catch indicators were: 1) Percentage of children aged 0-23 months who are underweight (<-2 SD from the median weight-for-age, according to WHO/NCHS reference population), 2) Percentage of children aged 0-23 months who were born at least 24 months after the previous surviving child, 3) Percentage of children aged 0-23 months whose births were attended by skilled health personnel, 4) Percentage of mothers with children aged 0-23 months who received at least at least two tetanus toxoid

injections before the birth of their youngest child, 5) Percentage of children aged 0-5 months who were exclusively breastfed during the last 24 hours, 6) Percentage of children aged 6-9 months who received breast-milk and complementary food during the last 24 hours, 7) Percentage of children aged 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday, 8) Percentage of children aged 12-23 months who receive measles vaccine, 9) Percentage of children aged 0-23 months who slept under good condition bed net (in malaria risk area) the previous night, 10) Percentage of mothers with children aged 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated, 11) Percentage of mothers of children aged 0-23 months who know at least two signs of childhood illness indicating the need for treatment, 12) Percentage of sick children aged 0-23 months who received more fluids and continued feeding during an illness in the past two weeks.

The survey of Health Facility Assessment included 1) Observation of sick child, 2) Health personnel interview, 3).Exit interview of sick child's mother and 4) Equipment/supplies check. The study indicators of HFA included health personnel's skills (assessment, treatment, counseling and correct management of severely ill children), the availability of drugs, equipment and supplies, and the IMCI training coverage. Also supervisions by the Local Health District to each health facility became an indicator of HFA.

4.3. Sampling Design

District of Pandeglang covers 2.747 km2 or 29.98% of Banten Province or 6% of West Java Province. District of Pandeglang consists of 22 sub-districts, and 322 villages. The project location was selected by the team of local government staffs which consisted of several sectors related to health problems, PCI and YPSI staffs, directly coordinated by Bappeda District of Pandeglang. The criteria among others were:

- High percentage of poor families
- High percentage of undernourished children under age five
- Low immunization coverage
- Low coverage of posyandu activities
- Relatively high community participation.

According to those criteria, the team had selected 7 sub-districts as the potential project location namely Patia, Angsana, Pagelaran, Menes, Saketi, Panimbang and Jiput. Field trip was done to chose the project location. Futhermore, four sub-districts were chosen based on the previous criteria and the availability of assistance or aids from other donor agencies. Villages which received aids from any donor agencies were excluded. The villages which were included in the study can be seen in the next table.

Table 4.1. List of Villages Included in the Study, by Sub-district, Pandeglang District, 2003

No	Sub-district	Villages
1	Angsana	Padaherang, Karangsari, Cikayas, Cipinang and Kramatmanik.
2	Patia	Desa Sidamukti, Karyasari, Cibungur, Rahayu and Babakankeusik.
3	Pagelaran	Desa Kartasana, Margagiri, Bama, Margasana, Tegalpapak, Montor, Sindanglaya, Sukadame, Senangsari and Pagelaran.
4	Saketi	Desa Saketi, Ciandur, Medalsari, Sukalangu, Langensari, Parigi,Girijaya, Sodong, Mekarwangi dan Sindanghayu

The population of this baseline survey was the mothers of children aged 0-23 months. As a matter of fact we did not have the sampling frame of the population. Considering the width of Pandeglang District and the availability of maternal and child health data, this project decided to use cluster sampling. The traditional 30-cluster sampling data is widely accepted and is an efficient way to collect program-wide data. Calculation of sample for a simple random method yielded samples of 96, where:

$z = 1.96$ (95% confidence level), statistical certainty chosen

$p = 0.5$, estimated level/coverage to be investigated

$q = 1-p$

$d = 0.1$, precision desired

In cluster sampling the homogeneity of each cluster caused a bias called design effect. To compensate this bias, the size of a cluster sample should be at least double the size of a simple random sample. For KPC surveys the sample size usually increased to 300 because KPC surveys are used to estimate coverage for many different technical interventions. In this baseline study,

due to several important coverage need to be studied and the availability of resources, the number of samples was increased to 450.

In each village, 15 respondents were drawn randomly from the population in the community. The process of respondents selection was done by using "spin the bottle" technique to identify the starting point within the area. All target population who resided along the direction of the mouth of the bottle from the center of the community until the edge of the community were listed and numbered. One sample was drawn randomly from those lists, and taken as the first respondent. The second respondent was taken by visiting the closest house of the first respondent. Henceforth the next respondent was taken using similar technique to the withdrawal of respondent number two.

In addition to the respondents, purposive pregnant mothers and children aged 0-59 months were recruited to be weighed and measured for the purpose of anthropometric survey.

The number of health facilities and health personnel in Pandeglang District are shown in Table 4.2 and Table 4.3.

Table 4.2. Health Facilities in District of Pandeglang, 2003

NO	SUB-DISTRICT	NUMBER OF FACILITIES			
		HEALTH CENTER	AUXILIARY HEALTH CENTER	VILLAGE DELIVERY HUT	MOBILE HEALTH CENTER
1	SAKETI	1	2	0	4
2	PAGELARAN	1	0	0	0
3	PATIA	1	4	1	14
4	ANGSANA	1	0	0	10

Table 4.3. Type of Health Personnel, District of Pandeglang, 2003

NO	HEALTH CENTER	HEALTH PERSONNEL			
		PHYSICIAN & DENTIST	MIDWIFE	NURSE	HEALTH ASSISTANT
1	SAKETI	3	10	5	3
2	PAGELARAN	3	5	7	2
3	PATIA	3	8	7	2
4	ANGSANA	0	3	5	1

Source: HFA survey, District of Pandeglang, December 2003

There were 4 health centers in Pandeglang District, all of them were taken as sample for HFA. Also health personnel who were chosen as sample were midwives or nurses who delivered services for under five and mothers. The samples for HFA can be seen in Table 4.4. The location of the sample was decided by considering the site plan of CHOICE project implementation.

Table 4.4. Sample of Health Facilities, Health Facility Assessment, District of Pandeglang, 2003

NO	SUBDISTRIC	MIDWIFE			NURSE		
		HEALTH CENTER	AUXILIARY HEALTH CENTER	PRIVATE MIDWIFE	HEALTH CENTER	AUXILIARY HEALTH CENTER	PRIVATE NURSE
1	SAKETI	1	0	2	0	1	0
2	PAGELARAN	0	0	2	1	0	0
3	PERDANA	1	0	2	0	1	0
4	ANGSANA	1	0	2	0	0	0

4.4. Training

For the purpose of KPC data collection, 5 supervisors and 15 data collectors were recruited. Supervisors were recruited by inviting researcher who fulfill several criteria such as having some experiences in data collection, capable of using Microsoft Word, Excel and preferably SPSS. The supervisors consisted of 2 women and 3 men. Four were YPSI staffs and 1 was PCI staff. The criteria for data collectors were person who had training in health and own high school diploma. In fact, the project was lucky to have 15 students of Academy of Nursing in Serang as data collectors. Only 2 of them were men. Training of supervisors was done on November 18 until November 22, 2003 in Jakarta. The objectives of the training were:

- Trainee will comprehend the CHOICE project
- Trainee will understand the purpose of BASELINE data collection
- Trainee will understand his role in the project
- Trainee will be able to interview respondents
- Trainee will be able to manage the data
- Trainee will be able to communicate better with the data collectors or community in general
- Trainee will be able to check and verify data
- Trainee will be able to entry data using SPSS program

- Trainee will be able to clean data
- Trainee will be able to process data

The trainers included: the project manager of CHOICE, the PCI staff and the consultant team. The materials of the training included the overview of the CHOICE project, organizational structure of the baseline study, questionnaire's review, data management, anthropometric measurement, simulation, field practice and discussion. Data entry, cleaning, and processing were also discussed and practiced during the training. Detailed schedule can be seen in Annex 2.

Training for data collectors was done in Pandeglang, 9 to 11 December 2003. The objectives of the training were:

- Trainee will comprehend the CHOICE project
- Trainee will understand the purpose of BASELINE data collection
- Trainee will understand his/her role in the project
- Trainee will be able to interview respondents
- Trainee will be able to manage the data
- Trainee will be able to communicate better with the supervisors or community in general

The data collectors received almost the same training as the supervisors, except data entry, cleaning and processing activities. The trainers included: the project manager of CHOICE, the PCI staffs, supervisors and the consultant team. The timetable can be seen in Annex 2.

HFA data collection was done by 12 Local Health District staff. They were recruited under several criteria such as (1) work in institutions which supervise the health facilities will be studied, (2) had been trained on Integrated Management of Childhood Illness (IMCI). Unfortunately only 2 local health staffs who had been trained in IMCI and they had other responsibility, so the project decided to drop the second criterion and oriented the data collectors on IMCI. The training was done in 2 days, by PCI staff who is a physician and having experiences as supervisor of HFA data collection on CHANCE project, had IMCI and TOT IMCI training. Besides, she had also acted as co-facilitator on IMCI training.

HFA training was done on December 15 and 16, 2003 in Pandeglang, with key speaker note by the Head of District Health Office. The materials covered the overview of PCI and CHOICE project; the overview, objectives and preparation of the survey, survey methodology, introduction of IMCI approach, questionnaires review and simulation. The detailed of training schedule can be seen in Annex 2.

4.5. Data Collection

On average KPC interview lasted for 45 minutes to 1 hour. Data collectors were divided in 5 teams; each team consisted of 3 data collectors and. was led by one supervisor. Each data collector was responsible for KPC data collection in 2 villages, but technically the data collection in each village was done together by those 3 data collectors in each team, led by the supervisor. Soon the data was collected in 1 village, the team moved to the next closest village. Data collection in 1 village was done around 1.5 to 2 days. In fact the whole data collection lasted for 14 days, caused by flooded in some of the area. To maintain the quality of data collection, the consultant team made field supervisions to train supervisors in verification and data management. Those field supervisions were also attended by the data collectors. Several questionnaires were reviewed to check its logic and accurate filling. The supervisions were done separately for each supervisor.

The HFA data collection was done by conducting direct observations and interviews. Observation and interview were done to evaluate how the health personnel manage the sick children which included assessment, correct treatment, proper counseling and management of severely ill children. Observation health facilities covered the availability facilities. supplies and equipment and essential drugs for sick children. The objectives of interviewing child caretaker was to study the counseling content given by health personnel in relation with the illness suffered by the children.. One team which consisted of 3 persons was assigned to collect data from 1 health facility. Time allocated for HFA data collection was 4 days, one team was expected to assess 1 health facility per day. There were 14 health facilities which need to be assessed. In each health facility, as many as 3 sick children were studied. The observation of sick child management (questionnaire :sick child) needed 2-15 minutes, but for the complete filling of the questionnaire needed another 10 minutes. Interview with child's caretaker (questioner:-exit interview – sick child) took 10 minutes, and the interview and observation of health personnel (questioner: health worker interview) required 30 minutes to be completed. The checklist observation of equipment and supplies (questioner : equipment and supply check list) in health facility needed 45 minutes to fill.

Several obstacles encountered during the HFA data collection were: (1) Case validation was not done, because of resources limitation; (2) Each team had to visit health facilities more

than once because no sick child came for treatment; (3) Some of data collectors still raised close questions.

4.6. Data Management and Analysis

All filled KPC questionnaires were rechecked by the supervisors together with the data collectors. Incomplete questionnaires were given back to the data collectors to be completed. Each questionnaire which was submitted to the supervisors was recorded in the form control. Questionnaires were registered according to the number of the respondents. Questionnaires from each village were put together in one file, so that those questionnaires are easy to find whenever needed for the purpose of data cleaning. For KPC, SPSS 11.0 Program was used for both data entry and analysis. The data base was designed and developed by the consultant team in collaboration with PCI staffs. Data entry was done by 3 supervisors, and was lasted for 10 days. Data cleaning was done by the consultant team and the supervisors. It took 5 days to clean the data. In order to obtain accurate data, the supervisors and the consultant team went through some of the questionnaires.

The HFA data entry was done by PCI staff who was also performed as the trainer of the HFA training. The data entry lasted for 6 days, using SPSS 11.0 Program. For the purpose of analysis also that program was utilized. Data cleaning, which needed 4 days was done by the consultant team and the PCI staff who entry the data. During the data cleaning, reviews some of the questionnaires were conducted to get accurate data..

V. RESULTS

5.1. Priority Child Health Indicators

5.1.1. Sentinel Measure of Child Health and Well Being

According to WHO 1995 and WHO 2000 classification, the severity of underweight among under-five classified as low if the underweight prevalence is less than 10%; medium if the underweight prevalence is between 10 to 19%; high if the underweight prevalence is between 20 to 29%; and very high if the prevalence is 30% or more (WHO, 1995; WHO, 2000). The prevalence of underweight among children aged 0-23 months in Pandeglang was 23.5% (16.9%

are moderately and 6.6% are severe malnourished), which shows high severity of the problem. (Table 5.1.3.5, Annex 3).

Among the four sub-district study areas, Angsana led with the highest prevalence of underweight children aged 0-23 months as many as 27.3%, followed by Patia 24.4%, Pagelaran 22.7%, and Saketi, 21.9% (Table 5.1.3.8, Annex 3). There was no significance difference between prevalences of underweight among boys and girls ($p>0.05$) (Table 5.1.3.4, Annex 3). Prevalence of severe underweight in Pagelaran was 8.7%, Angsana 6.5%, Patia 6.4%, and Saketi 4.6%. There was no significance difference between prevalences of severe underweight among boys and girls ($p>0.05$) (Table 5.1.3.4, Annex 3).

5.1.2. Prevention of Illness/Death

The percentage of children aged 0-23 months who were born at least 24 months after the previous surviving child was nearly 93%. This survey also found that most deliveries were attended by traditional birth attendants (TBAs) (83.6%), while the figure for health personnel was only 15.8%.

Only 16 (3.5%) mothers owned mother health cards, and verification of those cards showed that there were 11 (68.75%) mothers who received two Tetanus Toxoid injections, 2 mothers received once (12.5%) and 3 of them did not get any.

Exclusive breastfeeding among infants aged 0-5 months was 48.5%, and the median duration of exclusive breastfeeding was 1.0 month. Percentage of infants aged 6-9 months who received breast-milk and complementary food during the last 24 hours was 89.0%.

Among children aged 12-23 months who owned immunization card, only 51.1% received complete immunization against the five vaccine-preventable diseases before the first birthday, and 6.4% were fully vaccinated after the first birthday. The rest did not receive complete immunization. The percentage of children aged 12-23 months who received measles vaccine was 61.7%.

Even though Pandeglang is not an endemic area for malaria, this survey tried to ask respondents towards the use of bed net. The percentage of children aged 0-23 months who slept under insecticide-treated net the previous night was 0%.

There were 1.3% mothers who reported that they wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.

5.1.3. Management and Treatment of Illness

Knowledge of child danger signs such as look unwell or not playing normally, not eating or drinking, lethargic or difficult to wake, high fever, fast or difficult breathing, vomiting, and convulsions is very important to mothers so that they can identify the right time to bring children to health facility. Only 28.7% mothers could mention at least 2 danger signs.

Children with diarrhea should be given more fluids and offered the same amount or more food during the illness. The percentage of children aged 0-23 months with diarrhea in the last 2 weeks who were offered the same amount or more food was 73.4%.

5.2. Environment and Selected Maternal Child Health Indicators

This survey found that 54.9 % households had access to safe drinking water for all year long. Around twenty percent of the households which usually used safe water sources, did not use the sources all year long. It is presumed that they switched to other unsafe sources, because during dry season some of the water sources dried off. Around 25% households used unsafe water sources for drinking water all year long. In general the sources were the open wells, surface water, and open rain water reservoirs. The percentage of household which had access to healthy toilet was 27.7%. The vast majority of the respondents (57.3%) reported that they defecated on open places which could possibly transmits infectious diseases, while the rest used traditional pit toilet.

Around 24% mothers of children aged 0-23 reported occurrence of diarrhea during the last 2 weeks, but only 11% children with diarrhea received oral rehydration solutions (ORS) and/or recommended home fluids. The percentage of children with diarrhea who were offered more fluids during the illness was 34.9%. Checking was done to study whether mothers understood how to prepare ORS. This study found that among mothers of children with diarrhea, only around one fourth could correctly explain the preparation of ORS, while among all respondents the figure was 27.7% (Table 5.1.5.2, Annex 3).

Out of 151 children with cough, 60 (39.7%) of them experienced fast or difficult breathing. Around half (56.7%) of them were taken to health facility by mothers or received antibiotics from alternative sources.

Only 16 (3.7%) mothers owned maternal cards. Around 66.6% of mothers said that they had antenatal care at least once during the pregnancy of the youngest child. Percentage of mothers who received iron tablets during the last pregnancy was 77.8%, but only 12.9% of them received for 90 days or more. In addition, percentage of pregnant mothers with mid-upper arm circumference (MUAC) less than 23.5 cm was 32%.

Right after the delivery, most babies (80%) were bathed, and only 0.4% were immediately breastfed as it should be. Not all babies were placed with mothers immediately, there were 36.9% babies who were separated from their mothers after the delivery.

After the delivery mothers are urged to have postpartum check to health personnel. As many as 58.9% mothers had at least one postpartum check Around 67% of them did the first visit less than 1 week, 30.2% between 1-6 weeks, and the rest after 6 weeks. Around 50% mothers who went for postpartum check visited health personnel, and the rest visited TBAs or cadres.

Mothers are expected to know the postpartum and neonatal danger signs indicating when health personnel's help is needed. Postpartum danger signs are fever, excessive bleeding and smelly vaginal discharge, while neonatal danger signs are disability to suck, fast breathing, not active, redness around umbilical cord and red or discharging eye. Percentage of mothers who were able to mention at least 2 postpartum danger signs was only 4.7%, while the percentage of mothers who were able to mention at least 2 neonatal danger signs was 5.8%. Percentage of mothers who received vitamin A during the first 2 months after delivery was only 10%.

The number of mothers who were eligible to use contraception was 441, because 9 of the respondents were pregnant. Among them, 297 (67.3%) were using modern contraception, and the most popular contraception was injectables (79.5%).

There were 124 respondents who mentioned that they did not want or not sure to have more children, but among them only 65 respondents (52.4%) used modern contraception.The rest did not use any contraception at all, which shows the unmet need for family planning service in Pandeglang (13.3%).

5.3. Health Facility Assessment

Health Facility assessment using the USAID/BASIC Integrated Health Facility Assessment tools, was conducted in order to obtain the information of the availability and the quality of health services especially child health services related to integrated management of child illnesses. The priority indicators for IMCI at health facility level were collected which inlcuded 1) Health worker skills (Assessment, correct treatment and cunseling, and correct management of severely ill children) and 2) Health system supports for IMCI (supervision, drug, equipment and supplies and IMCI training coverage.

a. IMCI training coverage

As shown by the following table, all midwives work in the project areas have not been trained on IMCI.

Training on maternal and child health received by midwives in the last 2 years

		Type of training received							
Sub-district	**No. of Mid-wives**	**Social Maternal and perinatal audit**	**Life Saving Skills**	**Clean & Safe Delivery**	**Inter-personal Communication / Counseling skills**	**IEC/ Family Planning**	**Lactation MGT**	**IMCI**	**Others**
Saketi	10	10	5	6	0	0	0	0	0
Pagelaran	5	5	0	0	0	0	0	0	0
Patia/Perdana	8	8	5	7	7	4	0	0	0
Angsana	3	3	3	2	1	0	0	0	0
	26	26	13	15	8	4	0	0	0

b. Health Worker Skills
b.1. Assessment.

Table 5.2.1 shows that from 37 client-provider interactions observed, no child checked for 3 general danger signs, no child checked for the presence of cough, diarrhea and fever, only 8 children checked on their vaccination status, 7 children checked their weight against growth chart and no child assessed for feeding. Index of integrated management or mean of 10

assessment tasks performed per sick child was 0.4. The result indicated that the competency of health workers in managing ill child is still low and need to be improved.

Table 5.2.1. Assessment			
No	**Indicator**	**Assessment**	
		No. of cases correctly assessed	No. of cases observed
1	Child checked for 3 general danger signs	0	37
2	Child checked for the presence of cough, diarrhea and fever	0	37
3	Child's weight checked against a growth chart	7	37
4	Child vaccination status checked	8	37
5	Child under 2 years of age assessed for feeding	0	18

No	Indicator	The Average Index
6	Index of integrated management*(arithmetic mean of 10 assessment task performed for each child : checked for 3 danger signs, 3 main symptoms, child weighted and weight checked against a growth chart, palmar pallor, vaccination status) divided by 10)	0.4

c.2. Correct treatment and counseling

As shown in table 5.2.2,. no child was diagnosed as pneumonia, diarrhea with blood, acute ear infection, malaria and anemia during the observation, so that we can not evaluate the appropriateness of antibiotics/anti-malaria treatment. It was also revealed that only eight children who was treated appropriately in term of antibiotics prescription. The remaining 25 children who did not need antibiotics were prescribed with antibiotics.

Counseling skills of the providers is still lacking. Only 16 out of 37 mothers were advised to give extra fluids and continue feeding. Immunization was only given to one out of 18 children who need vaccination. The HFA also found that only 14 mothers/caregivers of children who were prescribed with ORS and/or oral antibiotic could describe how to give the treatment. These indicate that the competency of providers in managing sick child is need to be improved.

Table 5.2.2. Correct treatment and counseling

No	Indicators	Pengobatan & konseling	
		Correct treatment and counseling	No. of cases observed
1	Child needing oral antibiotic and/or antimalarial is prescribed drug(s) correctly (pneumonia, and/or dysentery, and or malaria, and/or acute ear infection, and/or anemia in high malaria risk areas)	No cases	
2	Child not needing antibiotic leaves the facility without antibiotic	8	33
3	Caretaker of sick child is advised to give extra fluids and continue feeding	16	37
4	Child needing vaccinations leaves facility with all needed vaccinations	1	18
5	Caretaker of child who is prescribed ORS and/or oral antibiotic and/or an antimalarial can described how to give treatment	14	29

c.3. Management of severely ill children

The team also found that the health worker even did not recognize the severely signs of children with pneumonia which are very easy to be identified by recognizing lower chest wall in-drawing and stridor in calm child (a harsh made when the child in-hales indicate risk of respiratory tract obstruction). One case who was diagnosed by the team as severe pneumonia, that needed referral to higher level of health facility, was not referred by the health worker.

Table 5.2.3 : Correct management of severely ill children

No	Indicator	Severely ill children referred**	
		no. cases referred t	No. of cases observed
12	Child needing referral is referred	0	1

c. 4.Health system supports for IMCI

There are two essential components that need to be strengthened to improve the quality of health services. These two components are : the provider's compliance to health services standard of procedures and the availability of essential drugs, equipment and supplies. The HFA findings shown in table 5.2.4 indicated that only 2 out of 14 surveyed health workers reported that they had received at least one supervision in the last six months. The quality of supervision is still questioning, as they reported that the supervision was mostly focused on the administrative tasks.

Tabel 5.2.4. Supervision

No	Indicator	Supervision	
		No. of health facilities received supervisory visit	No. of health facilities surveyed
1	Health facility received at least one supervisory visit that included observation of case management during the previous six months	2	14

As indicated in table 5.2.5, not all eight essential oral drugs for IMCI were available in each surveyed health facilities. As revealed from HFA results, only 4 out of 14 facilities completed with these 8 essential oral drugs (index of availability of essential oral treatment is 0.79). The availability of injectable drugs for referral treatment were even worse, only 5 facilities had one injectable drugs (IMCI requires 4 drugs), or the index was only 0.09. HFA also found that all 4 vaccines were available in all Public Health Centers and in the 5 private health facilities run by midwives or the average index of the availability of four vaccines is 0.64. . In addition, from the four Puskesmas observed, only 2 Puskesmas have adequate facilities and maintenance of cold chain, one puskesmas do not have thermometer and one Puskesmas did not regularly check the refrigerator's temperature .

Table 5.2.5 The availability of drugs, equipment and supplies

No	Indicator	The average index
1	Index of availability of essential oral treatment (arithmetic mean of essential oral drugs recommended for home treatment divided by 8)	0.79
2	Index of availability of injectable drugs for pre-referral treatment (Arithmetic mean of recommended injectable pre-referral for children and young infant with severe classification needing immediate referral divided by 4)	0.09
4	Index of availability of four vaccines (Arithmetic mean of recommended vaccines available at each facility at the days of visits, divided by 4)	0.64

No.	Indicator	No of health facilities that have equipment and supplies	No. of health facilities surveyed
3	Health facility has the equipment and supplies to provide full vaccination services on the day of survey***	2	4

VI. DISCUSSION

6.1. Sentinel Measure of Child Health and Well Being

The prevalence of underweight among children aged 0-23 months in Pandeglang shows a high severity of the problem. This WAZ (weight for age) indicator reflects body mass relative to chronological age. The causes of underweight usually just happened recently, such as acute diarrhea or acute respiratory infection (ARI). Two factors which might be associated with problem of underweight children in Pandeglang were food intake and childhood diseases. Problems in food intake among others were early introduction of food which in return reduce the production of breast-milk; early weaning which was shown by the median of exclusive breastfeeding (1.0 month);and inadequate food intake which was indicated by mothers' report that 11 % of breastfed infant aged 6-9 months did not received complementary feeding in the last 24 hours. Diseases among children under five which causes underweight are diarrhea and ARI. The prevalence of diarrhea in Pandeglang was higher compare to the national figure (24.2 vs.11)

in 2003. Also the prevalence of ARI was higher (13.3 vs. 8) (IDHS, 2002-2003). Beside those two factors, maternal nutritional status in Pandeglang, which was shown by the high percentage of MUAC less than 23.5cm and low coverage of iron tablet distribution, might also had contribution to underweight children aged 0-23 months.

To lower the prevalence of underweight children, a comprehensive program should be done which covers activities aimed to mothers, children, health facility, health personnel, cadres and environment.

Angsana led with the highest prevalence of underweight children aged 0-23 months. The causes were among others, the number of health facilities and health personnel in Angsana were lesser compare to other sub-districts. Pagelaran which had the same number of health facilities with Angsana, in fact had more health personnel as can be seen in Table 4.3 in page 11. Most of health personnel in Pagelaran had private practice, they did not work in the health centre. Pagelaran had 3 physicians; while Angsana had no one, the health centre in Angsana was headed and led by a midwife. The bad transportation system in the sub-district which limit access to health centre or posyandu was also made a contribution to the high prevalence of underweight children. Intervention in Angsana should include addition of health facilities and health personnel and its distribution. Also improvement of communication system such as road repair and addition is crucial too.

6.2. Prevention of Illness/Death

Women in Indonesia generally favor long interval between births. The overall median birth interval was 54 months in 2003. Fifty-seven percent of births in the last 5 years occurred at least 48 months after the preceding birth, and only 14% of births took place within 2 years of a previous birth (IDHS, 2002-2003). Long interval between births would allow mothers to take care the older child better than short interval. In Pandeglang, birth interval between 2 youngest children was satisfying because nearly 93% respondents showed interval of at least 24 months. It looks like that family planning program has impact to the fertility rate in Pandeglang, but further investigation need to be done to find out whether the sufficient birth interval was caused merely by the decrease of fertility rate or because of high infant or under five mortality rate and miscarriages or abortions.

Although 66.6% mothers claimed that they had at least one visit to health personnel, the vast majority of mothers delivered babies at home (90.2%) and the deliveries mostly were attended by traditional birth attendants (TBAs). Those data are not surprising because in Indonesia, despite the large proportion of women who receive antenatal care from health personnel, 60% still deliver babies at home (IDHS, 2002-2003). Up to now traditional birth attendants still play a great role in attending deliveries at home, as shown by the numbers in West Java and Gorontalo which were 50% and 51% respectively (IDHS, 2002-2003). Shortage of health personnel and the problem of its distribution made the Local Health District was unable to provide safe delivery care for most mothers in Pandeglang. For the time being increasing TBAs' role in maternal and child health program is one of the solution.

It is very difficult to determine the actual percentage of pregnant mothers who received 2 TT injections in the community, because only 16 mothers owned cards. If we use data from interviews with mothers, 70% said that they had TT immunization at least once. The national figure revealed that mothers who received 2 or more TT was around 50%, while for Banten Province was 46% (IDHS, 2002-2003). Looking at those data we do believe that the actual prevalence of mothers who received 2 TT immunization was not very far from the national figure, but this assumption is somewhat weak because is not supported by any document. Most mothers did not keep the mother health cards because they did not get any. The evidence of getting TT were written in the medical records which were kept in health facilities. New regulation should be executed by allowing mother health card to be kept by mothers. This regulation needs to be informed to any health facilities including private midwives and nurses. Low prevalence of TT immunization was caused by several problems such as lack of accessibility to health facilities and the proportion of health facilities that have the equipment and supplies to support vaccination services was only 0.5.

It is the official policy of WHO and UNICEF that exclusive breastfeeding should be adequate to fulfill babies' need for four to six months. Exclusive breastfeeding in Pandeglang among infants aged 0-5 months was 48.5% and the median duration of exclusive breastfeeding was 1.0 month. For comparison, throughout the country, infants were introduced to other liquid and food at the very early age; and only 14% of infants age 4-5 months were exclusively breastfed (IDHS, 2002-2003). For urban areas the figures much lower than rural areas; for instance in Jakarta at 5 months of age the prevalence was under 10%. In Banten the prevalence

of exclusive breastfeeding among infants aged 3-5 months was 14.4% (HKII, 2002). These explain that half of mothers did not know the importance of exclusive breastfeeding, which was also shown by finding that 70.8% infants were introduced fluid or food too early that is during 3 days after delivery. This feeding practice inflicted a loss upon infants. In addition around half of mothers did not give colostrums to babies. Also this survey found that only 12.4% mothers breastfed the babies within 1 hour after delivery. This number is below the national figure which was 27% (IDHS, 2002-2003). Children are recommended to be breastfed for 2 years but at the age of 6 months, infants should get complementary feeding in order to accomplish perfect physical and mental development. Foods other than milk provide significant sources of energy and other nutrients to supplement the basic intake from human milk or formula (Owen, 1999). Percentage of infants aged 6-9 months who received breastfeeding and solid foods in the last 24 hour was 89%, indicating that some 11% children did not get enough food. This fact shows that the knowledge of mothers towards breastfeeding is not sufficient enough even though this finding is lower than the national figure which was 25% in 2003 (IDHS, 2002-2003).

It is clear that we found several breastfeeding problems in the District of Pandeglang. A thorough investigation need to be done by conducting depth-interviews and FGDs among mothers, health personnel, cadres, and TBAs to understand why mothers do not give colostrums, why prelacteal feeding happens, why food introduced so early, why some mothers did not give complementary food to infants aged 6 to 9 months, and the role of each provider in breastfeeding management.

Immunization is one of important health care needed by under five. It is given to enhance child's immune response towards some common infectious disease. Children at one year of age are recommended to have minimally BCG, 3 polio, 3 shots of DPT and measles. A study in Indramayu found that children who got complete immunization had better growth performance compared to those with incomplete immunization or those with none (Utomo, 1996, in Utomo, 1998). In Pandeglang, among children 12-23 months who owned immunization card, only 51.1% of them received complete immunization before the first birthday, this number is similar with the national figure which was 52% in 2003 (IDHS, 2002-2003). The percentage of children aged 12-23 months who received measles vaccine was 61.7%. This figure is below the national figure which was 87.3% in 2001 (Departemen Kesehatan, 2002). Low coverage of complete immunizations were might be caused by several factors such as the knowledge and attitude of the

community, the information given by the local government and also the availability of the services. Health facility Assessment found that the proportion of health facility that have the equipment and supplies to support full vaccination services was only 0.5, and index of the availability of four vaccines was only 0.6. Good knowledge and attitude of the community, or complete information will be a waste if not accompanied by efforts to provide sufficient vaccine and accredited cold chain.

The high prevalence of diarrhea in Pandeglang, might caused among others by high percentage use of unsafe drinking water, inadequate excreta disposal, and bad habits of maternal hand washing. There were only 1.3% mothers who washed their hands with soap or ash before or after doing special task which could possibly transmit diseases. If the minimal (2) answers is applied, also the percentage was still low only 12.9%. The role of health education is very important in changing habits in washing hands before doing special tasks.

6.3. Management and Treatment of Illness

Childhood illness is one of the variables which have significant association with nutritional status of children. Together with inadequate dietary intake, disease tend to create vicious circle. Infection may precipitate widespread weight loss throughout a community, as happen in children during a severe epidemic of measles. Beside measles; other diseases such as diarrhea, respiratory infections, tuberculosis, malaria, and intestinal parasites are specific infections often occurred in malnourished children (Tomkins, 1992). The combination of malnutrition and infectious disease is deadly. In a well nourished child, a common infectious disease is usually a passing illness, but in a malnourished child the same disease can precipitate life-long disabilities. A slow sequence of disease followed by malnutrition leads to stunting and wasting, and affects mental development. The survivors have special difficulties in terms of their cognitive and physical development. Their handicap is lasting (Brundtland, 2000).

Knowledge of child danger signs such as look unwell or not playing normally, not eating or drinking, lethargic or difficult to wake, high fever, fast or difficult breathing, vomiting, and convulsions is very important for mothers so that they can identify when they need to bring children to health facility. Some 28.7% mothers could mention at least 2 danger signs. This figure is very low and could delay early diagnosis and prompt treatment because the children will not be timely brought to health facility. This condition is stiffened by the quality of health

services in the health facility as shown by the low proportion of indicators of diagnostic and therapy assessment (Table 5.2.1 and Table 5.2.2).

Children with diarrhea who were offered the same amount or more food during the illness was 73.4%. The rest did not get enough food, maybe because mothers tried to limit the amount of food given to children. This condition was existed because the health personnel did not give enough and clear information as proved by HFA results, which show that the proportion of caretakers of sick child who were advised to give extra fluids and continue feeding was only 0.29; and also only 40% of them understood how to give treatment to sick children at home. Health personnel should be encouraged to give complete and clear information how to take care of sick children at home.

6.4. Environment and Selected Maternal and Child Health Indicators

6.4.1. Water and Household Sanitation

Environment is important to the health status of a community. Infectious diseases like diarrhea, tuberculosis or malaria are related to environment condition. The causes of high percentage of diarrhea among children aged 0-23 months among others are high percentage use of unsafe drinking water, inadequate excreta disposal, bad habits of maternal hand washing. Some 54.9% households used safe water sources for drinking water, and the percentage of household which had access to healthy toilet was only 27.7%. Almost 60% respondents pointed out that they defecated on open places, which could possibly transmit diseases. The national figure for safe water sources for drinking water and healthy toilet were around 75% and 61.2% respectively (Departemen Kesehatan, 2002). It means that the environmental sanitation in Pandeglang was still need to be improved. Several intervention can be done among others are to educate community to comprehend the importance of building protected wells or reservoirs; increase households' access to safe drinking water and avoid using surface water for tooth brushing.

6.4.2. Diarrhea

Diarrhea was reported by 24.2% of respondents, but only 11% children with diarrhea received oral dehydration solutions (ORS) and/or recommended home fluids. Patients with diarrhea but no signs of dehydration usually have fluid deficit, but equal to less than 5 percent of

their body weight. Although those children are lack of distinct signs of dehydration, they should be given more fluid than usual to prevent the development of dehydration as specified in WHO Treatment Plan A (WHO, UNICEF, 1999). Knowing that their children was experiencing diarrhea, 59.5% mothers sought outside advice or treatment for the illness. The prevalence of diarrhea in Pandeglang is higher than the national figure and Banten which were 11% and 14.4% respectively (HKII, 2002; IDHS, 2002-2003). Also the percentage of sick children who got ORS was lower than the national figure (11 vs. 36). Similar to the national figure, around half of those children were taken to health facilities or other providers (IDHS, 2002-2003). Referring to the use of ORS, it is not surprising because among mothers of children with diarrhea, only around one fourth could correctly explain the preparation of ORS; while among all respondents the figure was 27.7%. Maybe this condition was existed because the health personnel did not give enough and clear information as proved by HFA result, which showed that the proportion of caretakers of sick child who were advised to give extra fluids and continue feeding was only 0.29; and also only 40% of them understood how to give treatment to sick children at home.

6.4.3. Acute Respiratory Infection

The prevalence of acute respiratory infection was 13.3%, which was higher than the national figure (8%). Similar to the national figure, half of children with ARI were taken to health facility by mothers (IDHS, 2002-2003). It means that the rest did not get prompt treatment. Considering that ARI has a significant role (18%) in under five mortality rate (WHO, 2000), which also supported by Indonesia data (22.8%) (Surkesnas, 2001); it is a need to do special program to increase family's awareness about the danger signs of ARI.

Based on the relatively high prevalence of ARI and inadequate case management which was identified by HFA survey, training on Integrated Management of Childhood Illness (IMCI) is a must. Also improvement of health facility support is crucial.

6.4.4. Antenatal Care

Around 95% of mothers said that they had antenatal care at least once during the pregnancy of the youngest child. Visit to traditional birth attendants was the most prominent, 67.1%; and visit to health personnel was 66.6%. It means that mothers did not only visit health personnel, but also were visit and/or visited by traditional birth attendants. Only 16 (3.7%)

mothers owned mother health card, and the observation of the cards showed that 62.5% of mothers went to health personnel for 1-3 visits, and 37.5% for 4 or more visits. The national figure for K1 was 92%, and for K4 was 81%. K1 for Banten Province was 86% (IDHS, 2002-2003). From those data we can conclude that antenatal care in Pandeglang was not fulfilled the national standard and also below Banten's achievement. Poverty maybe one of the underlying cause of low antenatal visit. Mothers could not afford the antenatal visit, because they did not have money for the services nor the transportation. Data from Local Health District showed that the number of health facility and health personnel were limited. The distribution of health facilities and health personnel were also uneven, so that health services was beyond mothers' reach. Indonesia government initiated the Social Safety Net in Health Program since 1998, but it is known that the implementation is still unsatisfying. The local government should rearrange that program in order to reach its targets and objectives.

Iron–deficiency anemia is the most common nutritional disorder in the world. It is particularly prevalent among infants, young children and pregnant women. Severe iron deficiency causes suppression on several aspects of immune system. These factors can result in increased susceptibility to infection, especially bacterial infection. One risk factor of iron-deficiency among children is anemic mothers. Most public health programs include iron supplement to pregnant women, the recommendation is to take iron tablets for not less than 90 days. In this survey the prevalence of mothers who received iron tablets during the last pregnancy was 77.8%, but only 12.9% of them took for 90 days or more. For comparison, in 2002-2003, 78% of women in Indonesia who had antenatal care, received iron tablet; but only 30% of them received iron tablets for 90 or more days (IDHS, 2002-2003). The low percentage of pregnant women who received iron tablets for 90 days or more was because they did not visit the health personnel, as can be seen from the percentage of K4. But for the success of the program a thorough evaluation of iron tablets distribution also need to be done.

6.4.5. Delivery and Immediate Newborn Care

Soon alter a baby is born, he should be placed on mother's chest to allow him to suck the breast. This will makes baby feels warm and secure. Also the production of breast-milk will initiated by sucking the breast as soon as possible.

This survey found that after the delivery, most babies were bathed or cleaned. Only 0.4% were immediately breastfed as it should be. Also there were around 37% babies who were separated from their mothers after the delivery. These data show that the management of newborn in Pandeglang was not aligned with the government's policy. The management of newborn should be disseminated not only to health personnel/facilities, but also to the traditional birth attendants.

6.4.6. Postpartum Care

After the delivery mothers are urged to have postpartum check to health personnel. Around 60% mothers had at least one postpartum check-up, but only 50.9% of them visited health personnel. Compare to the national figure (80%) the postpartum check-up in Pandeglang is lower (IDHS 2002-2003), although the number in IDHS was not clear whether the postpartum check-up were done by health personnel or traditional birth attendants. As many as 30.2% of mothers went in appropriate time, 1 to 6 weeks after delivery. This finding shows that the majority of the mothers did not come in appropriate time. The national figure show similarity, 62% of the postpartum check-up were done 2 days within delivery and 13% between 3 to 6 days after delivery. It was not clear by whom the postpartum check-up were done (IDHS, 2002-2003). Survey revealed that the first postpartum check was done by health personnel (50.9%) and the traditional birth attendants (39.3%). This fact shows that the role of traditional birth attendants in postpartum check-up was still significant. The Local Health Department should train the TBAs how to do postpartum check-up and to identify the postpartum and neonatal danger signs.

Percentage of mothers who were able to mention at least 2 postpartum danger signs was only 4.7%, while the percentage of mothers who were able to mention at least 2 neonatal danger signs was 5.8%. This condition will delay mothers to seek for help and/or bring their children for treatment and would produce maternal and neonatal death. Neonatal mortality rate in Banten was 16 per 1,000 live births (IDHS, 2002-2003), tetanus neonatorum is one of the most important causes. There is no data on maternal mortality rate in Banten, but the maternal mortality rate for Indonesia was 373 per 100,000 live births (Departemen Kesehatan RI, 2002).

Vitamin A deficiency is known as the world's leading cause of preventable blindness in young children and contributes significantly to the high death rates among young children in malnourished community. The important role of vitamin A is its ability to repair immune

function. Vitamin A supplementation is therefore a crucial immediate intervention that can break the malnutrition-infection complex. Trials showed that routine vitamin A supplementation given between 6-72 months of age can reduce overall mortality by at least 23%. Given to lactating mothers during postpartum, will protect infants from vitamin A deficiency (Brundtland, 2000). Prevalence of children under 2 years who received vitamin A during the past 6 months was unsatisfactory, only 41.3%. That prevalence was evenly distributed in the sampling areas. Giving vitamin A to mothers during 2 months after delivery will protect breastfed babies from vitamin A deficiency. In this survey prevalence of mothers who received vitamin A during the first 2 months after delivery was only 10%. This finding is below the Banten figure which was 14.6% and similar with the lowest coverage among all sites of NHS (HKII, 2002). This figure is low because only 30% mothers said that they went to health personnel for postpartum check. A thorough evaluation need to be done to study the causes of that low prevalence, for instances the availability of vitamin A in the District Health Office, its distribution to health facilities in each sub-district and how vitamin A was distributed to mothers and children.

6.4.7. Child Spacing

Nine of the respondents was pregnant, so the number of mothers who were eligible to use contraception was 441. Among them, 297 (67.3%) were using modern contraception, 142 (32.1%) were not using any contraception, and 2 of them were using traditional contraception. Compare to national figure which was 57%, the figure of current users in Pandeglang was high (IDHS, 2002-2003).

More than half mothers (53.5%) used injectables, followed by pills (13.1%), implant (6%), IUD 1%, and 1 respondent was sterilized. The pattern of contraceptive use in Pandeglang is similar with the national pattern, injectables is the most popular contraception (IDHS, 2002-2003). Considering the economic condition of the community, special effort need to be done to switch the contraceptive use from injectables to IUD which is known to be more economical.

There were 124 respondents who mentioned that they did not want or not sure to have more child, but among them only 65 respondents (52.4%) used modern contraception. The rest did not use any contraception at all, which shows the unmet need for family planning, around 13%. This fact shows that there is a higher degree of unmet need for family planning services compare to the national figure which was 9% and Banten Province (10%).

6.5. Health Facility Assessment

To provide better quality of child health, the health facilities required to have 10 recommended drugs include recommended antibiotic for pneumonia, recommended antibiotic for dysentery, recomended anti malarial, paracetamol/aspirinl, Iron tablet/syrup, vitamin A, mebendazol, and ORS. As found by the HFA, the complete drugs are only available in the 4 facilities among the 14 surveyed health facilities , or the average index of the availability of essential oral treatment is still low (0.79). In addition, four vaccines are not available in all 14 surveyed health facilities. This condition is very much related to the low coverage of child vaccination in this areas. The 5 health providers reported that they only provide immunization services once a month in their responsible villages, so that it is not necessary for them to keep vaccines in their clinics. In summary, the low level of health services quality has been reflected from the insufficiency of health providers especially midwives, insufficiency of drugs and supplies for management of childhood illness and the provider's competence in performing assessment, correct treatment and counseling and in managing severely ill children. The lack of provider's competence is very much related to the IMCI training coverage, as found in the HFA, none midwives have been trained in IMCI.

Given this situation, a serious attention from the District Health Office is needed in order to improve the quality of maternal and child health services. In line with the project objective, PCI should also support the DHO to improve the competence of health providers in providing maternal and child health through trainings, orientation and other information dissemination activities to update their skills and knowledge.

VII. CONCLUSIONS AND RECOMMENDATIONS

7.1. Conclusions

Using WAZ indicator, the nutritional status of children aged 0-23 months in Pandeglang shows high severity problem of underweight. That condition was related to several factors. One of them was acute illnesses suffered by the children, which was shown by the high prevalence of diarrhea, acute respiratory infection, and other respiratory diseases accompanied by fever and/or cough. The high prevalence of infectious diseases could produce high infant and child mortality rate, if not properly managed. The management and treatment of sick children in Pandeglang is still inadequate, only around one-fourth of mothers could mention at least 2 child danger signs. Mothers' knowledge and practice towards the management of child with diarrhea was still insufficient. Preparation of ORS was only known by less than 30% mothers. The quality of health services in Pandeglang was also not satisfying nor supporting which was shown by health personnel's disability in doing correct assessment, treatment and counseling and managing

severely ill children according to IMCI guidance, also limited availability of drugs especially the injectable drugs. The percentage of infants under 12 months who got complete immunization also showed the weakness of health services. Measles is a common disease which lead to malnutrition condition, but in fact the coverage of measles vaccination was below the national figure. Supervisions from the Local Health District to health facilities were not sufficient too.

One of the underlying causes of those infectious diseases is poverty, whereas in Pandeglang was shown by income per capita, and level of education of the community. Only half of sick children were brought to health facility/personnel, because families did not have money, or the health facilities and personnel were far away from their house. Health insurance was still not popular for the community, while the Social Safety Net for Health Program has not been developed well. Poverty would also influence the condition of environment which could contribute the prevalence of infectious diseases. Proxy variables which influence the prevalence of infectious diseases were high use of unsafe drinking water, limited access to healthy toilet and bad habits in maternal hand washing before or after doing several important tasks related to disease transmission. The important role of vitamin A is its ability to repair immune function. Coverage of vitamin A distribution which is a crucial immediate intervention that can break the malnutrition-infection complex was low too.

The nutritional status of children aged 0-23 months in Pandeglang could also resulted from low maternal nutritional status. Around 30% pregnant women were undernourished, and the coverage of iron supplementation was insufficient. Low maternal nutritional status provokes low birth weight babies. Poverty also influenced the quantity and quality of food intake because mothers could not buy enough food for the whole family. Food distribution in the family in Pandeglang is still in question; while facts in other regions in Indonesia showed that fathers got first priority. Mothers did not go to health facility for antenatal, delivery or postnatal care because they did not have enough money, or lived far away from the health facility/personnel. The transportation system was still bad, especially inter-villages and intra-village. This condition affected mothers health seeking behavior, they relied on the TBAs for maternal and child care. The TBAs who resided in their community still have a big role in maternal or even child care, and as the consequences this would influences the prevalence of tetanus neonatorum among newborn babies. However the prevention of tetanus neonatorum was not sufficient which was proved by the low coverage of TT.

Other important factor influences malnutrition among children under two is the practice of breastfeeding, such as early weaning, or early introduction of food. In Pandeglang early introduction of food was existed in a relatively high percentage, and started at the very early month of life. The median of exclusive breastfeeding was very low. A part of infants did not received complementary feeding as it should be. Mothers' ignorance maybe was the root of these wrong practices.

Birth interval in Pandeglang is satisfying in terms of time spent by mothers to rear the older child; but still in question whether there were no deaths between those 2 youngest children, because the degree of unmet need for family planning was still high.

It can be concluded that factors that influenced low nutritional status of children under two, high childhood morbidity, low coverage of antenatal, delivery and postpartum care by health personnel; among others are poverty, low level of education, lack of access to health facility/personnel, low standard of health facilities and health personnel, lack of mothers' knowledge and practice towards breastfeeding, complementary feeding, hand washing, child care. Bad transportation system which hampers referral cases contributed maternal and child mortality rate.

7.2. Recommendations

Several intervention need to be done to improve the nutritional and health status among children aged 0-23 months in Pandeglang:

I. Improving health workers' skills

- Training of health personnel on IMCI, which will increase their ability to examine or treat sick children, and give relevant information to mothers/caretakers.
- Training for cadres to give information on maternal and child care to mothers or caretakers.
- Train the traditional birth attendants, so that mothers and children will receive the minimal requirement care during antenatal, delivery and postnatal.
- Training of health personnel on the knowledge and practice of breastfeeding so that they can train cadres or mothers

II. Improving the health system to deliver IMCI

- Improvement of health facility's inputs, such as providing cold chain, vaccines, drugs both oral and injectables
- Number of health personnel in Pandeglang is not enough; effort to increase number of health personnel which is distributed evenly in both rural and urban areas will accelerate the improvement of maternal and child health status in Pandeglang
- Development and execution of standard operating procedure in each health facility
- Increase supervision function of the Local Health District
- Arrange appropriate Social Safety Net for Health Program, so that poor people can get and use their right
- Rearrange the distribution of vitamin A and iron tablets.

III. Improving family and community practices

- Educate the community towards the promotion of health, the prevention of child disease and nutrition
- Educate the community towards the importance of breastfeeding, exclusive breastfeeding, and complementary feeding
- Educate the community to comprehend the importance of building protected wells or reservoirs; avoid using surface water for drinking, food preparation and tooth brushing; changing habits in hand washing before and after doing special tasks.

IV. Inter-sectoral programs

- There are several interventions beyond the health sector which need to be implemented together with health intervention. The improvement of environmental sanitation is very important. Local government should help community to increase the access to safe drinking water and sanitary excreta disposal. Construction or reconstruction of the roads in the villages or inter villages is a must, and need to be supported by the availability of public transportation.
- A campaign need to be done to invite the community to utilize their garden to plant vegetables, fruits and raise livestock. This can be done by local media such as radio or local newspaper if any. Cadres and head of the village also can be involved in this activity.

Before the intervention, several evaluation need to be done for the success of the program intervention among others are:

1. Several activities can be done such as evaluation of previous training for TBAs to learn its weakness, FGDs with mothers and TBAs to study what kind of mother and child care are being done by TBAs and why mothers prefer to see TBAs than the health personnel.
2. Vitamin A and iron tablets preparation and distribution are need to be evaluated.
3. Breastfeeding knowledge, beliefs and practices among mothers need to be elucidated by conducting FGDs to understand early introduction of food, early weaning, and practice of breastfeeding.
4. Evaluation and FGDs should be done to study the implementation of Social Safety Net for Health Program.

REFERENCES

Badan Pusat Statistik. 2003. 2002-2003 Indonesia Demographic and Health Survey. Key Findings. Jakarta.

Badan Pusat Statistik. 2002. National Socio-Economic Survey. Jakarta.

Bardosono, S. (2003). Determinants of Child Malnutrition During the Economic Crisis in Selected Poor Areas of Indonesia. Dissertation. Post Graduate Program, University of Indonesia, Jakarta.

Brundtland, G.H. (2000). Nutrition and Infection: Malnutrition and Mortality in Public Health. Nutr.Rev. 58:S1-S4.

Departemen Kesehatan Republik Indonesia. (2001). Profil Kesehatan Indonesia, Jakarta.

Helen Keller International /Indonesia. 2002. Nutrition and Health Surveillance in Rural West Java. Crisis Bulletin 4 (9), Jakarta.

Helen Keller International /Indonesia. 2002. Nutrition and Health Surveillance in Urban Slums of Jakarta. Crisis Bulletin 4 (1), Jakarta.

Helen Keller International /Indonesia. 2002. Nutrition and Health Surveillance in Rural Banten. Crisis Bulletin 4 (8), Jakarta.

Pemerintah Kabupaten Pandeglang. Dinas Kesehatan. (2002). Profil Kesehatan Kabupaten Pandeglang 2002.

Scrimshaw, N.S. (1994). The Consequences of Hidden Hunger for Individuals and Cosieties. Food and Nutr. Bull. 15: 3-24.

Tomkins, A.M. (1992). Nutrition and Infection. In: Protein Energy Malnutrition. British Library Catalouging in Publication Data, London.

World Health Organization. (1995). Physical Status: The Use and Interpretation of Anthropometry. Report of a WHO Expert Committee, World Health Organization, Geneva.

World Health Organization. (1997). Improving Child Health. IMCI: the integrated approach, Division of Chile Health and Develpoment. World Health Organization, Geneva.

World Health Organization, Unicef. (1999). Management of Childhood Illness in Developing Countries: Rationale for An Integrated Strategy. IMCI Information. Department of Child and Adolescent Health and Development, World Health Organization, Geneva.

World Health Organization. (2000). The Management of Nutrition in Major Emergency. World Health Organization, Geneva.

Annex 3A

MOU with YPS-Indonesia

PERJANJIAN KERJA SAMA
ANTARA
PROJECT CONCERN INTERNATIONAL
DENGAN
YAYASAN PEMERHATI SOSIAL INDONESIA
DALAM RANGKA
PENGUMPULAN DATA DASAR DAN PERSIAPAN PROYEK
CHILD HEALTH OPPORTUNITIES INTEGRATED WITH
COMMUNITY EMPOWERMENT

Pada hari ini, tanggal satu bulan November tahun dua ribu tiga telah diadakan perjanjian kerja sama antara para penanda-tangan yaitu :

1. PROJECT CONCERN INTERNATIONAL, dalam hal ini diwakili oleh : Glenn Gibney, dalam kedudukannya sebagai Country Director, yang selanjutnya disebut sebagai PIHAK KESATU.

2. YAYASAN PEMERHATI SOSIAL beralamat di Jalan Empu Tantular Raya No. 26 Perumnas II, Karawaci Tangerang dalam hal ini diwakili oleh Titin Kustini dalam kedudukannya sebagai Program Manager, yang selanjutnya disebut sebagai PIHAK KEDUA

Perjanjian kerja sama ini dalam rangka untuk Pengumpulan Data Dasar dan Persiapan Proyek Child Health Opportunities Integrated with Community Empowerment atau disingkat CHOICE di wilayah Kecamatan Saketi, Pagilaran, Angsana dan Patia di Kabupaten Pandeglang, dan agar tercapainya tujuan secara optimal, efektif dan efisien; maka PIHAK KESATU mempercayakan kepada PIHAK KEDUA untuk melaksanakan kegiatan/ proyek yang dimaksud sebagaimana yang dijabarkan dalam uraian pekerjaan yang tertuang di dalam Ihtisar Proyek yang telah disepakati oleh kedua pihak (terlampir)

PASAL 1
JANGKA WAKTU KONTRAK:

Kedua pihak telah sepakat untuk melangsungkan perjanjian kerja ini dalam waktu selama tujuh (7) bulan, terhitung mulai dari tanggal 1 November 2003 sampai dengan tanggal 31 Mei 2004

PASAL 2
RUANG LINGKUP PEKERJAAN

PIHAK KESATU menerima PIHAK KEDUA sebagai mitra kerja di bawah koordinasi dan supervisi PIHAK KESATU. Personil dari PIHAK KEDUA yang sudah disepakati kedua belah pihak, akan melaksanakan kegiatan-kegiatan sebagai berikut :

1. Bertindak sebagai supervisor pelaksanaan survey data dasar.
2. Bersama-sama dengan staff PIHAK KESATU dan konsultan, melatih enumerator dalam melakukan pengumpulan data.
3. Mengorganisir dan memfasilitasi pertemuan-pertemuan di tingkat kecamatan dan desa untuk persiapan pengumpulan data dasar .
4. Bersama-sama dengan staff PIHAK KESATU, membimbing dan mengawasi enumerator dalam melakukan pengumpulan data serta bertanggung jawab untuk menjaga kebenaran data.
5. Membantu staff PIHAK KESATU dalam melakukan entry dan manajemen data.
6. Melakukan kegiatan-kegiatan untuk persiapan pelaksanaan proyek setelah selesai pengumpulan data dasar.
7. Bersama-sama dengan PIHAK KESATU mengorganisir Lokakarya Hasil Survey Data Dasar .
8. Bersama-sama dengan PIHAK KESATU melakukan pendekatan dan menghadiri pertemuan-pertemuan dengan stakeholders di tingkat Kabupaten.

Rincian lingkup pekerjaan, yang akan dilaksanakan meliputi tujuan kegiatan, rangkaian kegiatan yang akan dilaksanakan, waktu pelaksanaan/time frame dan keluaran yang akan dihasilkan, dituangkan dalam Ihtisar Proyek yang telah disepakati oleh kedua belah pihak

AGREEMENT
BETWEEN
PROJECT CONCERN INTERNATIONAL
AND
YAYASAN PEMERHATI SOSIAL INDONESIA
FOR
COLLECTION OF BASE LINE DATA
AND
PREPARATION OF
CHILD HEALTH OPPORTUNITIES INTEGRATED WITH
COMMUNITY EMPOWERMENT PROJECT

This AGREEMENT is signed on this 1 November 2003 by:

1. PROJECT CONCERN INTERNATIONAL, represented by its Country Director: Mr. Glenn Gibney, hereinafter referred to as FIRST PARTY.

2. YAYASAN PEMERHATI SOSIAL INDONESIA with address at Jalan Empu Tantular Raya No. 26 Perumnas II, Karawaci Tangerang represented by its Program Manager: Titin Kustini, hereinafter referred to as SECOND PARTY.

Under this AGREEMENT, FIRST PARTY agrees to use the service of SECOND PARTY to Collect Base Line Data and Prepare Child Health Opportunities Integrated with Community Empowerment Project (hereinafter referred to as CHOICE) in the following sub-districts: Saketi, Pagilaran, Angsana and Patia of Pandeglang District, and to achieve the project objectives optimally, effectively, and efficiently. FIRST PARTY trusts SECOND PARTY to carry out project activities following the job description presented in the Project Outline agreed upon by both parties (attached).

CLAUSE 1
DURATION OF CONTRACT:

This AGREEMENT shall take effect on 1 November 2003 and shall remain valid for a period of seven (7) months or until 31 May 2004.

CLAUSE 2
SCOPE OF WORK

FIRST PARTY shall consider SECOND PARTY as a working partner under coordination and supervision of FIRST PARTY. Staff or personnel of SECOND PARTY approved by both parties shall be responsible for the following project activities:

1. Acting as supervisors of the base line survey
2. Together with staff and consultants of FIRST PARTY, training enumerators on data collection
3. Organizing and facilitating meetings at sub-district and village levels during the preparation of base line data collection.
4. Together with staff of FIRST PARTY, guiding and supervising enumerators during base data collection and being responsible for ensuring data reliability and accuracy.
5. Assisting staff of FIRST PARTY for data entry and management.
6. Conducting relevant activities for preparation of project implementation after finishing base line data collection
7. Together with staff of FIRST PARTY, organizing Workshop on Results of Base Line Data Survey.
8. Together with staff of FIRST PARTY, organizing meetings with and approaching district level stakeholders.

Details of scope of work to carry out, including objectives, series of activities, time frame and outputs, are described in the Project Outline already approved by both parties (attached). This document shall be an inseparable part of this AGREEMENT.

(terlampir). Dokumen ini merupakan bagian yang tak terpisahkan dari perjanjian kerja ini

PASAL 3
HAK & KEWAJIBAN PIHAK KESATU

1. PIHAK KESATU berkewajiban menyediakan dana untuk mendukung keberhasilan pelaksanaan kegiatan sebagaimana tercantum dalam pasal 2 perjanjian ini kepada PIHAK KEDUA. Besarnya dukungan dana dan waktu pembayaran sebagaimana tercantum dalam pasal 5 (lima), sedang penggunaanya sebagaimana tercantum dalam Ihtisar Proyek yang telah disepakati oleh kedua belah pihak.

2. Dengan maksud untuk menjamin penggunaan dana yang disediakan PIHAK KESATU secara tepat dan benar, PIHAK KESATU dengan/atau yang ditunjuk oleh PIHAK KESATU mempunyai hak untuk mengunjungi dan menginspeksi aktifitas proyek; dan / atau mengaudit catatan, pembukuan yang berkaitan dengan proyek yang dilaksanakan di dalam perjanjian ini.

PASAL 4
HAK dan KEWAJIBAN PIHAK KEDUA :

1. PIHAK KEDUA berhak untuk mendapatkan dana untuk mendukung keberhasilan pelaksanaan semua kegiatan/pekerjaan yang menjadi kewajiban PIHAK KEDUA, yang besarnya sebagaimana tercantum dalam pasal 3 (tiga) dan 5 (lima) perjanjian ini.

2. PIHAK KEDUA berkewajiban untuk:
   a. Melaksanakan pekerjaan sebagaimana dimaksud dalam pasal 2 (dua).
   b. Pada akhir kegiatan, berkewajiban untuk membuat dan menyerahkan laporan akhir kegiatan secara benar dan dapat dipertanggungjawabkan kepada PIHAK KESATU yang berisi data dan informasi yang menunjukkan pencapaian tujuan kegiatan yang telah disepakati bersama dengan PIHAK KESATU. Laporan tersebut harus sudah diserahkan selambat-lambatnya 10 hari setelah seluruh rangkaian kegiatan berakhir.
   c. Menyelenggarakan pembukuan sesuai dengan prinsip dasar pembukuan umum dan persyaratan administrasi serta keuangan PIHAK KESATU serta menyerahkan kepada PIHAK KESATU laporan keuangan bulanan dilengkapi dengan bukti-bukti pengeluaran, dalam 7 (tujuh) hari pertama bulan berikutnya.
   d. Memisahkan dengan jelas semua biaya yang diterima dan dikeluarkan untuk proyek CHOICE dari penerimaan dan pengeluaran biaya untuk proyek yang didanai pihak lain.
   e. Mengembalikan seluruh jumlah dana yang disediakan oleh PIHAK KESATU , yang tidak dibutuhkan atau tidak digunakan sesuai tujuan yang telah disepakati.
   f. Mengembalikan sisa dana yang tidak terpakai kepada PIHAK KESATU.

3. Setiap perubahan terhadap tujuan, kegiatan sasaran program ataupun alokasi penggunaan dana baik sebagian maupun keseluruhan, maka PIHAK KEDUA wajib untuk melaporkan dan mendapatkan persetujuan dari PIHAK KESATU. Apabalia berdasarkan hasil evaluasi program maupun pemeriksaan pembukuan keuangan ditemukan adanya penyimpangan penggunaan dana ataupun terhadap pelaksanaan proyek, maka PIHAK KEDUA berkewajiban untuk menanggung dan membayarkan semua kehilangan / kerugian financial sebagai akibat atas penyimpangan tersebut. Untuk ini PIHAK KEDUA membebaskan PIHAK KESATU dari segala tuntutan hukum.

PASAL 5
DANA DAN CARA PEMBAYARAN

CLAUSE 3
RIGHTS & DUTIES OF FIRST PARTY

1. FIRST PARTY shall provide funds to SECOND PARTY for supporting the activities described in CLAUSE 2. The amount of funds to be provided by FIRST PARTY and payment procedures shall be explained in CLAUSE 5 for project activities described in the Project Outline agreed upon by both parties.

2. In order to ensure proper utilization of funds disbursed by FIRST PARTY, FIRST PARTY with/or other parties appointed by FIRST PARTY shall have the right to visit and monitor project activities; and/or audit records or books of account relating to the implementation of the project under this AGREEMENT.

CLAUSE 4
RIGHTS AND DUTIES OF SECOND PARTY:

1. SECOND PARTY shall have the right to obtain the funds disbursed by FIRST PARTY for such amount (s) as is explained in CLAUSE 3 and 5 of this AGREEMENT for use to support the implementation of all project activities stated as duties of SECOND PARTY.

2. SECOND PARTY shall be responsible for:
   a. implementing all works as are stated in CLAUSE 2.
   b. at the completion of this project, preparing and submitting accurate and accountable final project report to FIRST PARTY. This report shall contain data and information on achievement of the objectives of the project activities. This report shall be already received by FIRST PARTY no less than 10 days after the completion of the whole project activities.
   c. carrying out bookkeeping based on basic principles of general accounting and administration and financial requirements of FIRST PARTY and submitting monthly financial reports to FIRST PARTY including proofs of payments within first 7 (seven) days of the following month.
   d. clearly splitting expenses received or paid for CHOICE from those received and paid for other projects funded by other parties.
   e. in case the funds shall not be needed or used for achieving project objectives already agreed upon, turning over the whole funds to FIRST PARTY.
   f. turning over any reminding funds to FIRST PARTY.

3. SECOND PARTY shall be responsible to report any amendments to this AGREEMENT regarding project objectives, activities, targets, and fund allocation, partly or as a whole, to FIRST PARTY upon which approval from FIRST PARTY shall be made available. In case of fraud of fund uses and management or of deviation of program activities proven through an evaluation of the project bookkeeping or activities, SECOND PARTY is legally responsible to bear all financial losses/harms of such fraud or deviation. SECOND PARTY will indemnify FIRST PARTY from all imposition of legal liability.

CLAUSE 5
FUNDS AND PAYMENT PROCEDURES

5.1. Dana

1. Untuk melaksanakan semua kewajiban PIHAK KEDUA sebagaimana tercantum dalam pasal 2 (dua), PIHAK KESATU menyediakan dana sebesar tujuh puluh enam juta delapan ratus enam puluh ribu rupiah (Rp.76.860.000) sudah termasuk dengan pajak pendapatan.
2. PIHAK KEDUA harus menggunakan dana tersebut untuk membiayai kegiatan sebagaimana tertulis dalam Ihtisar Proyek dan Anggaran Proyek.
3. Semua bunga Bank yang dhasilkan oleh rekening bank untuk Proyek ini, menjadi bagian dari dana proyek dan harus digunakan hanya untuk keperluan proyek

5.2 Cara Pembayaran:

1. Dana sebagaimana tercantum dalam pasal 5.1 dibayarkan secara bertahap seperti yang termuat dalam Pasal 5.3 di bawah.
2. Dana tersebut dibayarkan kepada PIHAK KEDUA melalui rekening BANK PIHAK KEDUA, yaitu Bank Mandiri , Cabang Cikokol Tangerang rekening No 118-00-0110819-9, atas nama: Yayasan Pemerhati Sosial Indonesia (YPSI).
3. Dana yang sudah diterima PIHAK KEDUA apabila terjadi sesuatu hal sehingga kegiatan ataupun dana tersebut tidak dapat digunakan sesuai dengan rencana penggunaan dana yang telah disepakati, baik sebagian maupun keseluruhan, maka PIHAK KEDUA berkewajiban untuk mengembalikan dana tersebut kepada PIHAK KESATU.

5.3 Tahapan Pembayaran

Dana dimaksud pada pasal 5.1 akan dibayarkan secara bertahap dengan rincian sebagai berikut :

1. Pembayaran pertama sebesar dua puluh satu juta sembilan ratus enam puluh ribu rupiah (Rp. 21.960.000) akan dibayarkan oleh PIHAK KESATU segera setelah ditandatanginya perjanjian ini.
2. Pembayaran berikutnya akan dilakukan setiap 2 bulan berdasarkan permohonan pembayaran oleh PIHAK KEDUA, setelah PIHAK KEDUA mempertanggungjawabkan penggunaan keuangan sesuai dengan ketentuan administrasi dan keuangan.

PASAL 6
LARANGAN DAN SANKSI :

1. Telah disepakati bersama bahwa PIHAK KEDUA sudah, mengetahui dan memahami Visi, Misi, Identitas dan prinsip program Project Concern International serta telah sepakat untuk mendukung dan mematuhi upaya pencegahan Korupsi,Kollusi dan Nepotisme (KKN). Oleh sebab itu dalam pelaksanaan perjanjian kerja ini harus sesui dengan Visi, Misi, Identitas, prinsip program dan kode etik pencegahan KKN dari PIHAK KESATU.
2. Termasuk dalam larangan ini adalah hal-hal yang dapat menimbulkan ataupun berpotensi untuk menimbulkan isu “sara” (suku, agama dan ras) baik dalam penugasan staff, pembuatan maupun penyediaan meteri yang berkaitan dalam pelaksanaan kegiatan maupun hal hal lain yang berkaiatn dengan pelakasnaan perjanjian kerjasama ini.
3. PIHAK KEDUA dilarang menugaskan, memindahkan hak dan kewajiban, menyerahkan hak dan kewajiban atau pun membuat suatu tindakan lainnya yang menyimpang, baik secara sebagian maupun seluruhnya dari Perjanjian Kerjasama ini tanpa terlebih dahulu mendapat ijin tertulis dari PIHAK KESATU.
4. PIHAK KEDUA, dilarang membocorkan kepada pihak lain baik secara langsung maupun tidak langsung baik sebagian ataupun keseluruhan terhadap data dan informasi yang diketahui dan atau diperoleh berkaitan dengan proyek ini atau pun yang diberikan oleh PIHAK KESATU.
5. Jikalau larangan tersebut dilakukan oleh PIHAK KEDUA yang berakibat merugikan penugasan pokok, maka diperlakukan sanksi

5.1. Funds

1. To support SECOND PARTY in carrying out its entitled responsibilities as stated in CLAUSE 2, FIRST PARTY shall provide SECOND PARTY a total of Rp.76.860.000 (said: seventy six million eight hundred thousand rupiah) included income tax.
2. SECOND PARTY shall use the fund to finance all project activities stated in the Project Outline and Project Budget.
3. Bank interests received shall become part of the project fund and be used only for the purposes of the project.

5.2 Payment Procedures:

1. The fund of such amount stated in CLAUSE 5.1 shall be disbursed to SECOND PARTY in several installments following Terms of Payment described in CLAUSE 5.3.
2. The fund shall be transferred to the bank account of SECOND PARTY: Bank Mandiri, Cabang Cikokol Tangerang, account number: 118-00-0110819-9, account holder: Yayasan Pemerhati Sosial Indonesia (YPSI).
3. In case SECOND PARTY could not use the fund, partly or as a whole, to perform project activities agreed upon by both parties due to certain causes, SECOND PARTY is entitled to return the funds to FIRST PARTY.

5.3 Terms of Payment

The funds stated in CLAUSE 5.1 shall be disbursed to SECOND PARTY in several installments:

1. First payment: an amount of Rp. 21.960.000 (said: twenty one million nine hundred and sixty thousand rupiah) shall be paid by FIRST PARTY after the signing of this AGREEMENT.
2. Subsequently, FIRST PARTY shall provide funds to SECOND PARTY on a written request made by SECOND PARTY every 2 months after having satisfied that all the previous installments of the funds released earlier stand fully and properly utilized.

CLAUSE 6
PROHIBITION AND SANCTION:

1. It is agreed that SECOND PARTY has already acknowledged and understood the program vision, mission, identity and principles of Project Concern International and agreed to support and comply with all measures to prevent corruption, collusion, and nepotism. Therefore, the implementation of this AGREEMENT shall comply with program vision, mission, identity, principles and ethics/measures to prevent corruption, collusion, and nepotism of FIRST PARTY.
2. SECOND PARTY shall not practice matters that might rise or are potential to raise issues related to ethnicity, religion, and race in staff assignment and production of materials related to implementation of projects activities stated in this AGREEMENT.
3. SECOND PARTY shall not make any assignments, remove or release rights and duties, or undertake any misconducts deviating, in parts or as a whole, from this AGREEMENT without written approval from FIRST PARTY.
4. SECOND PARTY shall not pass on or divulge to any other person, directly or indirectly, partly or as a whole, data and any other information which may come into the possession or under the control of SECOND PARTY or given by FIRST PARTY regarding this project.
5. In case SECOND PARTY shall breach such prohibition resulting in any harm to its main responsibilities, FIRST PARTY may terminate

pembatalan perjanjian dengan segala akibat hukumnya termasuk tuntutan ganti rugi karena kesalahan PIHAK KEDUA.

6. Bila terjadi hal-hal yang tidak dikehendaki dan mempunyai akibat buruk terhadap kepentingan umum, maka demi kepentingan para pihak, kedua belah pihak setuju untuk menyerahkan penyelesaian masalahnya untuk ditangani yang berwajib.

PASAL 7
FORCE MAJEURE:

1. PIHAK KEDUA harus segera memberitahu PIHAK KESATU dan sebaliknya PIHAK KESATU harus segera memberitahu PIHAK KEDUA secara tertulis mengenai Force Majeure, dengan pengertian "Force Majeure" dalam hal ini terbatas pada kejadian-kejadian yang disebabkan oleh hal-hal berikut :
   a. Bencana alam, seperti gempa bumi, topan, angin ribut, banjir, wabah penyakit atau penyebab lain yang serupa yang dapat menyebabkan kegiatan PIHAK KEDUA tidak mungkin atau tidak dapat dilaksanakan, baik keseluruhan maupun sebagian dari tanggung jawabnya menurut Perjanjian Kerjasama ini.
   b. Bencana yang disebabkan oleh manusia, seperti perang, pendudukan dengan kekerasan dan bersenjata, masyarakat dalam suasana revolusi, pengacauan/ pemberontakan, blokade, pemogokan yang dapat menyebabkan PIHAK KEDUA tidak mungkin atau tidak dapat melaksanakan seluruh atau sebagian tanggung jawabnya sebagaimana tersebut dalam Perjanjian Kerjasama ini.

2. Sejak saat pemberitahuan atau penerimaan pemberitahuan atas terjadinya Force Majeure tersebut, PIHAK KEDUA dibebaskan dari tanggung jawab atas setiap kegagalan pelaksanaan kewajibannya sehubungan dengan terjadinya Force Majeure tersebut.

3. Dalam keadaan demikian, kedua belah pihak berhak memutuskan Perjanjian Kerjasama ini setelah terhitung 1 (satu) hari sejak tanggal pemberitahuan tertulis kepada pihak lainnya dan oleh karenanya segera setelah diberikan atau diterimanya pernyataan pemutusan sebagaimana dimaksud di atas, PIHAK KEDUA harus segera mengambil tindakan penghentian pekerjaan secara tepat, teratur dan bertanggung-jawab.

4. Setelah pemutusan Perjanjian Kerjasama yang disebabkan terjadinya Force Majeure, PIHAK KESATU tidak diharuskan untuk melaksanakan pembayaran apa pun kepada PIHAK KEDUA, kecuali terhadap pekerjaan jasa-jasa yang telah dilaksanakan untuk pengeluaran-pengeluaran bagi penghentian pekerjaan secara teratur, serta untuk kerugian atas biaya dan pembayaran-pembayaran yang diderita PIHAK KEDUA dalam penyelesaian pekerjaan jasa-jasa dan pelaksanaan dari kewajiban-kewajibannya sehubungan dengan adanya Force Majeure ini, biaya dan pengeluaran-pengeluaran tersebut tidak akan timbul, jika tidak terjadi Force Majeure.

PIHAK KEDUA diwajibkan untuk memberikan laporan-laporan yang dapat dipertanggung-jawabkan kepada PIHAK KESATU terhadap semua kegiatan yang telah dilaksanakan dalam perjanjian ini.

PASAL 8
PENGHENTIAN JASA PIHAK KEDUA :

1. PIHAK KEDUA dapat mengakhiri Perjanjian dengan menyampaikan pemberitahuan tertulis 30 (tiga puluh) hari sebelumnya kepada PIHAK KEDUA; selanjutnya dalam hal terjadinya penghentian jasa ini, PIHAK KEDUA berhak mendapat semua pembayaran yang sudah menjadi haknya seperti diuraikan dalam Lingkup Pekerjaan dalam waktu 30 (tiga puluh) hari.

2. PIHAK KESATU dapat menghentikan pekerjaan jasa-jasa PIHAK KEDUA di bawah Perjanjian Kerjasama ini untuk setiap pelanggaran terhadap Pasal 2 (dua), 4 (empat) dan 6 (enam), dengan pemberitahuan secara tertulis dalam tenggang waktu 7 (tujuh) hari

this AGREEMENT with all its legal liabilities including any claims due to mismanagement of SECOND PARTY.

6. In the event of there arising any unwanted occurrences presenting any bad impacts towards public interests, both parties agree to refer their problems to the authority.

CLAUSE 7
FORCE MAJEURE:

1. SECOND PARTY shall remind FIRST PARTY and the other way FIRST PARTY shall remind SECOND PARTY in written regarding Force Majeure referred in this AGREEMENT as conditions caused by:
   a. natural disasters such as earthquake, typhoon, hurricane, flood, diseases, or other similar reasons that may cause SECOND PARTY unable to perform its duties or responsibilities stated in this AGREEMENT, partly or as a whole.
   b. other disasters caused by human beings such as war, occupation, revolution, rebellion, siege, riot, or strike that may cause SECOND PARTY unable to perform its duties or responsibilities stated in this AGREEMENT, partly or as a whole.

2. From the time when the information on Force Majeure is reported and accepted, SECOND PARTY shall be indemnified of any failures to carry out its responsibilities due to Force Majeure.

3. In such case, both parties can terminate this AGREEMENT effective 1 (one) day after the submission of the written report to other party and therefore shortly after receiving the statement of project termination, SECOND PARTY shall take measures to conclude its work appropriately, in a manageable manner, and accountably.

4. Upon termination of this AGREEMENT due to Force Majeure conditions, FIRST PARTY shall not be liable to make any payments to SECOND PARTY, except for costs for services already carried out, or expenses related to termination of works, or liabilities and payments bear by SECOND PARTY due to Force Majeure, where those shall not exist in case Force Majeure conditions do not exist.

SECOND PARTY will provide FIRST PARTY accountable progress reports for project activities carried out under this AGREEMENT.

CLAUSE 8
TERMINATION OF SERVICES OF SECOND PARTY:

1. FIRST PARTY may terminate this AGREEMENT upon giving 30 (thirty) days notice to SECOND PARTY in writing; SECOND PARTY shall be entitled to receive all payments earned as outlined in the Scope of Work through this 30 (thirty) days notice.

2. FIRST PARTY may terminate the services of SECOND PARTY under this AGREEMENT due to breach of CLAUSE 2 (two), 4 (four) and 6 (six) of this AGREEMENT, upon giving 7 (seven) days notice to SECOND PARTY in writing; upon termination of

kepada PIHAK KEDUA; dalam hal adanya penghentian seperti ini, PIHAK KEDUA berhak menerima imbalan atas jasa-jasa yang telah diberikan sampai saat penghentian dan biaya lain yang timbul sebagai akibat dari penghentian pekerjaan tersebut sepanjang biaya-biaya dimaksud wajar dan bisa dipertanggung-jawabkan.

3. Pada akhir Perjanjian ini, PIHAK KEDUA harus dengan segera mengembalikan semua dokumen milik PIHAK KESATU, baik yang dikumpulkan oleh PIHAK KESATU maupun yang dikirim kepadanya oleh PIHAK KESATU atau orang lain yang terlibat dalam pelaksanaan Lingkup Pekerjaan. Selanjutnya, dokumen yang berasal dari manapun atau yang dikumpulkan oleh PIHAK KEDUA dalam rangka menjalankan Lingkup Pekerjaan termasuk catatan-catatan, memorandum, buku-buku catatan, gambar-gambar, rancangan-rancangan, informasi keuangan, data survey, evaluasi atau informasi tertulis lainnya yang berhubungan dengan kegiatan PIHAK KESATU harus segera dikembalikan ke PIHAK KESATU menjelang akhir Perjanjian ini. Semua dokumen-dokumen tersebut di atas dan yang dikembangkan oleh PIHAK KEDUA dalam Lingkup Pekerjaannya akan tetap menjadi milik PIHAK KESATU

PASAL 9
KETENTUAN UMUM :

1. Pada pertengahan dan atau setiap tahapan kegiatan serta pada akhir masa kontrak, PIHAK KESATU berhak melakukan evalusi pelaksanaan pekerjaan yang telah dilakukan oleh PIHAK KEDUA, hasil evaluasi akan dipergunakan sebagai dasar untuk masukan kepada PIHAK KEDUA guna peningkatan efektivitas kegiatan selanjutnya maupun untuk menghentikan perjanjian kerja sama, setelah melalui proses diskusi.

2. PIHAK KESATU dan PIHAK KEDUA sepakat bahwa segala komunikasi tertulis di bawah Perjanjian Kerjasama ini dilakukan dalam bahasa Indonesia.

3. Setiap perubahan atau pun perbaikan terhadap Perjanjian Kerjasama ini hanya berlaku setelah ada kesepakatan tertulis dari kedua belah pihak.

4. Kedua belah pihak sepakat untuk mematuhi semua hukum, aturan-aturan dan peraturan-peraturan yang berlaku di Indonesia, termasuk yang ada di tingkat pusat / nasional, Tingkat I / propinsi, Tingkat II / Kotamadya - Kabupaten dan lembaga pemerintahan lain dan badan-badan lainnya yang sekarang atau nanti dapat berhubungan dengan PIHAK KEDUA.

5. Perjanjian ini merupakan Perjanjian seutuhnya antara kedua belah pihak dan akan membatalkan dan / atau menggantikan setiap pembicaraan lisan atau tertulis yang sebelumnya dilakukan antara kedua belah pihak, dan tidak dapat diubah atau diganti kecuali secara tertulis dan ditandatangi oleh kedua belah pihak.

PASAL 10
PENUTUP:

Perjanjian Kerjasama ini dianggap selesai apabila

1. PIHAK KEDUA sudah menyelesaikan semua kewajibannnya sebagaimana tercantum dalam pasal 2 (dua) dan 4 (empat) serta menyerahkan laporan akhir pelaksanaan pekerjaan dan telah dinyatakan diterima dengan baik oleh PIHAK KESATU.
2. PIHAK KESATU sudah membayar semua kewajiban keuangan seperti yang disebut dalam Pasal 3 (tiga).

PASAL 11

Perjanjian Kerjasama ini dibuat di Jakarta oleh kedua belah pihak dengan kebebasan tanpa kekeliruan, kesesatan, kesalah-pahaman dan tanpa unsur paksaan serta dijiwai itikad baik kedua belah pihak.

this AGREEMENT, SECOND PARTY shall be entitled to receive all payments earned upon services provided until the date of termination and other proper and accountable expenses as the consequences of the termination.

3. Upon termination of this AGREEMENT, SECOND PARTY shall promptly turnover to FIRST PARTY all documents of any nature made, compiled by, or delivered to the SECOND PARTY by FIRST PARTY or by other persons involved in the performance of the Scope of Work. Furthermore, all documents of any nature made or compiled by SECOND PARTY in the course of performing the Scope of Work including any notes, memoranda, notebooks, drawings, plans, financial information, research data, evaluations or other written information pertaining to operations of FIRST PARTY shall be promptly turned over to FIRST PARTY upon the termination of this AGREEMENT. All such documents mentioned above and developed by the SECOND PARTY in the course of the Scope of Work are, and will always be, the exclusive property of FIRST PARTY.

CLAUSE 9
GENERAL STIPULATIONS:

1. In the middle of a project phase and/or the end of the contract, FIRST PARTY shall have the right to evaluate the work completed by SECOND PARTY for which the results of the evaluation shall be used as the basis to provide feedbacks to SECOND PARTY for improving the effectiveness of the coming project activities or terminate this AGREEMENT following a discussion process.

2. All written communications under this AGREEMENT shall be made in Bahasa Indonesia.

3. Any amendment to this AGREEMENT can be made by mutual written consent by both parties.

4. Both parties shall comply with all Indonesian laws, rules and regulations, including those at national, provincial, municipal or other governmental authorities and any other bodies, which are now or may in the future become, applicable to the SECOND PARTY.

5. This AGREEMENT constitutes the entire AGREEMENT between the parties and shall supersede and replace any oral written communication heretofore made between the parties in relation to the subject matter hereof and may not be amended or modified except by a written instrument signed by both parties hereto.

CLAUSE 10
CLOSING:

This AGREEMENT shall end when:

1. SECOND PARTY has already completed all of its responsibilities described in CLAUSE 2 (two) and 4 (four) and submitted the final project report acknowledged well received by FIRST PARTY.

2. FIRST PARTY has already disbursed all the funds stated in CLAUSE 3 (three).

CLAUSE 11

This AGREEMENT is made and signed in Jakarta by both parties without any hesitation or pressures, misunderstanding, errors, and based on the good will of both parties.

Segala akibat hukum yang timbul dari persetujuan Perjanjian Kerjasama ini, kedua belah pihak memilih kediaman hukum (domisili) di Kantor Kepaniteraan Pengadilan Negeri Jakarta Selatan.	In the event of there being a dispute by and between the parties, it shall be referred to be settled under the jurisdiction of the courts of South Jakarta
Yang Membuat Perjanjian :	**Parties involved:**
PIHAK KESATU **Project Concern International**	**FIRST PARTY** **Project Concern International**
Glenn Gibney **Country Director**	**Glenn Gibney** **Country Director**
PIHAK KEDUA **Yayasan Pemerhati Sosial Indonesia**	**SECOND PARTY** **Yayasan Pemerhati Sosial Indonesia**
Titin Kustini **Program Manager**	**Titin Kustini** **Program Manager**

Annex 3B

MOU with Pandeglang District Government

PERJANJIAN KERJASAMA
COOPERATION AGREEMENT

Antara
Between

PEMERINTAH KABUPATEN PANDEGLANG
THE DISTRICT GOVERNMENT OF PANDEGLANG

Dengan
And

PROJECT CONCERN INTERNATIONAL

No. 444/144-Bapp/2004
NO. 01/PCI/agree/04

Dalam rangka
Within the of

PELAKSANAAN PROGRAM KESEHATAN
MASYARAKAT DAN GIZI TAHUN 2004-2007
IMPLEMENTATION OF COMMUNITY HEALTH
AND NUTRITION PROGRAM YEAR 2004 –2007

COOPERATION AGREEMENT BETWEEN THE DISTRIC GOVERNMENT OF PANDEGLANG WITH PROJECT CONCERN INTERNATIONAL **NO.** 444/ 144 Bapp/04	**PERJANJIAN KERJASAMA ANTARA PEMERINTAH KABUPATEN PANDEGLANG DENGAN PROJECT CONCERN INTERNATIONAL** **NO.** 444/ 144 Bapp/04
NO. 01/PCI/agree/04 FOR THE IMPLEMENTATION OF COMMUNITY HEALTH AND NUTRITION PROGRAM YEAR 2004 - 2007 Today, Wednesday, 4th (four) of February year two thousand and four (2004), a partnership cooperation agreement for the implementation of community's health and nutrition program for the period of year 2004 – 2007 has been declared in Pandeglang between : The district Government of Pandeglang, represented by H. ACHMAD DIMYATI NATAKUSUMAH as the Bupati of Pandeglang district, address Jalan A. Satriawijaya No.1 Pandeglang, herein after referred to as "PEMDA " AND Project Concern International, represented by GLENN GIBNEY as the Country Director of Project Concern International, address Jalan Tirtayasa 51 Kebayoran Baru, Jakarta Selatan, hereinafter referred to as "PCI" This agreement is made with the consideration that : 1. A partnership cooperation is needed to improve community health and nutritional status in the district of	**NO.** 01/PCI/agree/04 TENTANG PELAKSANAAN PROGRAM KESEHATAN MASYARAKAT & GIZI TAHUN 2004 – 2007 Pada hari ini Rabu, tanggal empat bulan Pebruari tahun dua ribu empat, bertempat di Pandeglang, telah dicapai kesepakatan untuk mengadakan Perjanjian Kerjasama Pelaksanaan Program Kesehatan Masyarakat dan Gizi Tahun 2004-2007 antara : Pemerintah Kabupaten Pandeglang yang dalam hal ini diwakili oleh H. ACHMAD DIMYATI NATAKUSUMAH selaku Bupati Pandeglang, beralamat di jalan A. Satriawijaya No. 1 Pandeglang yang selanjutnya disebut Pemerintah Daerah (PEMDA) DAN Project Concern International, yang dalam hal ini diwakili oleh GLENN GIBNEY selaku Country Director Project Concern International, yang beralamat di jalan Tirtayasa Raya No. 51, Kebayoran Baru, Jakarta Selatan, yang selanjutnya disebut PCI Dengan terlebih dahulu mempertimbang kan hal-hal sebagai berikut : 1. Bahwa adanya kerjasama diperlukan untuk memperbaiki status kesehatan dan gizi masyarakat di Kabupaten Pandeglang melalui penguatan kapasitas layanan Pemerintah,

Pandeglang through strengthening the capacities of government services, non-government organizations and the community; 2. This cooperation shall give fully attention to the health and nutrition of women of reproductive age and of the children under five years of age. 3. The fulfillment of responsibilities assumed by each of the parties will be done in a spirit of partnership;.	Organisasi Non-Pemerintah dan Masyarakat ; 2. Bahwa kerjasama, memperhatikan sepenuhnya status kesehatan perempuan usia subur dan gizi anak balita ; 3. Bahwa pemenuhan tanggung jawab kedua belah pihak akan dilakukan dalam semangat Kemitraan.
Based on the above considerations, in all good faith and intention, both parties hereto agree to enter into a partnership co-operation with the following stipulations :	Berdasarkan hal-hal tersebut, kedua belah pihak dengan penuh kepercayaan dan itikad baik, bersepakat mengadakan perjanjian kerjasama dengan ketentuan-ketentuan sebagai berikut :
Article 1 **Basis of Agreement**	**Pasal 1** **Dasar Perjanjian**
(1) This cooperation agreement based on the Extension of the Agreement Between the Ministry of Health of Indonesia and Project Concern International 1999 - 2004 on the Implementation of Community Health and Nutrition Programs through Strengthening Governmental, Non-governmental, and Community Capacities signed on 16 December 1999, currently in the process of being further extended for another five years. (2) This district cooperation agreement (DCA) between Pemda Pandeglang and PCI shall become basis of relationship between both parties	(1) Perjanjian kerjasama ini dibuat atas dasar Perpanjangan Perjanjian antara Departemen Kesehatan Republik Indonesia dan Project Concern International Tahun 1999-2004 tentang Pelaksanaan Program Kesehatan Masyarakat dan Gizi melalui Penguatan Kapasitas Pemerintah, Non-Pemerintah dan Masyarakat, yang ditandatangani tanggal 16 Desember 1999, yang pada saat ini sedang dalam proses perpanjangan lebih lanjut untuk lima tahun berikutnya. (2) Perjanjian Kerjasama Kabupaten (District Cooperation Agreement) antara Pemda Pandeglang dan PCI ini menjadi dasar hubungan kedua belah pihak
Article 2 **Objective and Major Intervention of 2004 -2007**	**Pasal 2** **Tujuan dan Intervensi Utama Tahun 2004 – 2007.**
(1) **Ultimate Goal** The goal of this community based,	(1) **Tujuan Akhir** Tujuan akhir dari proyek kesehatan

participatory health and nutrition project, named Child Health Opportunities Integrated with Community Empowerment (CHOICE) is "Improved health and nutrition status of under five year old children and women of reproductive age in the project-target villages	dan gizi berbasis masyarakat yang partisipatif bernama Child Health Opportunities Integrated with Community Empowerment (CHOICE) ini adalah "Meningkatnya status kesehatan dan gizi anak balita dan perempuan usia subur di desa sasaran proyek.
(2) **Program Objective** The above ultimate goal translates into the following program objectives : • Increased community access to primary health care service • Improved parents / caretakers' behaviors in the proper child nursing and care that support child survival, growth and development • The application of community based health development models	(2) **Tujuan Program** Tujuan akhir tersebut dijabarkan kedalam tujuan khusus program sebagai berikut: • Meningkatnya akses masyarakat terhadap pelayanan kesehatan primer • Meningkatnya perilaku orang tua / pengasuh anak dalam pengasuhan dan perawatan anak yang benar yang mendukung kelangsungan hidup, pertumbuhan dan perkembangan anak • Diterapkannya model pembangunan kesehatan yang berbasis masyarakat.
(3) **Program overview** The structure of this cooperation program is shown in figure 1. Program details are provided in annex 1, and is summarized below:	(3) **Tinjauan Singkat Program** Struktur program kerjasama ini adalah seperti terlihat pada gambar 1. Rincian lengkap program bisa dilihat di lampiran 1 dan secara ringkas sebagai berikut:
a. Through cross-sector coordination, this cooperation program will support important interventions that will lead to significant development of women and child livelihood. This program will promote the community's self-help capacities in managing the program in which they will assume the main role	a. Melalui koordinasi lintas sektor, program kerjasama ini akan mendukung intervensi penting yang akan membawa perkembangan yang bermakna bagi kehidupan perempuan dan anak balita. Program ini akan meningkatkan keswadayaan masyarakat yang akan memegang peranan utama dalam pengelolaan program
b. The appointment of project-target villages and sub-districts shall be conducted based on the following criteria: village with high poverty levels, high potential for participation, high malnutrition rate, low coverage of immunization and low Posyandu coverage.	b. Penentuan desa dan kecamatan sasaran proyek ditetapkan berdasar kan kriteria: desa dengan Keluarga pra sejahtera tinggi, potensi untuk partisipasi tinggi, malnutrisi tinggi, cakupan imunisasi rendah dan cakup an posyandu yang masih rendah.

Article 3 **Organization and Operational Aspect**	**Pasal 3** **Aspek Aspek Kelembagaan dan Operasional**
(1) Organizational and operational aspects not covered in this agreement shall be arranged in the • Program Detailed Implementation Plan and be guided by • Law No. 22 / 1999 on Regional Autonomy	(1) Hal-hal yang menyangkut kelembaga an dan operasional program yang tidak tercakup dalam perjanjian kerjasama ini diatur dalam • Rencana Rinci Pelaksanaan Program; dan mengacu pada • UU No. 22 Tahun 1999 tentang Pemerintahan Daerah
(2) The Bupati is responsible for ensuring the smooth running of the cooperation program on behalf of Pemda Pandeglang. The coordination of the program will be done by Survival, Development and Protection of children and women Team.	(2) Bupati bertanggung jawab atas kelancaran jalannya program kerja sama atas nama Pemda Pandeglang. Koordinasi pengelolaan program kerja sama akan dilakukan oleh Tim Kelangsungan Hidup Perkembangan dan Perlindungan Ibu dan Anak (KHPPIA) yang telah ada.
(3) The district agencies to be involved in the inter-sectoral coordination may include, but not be limited to the following: • Regional Development Planning Board (BAPPEDA) • Dictrict Health Service • District Statistic office • District Population,Family planning and Civilian registrar Service • District Education Service • District Community and Women Empowerment Office • Family Welfare Movement (PKK) Mobilization Team • District Agriculture Service • Community Organizations	(3) Instansi tingkat Kabupaten yang akan terlibat dalam koordinasi inter-sektoral dapat mecakup, namun tidak terbatas pada yang tertera berikut: • Bappeda • Dinas Kesehatan • BPS • Dinas Kependudukan, KB dan Catatan Sipil • Dinas Pendidikan • Kantor Pemberdayaan Masyarakat dan Perempuan • Tim Penggerak PKK • Dinas Pertanian • Organisasi/Lembaga Kemasyarakatan
(4) An annual work plan (RKT) will describe the activities that will be performed, the party responsible for the activities, time, and inputs from Pemda Pandeglang and PCI. The annual work plan shall become the basis for PCI in implementing activities in the field and preparing	(4) Rencana Kerja Tahunan (RKT) menjabarkan kegiatan yang akan dilaksanakan, penanggungjawab kegiat an, waktu, dan masukan dari Pemda Pandeglang dan PCI. RKT menjadi dasar bagi PCI dalam melaksanakan kegiatan di lapangan serta penyusunan instrumen

monitoring and evaluation instruments. Pemda Pandeglang together with PCI will conduct review and prepare annual plans for the program in this cooperation agreement. Mid-Term Program Review will be held at the end of 2005 whereas Final Program Review will be held in 2007	monitoring dan evaluasi. Pemerintah Daerah dan PCI secara ber sama-sama akan melaksanakan tinjau an dan perencanaan tahunan ter hadap program yang tercakup dalam perjanji an kerjasama ini. Tinjauan Tengah Program (Mid- Term Review) akan dilaksanakan pada akhir tahun 2005 sedangkan Tinjauan Akhir Program akan dilaksanakan pada tahun 2007.
Article 4 **PCI's Commitment**	**Pasal 4** **Komitmen PCI**
(1) To establish a program office in Pandeglang, staffed by adequate number of experienced relevant personnel. At the same time PCI will engage itself in a partnership with one or more local NGOs especially selected for implementing the program.	(1) PCI akan membuka sebuah kantor program di Pandeglang, dengan personil yang memadai, sesuai dan berpengalaman. Sekaligus PCI akan menjalin hubungan kemitraan dengan satu atau lebih LSM lokal yang khusus dipilih untuk melaksanakan program.
(2) To conduct and support orientation activities and training on the project design to all relevant district and sub-district level staff involved.	(2) Menyelenggarakan dan mendukung kegiatan Orientasi dan pelatihan tentang desain Proyek kepada semua staf terkait yang sesuai di tingkat Kabupaten dan Kecamatan.
(3) To follow the rules, procedure local culture and traditions in implementing the project especially at community level.	(3) Mengikuti semua peraturan, prosedur dan tradisi budaya setempat dalam melaksanakan proyek, terutama di tingkat masyarakat.
(4) To implement and fund specific activities (training, providing aids for community), directly or through its local NGO partner, These may include consultant, monitoring and evaluation and other activities needed by project, as agreed by PCI.	(4) Mendanai pelaksanaan berbagai kegiatan khusus (pelatihan, penyediaan bantuan bagi masyarakat), secara langsung maupun melalui LSM Lokal Mitranya. Semua ini termasuk biaya konsultan, biaya monitoring dan evaluasi dan kegiatan lain yang diperlukan proyek, yang disetujui PCI.
(5) Based on self-assessment of the capacity of Puskesmas and Polindes, to provide them with assistance (generally in the form of training and	(5) Berdasarkan telaah-diri terhadap kapasitas Puskesmas dan Polindes,

non-physical aids) to enable them to perform better in the implementation of this project. Physical aids may be considered if it is highly needed and still in PCI's mandate	PCI akan menyediakan bantuan (pada umumnya berbentuk pelatihan dan bantuan nonfisik) guna memungkinkan mereka berkinerja lebih baik dalam melaksanakan proyek. Bantuan fisik hanya akan dipertimbangkan apabila sangat diperlukan dan masih dalam mandat PCI.
(6) Providing routine, periodic, brief report to the district government / Program Coordination Team on the advancement and the result of the project every three months.	(6) Memberikan laporan periodik kepada Pemda/Tim Koordinasi Program-program (TKPP) secara rutin, ringkas an tentang kemajuan pelaksanaan proyek dan hasilnya setiap triwulan.
(7) Providing written or verbal explanation and clarification to district government of Pandeglang, when it is required.	(7) Memberi penjelasan dan klarifikasi kepada PEMDA bila diperlukan baik secara tertulis maupun lisan.
Article 5 **Commitment of the District Government**	**Pasal 5** **Komitmen Pemerintah Daerah**
(1) Pemda Pandeglang will appoint Dinas Kesehatan Kabupaten Pandeglang to become PCI's main counter part in implementing the project.	(1) Pemda Pandeglang akan menunjuk Dinas kesehatan Kabupaten untuk menjadi mitra utama PCI dalam pelaksanaan proyek.
(2) To help PCI in determining project target sub-districts and villages	(2) Membantu PCI dalam menentukan Kecamatan dan Desa sasaran proyek.
(3) Together with PCI's staff and other relevant stakeholders, to develop LongTerm Plan (2004-2007) and detailed annual plan based on the project design.	(3) Bersama staf PCI dan pihak terkait lain yang sesuai, membuat Rencana Jangka Panjang (2004-2007), dan rencana tahunan rinci berdasarkan desain proyek.
(4) To conduct monitoring and supervision of the project implementation	(4) Melakukan pemantauan dan penga wasan agar pelaksanaan proyek dapat berjalan sebagaimana rencana.
(5) To provide fund resource of APBD or another resource for implementing activities in the field.	(5) Menyediakan dukungan sumber dana yang berasal dari APBD maupun sumber dana lainnya sebagai pendamping terlaksananya kegiatan di lapangan.
(6) To provide administrative support, general procedure and problem	(6) Memberikan dukungan administratif, prosedural umum dan pemecahan

solving for any obstacles in the cooperation program.	masalah bila terjadi hambatan dalam program kerjasama ini.
Article 6 **Monitoring and Evaluation**	**Pasal 6** **Monitoring dan Evaluasi**
(1) The District Government in conjunction with PCI will review periodically the overall performance of the Program. The Survival, Development and Protection of children and women team will be responsible for coordinating regular monitoring and periodic evaluation of each program component and its constituent project.	(1) Pemerintah Daerah bersama-sama PCI akan melakukan tinjauan secara berkala terhadap kinerja program secara keseluruhan. Tim KHPPIA bertanggungjawab untuk mengkoordi nasikan pelaksanaan monitoring dan evaluasi terhadap setiap komponen program dan proyek yang bersesuaian.
(2) The overall framework for monitoring and evaluation of the district program will be undertaken according to the indicators and framework in annex 2	(2) Kerangka kerja untuk monitoring dan evaluasi program dilaksanakan sesuai dengan indikator yang termuat dalam matriks rencana pelaksanaan program kesehatan masyarakat dan gizi (lampiran 2)
(3) Program monitoring will be conducted every three months by district government together with PCI using agreed instruments	(3) Monitoring program akan dilaksanakan setiap triwulan oleh Pemda bersama PCI dengan menggunakan instrumen yang telah disepakati.
(4) During the annual review, the result and accomplishment during the year will be reviewed against the agreed Project Plan of Action. Progress and obstacles will be discussed and plan for the following year shall be agreed upon.	(4) Di dalam review tahunan, hasil yang dicapai dalam tahun tersebut akan dibandingkan dengan apa yang tertuang dalam Rencana Kerja Proyek. Kemajuan dan kendala akan dibahas dan rencana untuk tahun berikutnya akan disepakati.
(5) Monitoring and evaluation activities will include joint field visits by counterparts and PCI. Field visit report will be prepared and used as inputs for Project Progress Reports to be reviewed during annual review / planning meetings.	(5) Monitoring dan evaluasi mencakup kunjungan lapangan oleh mitra kerja bersama-sama PCI. Laporan kunjungan lapangan dibuat dan digunakan sebagai masukan untuk laporan kemajuan proyek yang akan dibahas dalam pertemuan perencanaan / review tahunan.

Article 7 **Agreement Period and Agreement Termination**	**Pasal 7** **Masa Perjanjian dan Pemutusan Perjanjian**
(1) The effective period of this agreement begins at the signing time of the agreement by both parties and expire on 30 September 2007, subject to the extension of agreement between PCI and the Ministry of Health of Indonesia.	(1) Masa berlakunya perjanjian ini dimulai pada saat perjanjian ini ditandatangani kedua belah pihak, dan berakhir pada tanggal 30 September 2007, tergantung pada perpanjangan atas perjanjian antara PCI dengan Departemen Kesehatan Republik Indonesia.
(2) This agreement is subject to the availability of the fund of PCI's donor, if PCI's donor decides to stop its funding, at least three months before it, the district government should be informed so that efforts may be made to maintain the program continuity.	(2) Perjanjian ini bergantung pada ketersediaan dana dari donor PCI, apabila donor utamanya memutuskan untuk menghentikan pendanaanya maka minimal 3 bulan sebelumnya akan diberitahukan kepada PEMDA agar dapat diupayakan kelanjutan program yang telah berjalan.
(3) Either PCI or district government has the right at all time to terminate this agreement on conditions that each party informs the other party in writing at least 3 (three) months before the termination by giving acceptable reasons for both parties.	(3) Baik PCI maupun PEMDA memiliki hak untuk sewaktu-waktu memutuskan perjanjian ini, dengan syarat memberi tahukan secara tertulis kepada pihak lainnya minimal 3 (tiga) bulan sebe lumnya dengan memberikan alasan yang dapat diterima kedua belah pihak.
Article 8 **Final Provision**	**Pasal 8** **Penutup**
(1) This Cooperation Agreement may be amended by mutual consent of the District Government and PCI, based on the outcome of the annual reviews, the Mid-Term Review or compelling circumstances.	(1) Perjanjian ini dapat diubah atas kesepakatan bersama antara Pemerintah Daerah dengan PCI, atas dasar hasil tinjauan tahunan, paruh tahun atau kondisi tertentu.
(2) Changes or additions in this agreement as stated in part (1) of this article, is expressly appended to and become part and parcel of this cooperation agreement.	(2) Perubahan perjanjian kerjasama sebagaimana dimaksud pada ayat (1) pasal ini dituangkan dalam bentuk addendum perjanjian kerjasama sebagai bagian yang tidak terpisahkan dari perjanjian ini.
(3) Changes or additions to any	(3) Perubahan / tambahan / addendum

stipulation of this agreement as stated in part (2) of this article will bind both parties if have been made in writing and signed by legal representatives of both parties.	sebagaimana dimaksud pada ayat (2) pasal ini akan mengikat kedua belah pihak bila telah dibuat secara tertulis dan ditanda tangani oleh kedua belah pihak.
(4) This agreement is written in two languages, namely Indonesian and English. In the event of there being a different interpretation concerning conditions of cooperation agreement, the Indonesia text shall prevail.	(4) Perjanjian ini ditulis dalam dua bahasa yaitu Bahasa Indonesia dan bahasa Inggris. Dalam hal terjadi perbedaan penafsiran mengenai ketentuan perjanjian kerjasama, maka yang menjadi acuan adalah yang tertulis dalam bahasa Indonesia.
(5) All points that have not been stipulated in this agreement will be decided through negotiation of both parties.	(5) Semua hal yang belum diatur dalam perjanjian ini akan diputuskan secara musyawarah oleh kedua belah pihak.
(6) For the implementation of this agreement with all its consequences, both parties have law domicile at the office of clerk of government court, district of Pandeglang, the province of Banten.	(6) Untuk pelaksanaan perjanjian ini beserta semua konsekwensinya kedua belah pihak menetapkan domisili hukum di Kantor Panitera Pengadilan Negeri Pandeglang Propinsi Banten.
Article 9	**Pasal 9**
This cooperation agreement has been made and signed by PEMDA and PCI in 2 (two) copies of which both copies are equally authentic.	Perjanjian kerjasama ini dibuat dan ditandatangani oleh pihak PEMDA dan PCI dalam rangkap 2 (dua) bermaterai cukup yang masing-masing mempunyai kekuatan hukum yang sama.

COUNTRY DIRECTOR PCI

GLENN GIBNEY

BUPATI PANDEGLANG

HJ. HERYATI NATAKUSUMAH

LOKASI PROYEK CHOICE

Kec. Pagelaran	Kec. Saketi	Kec. Patia	Kec. Angsana
Ds. Kartasana	Ds. Saketi	Ds. Sidamukti	Ds. Padaherang
Ds. Margagiri	Ds. Ciandur	Ds. Cibungur	Ds. Karangsari
Ds. Bama	Ds. Medalsari	Ds. Rahayu	Ds. Cikayas
Ds. Margasana	Ds. Sukalangu	Ds. Karyasari	Ds. Cipinang
Ds. Tegalpapak	Ds. Langensari	Ds. Babakankeusik	Ds. Kramatmanik
Ds. Montor	Ds. Parigi		
Ds. Sindanglaya	Ds. Girijaya		
Ds. Sukadame	Ds. Sodong		
Ds. Sendangsari	Ds. Mekarwangi		
Ds. Pagelaran	Ds. Sindanghayu		

DEWAN PERWAKILAN RAKYAT DAERAH
(DPRD)
KABUPATEN PANDEGLANG
Jl. Pendidikan No. 1 Telp. (0253) 201004 PANDEGLANG

Pandeglang, 19 Januari 2004

Nomor : 172.4 / 01/ 02 - DP/ 2004
Sifat : Penting
Lampiran : -
Perihal : **Persetujuan Perjanjian Kerjasama Pemda Pandeglang Dengan PCI**

Kepada
Yth. Sdr. **Bupati Pandeglang**
Di
PANDEGLANG

Memperhatikan Surat Bupati Pandeglang Nomor : 193 / 2035 – Huk / 2003 Tanggal 15 Desember 2003 Perihal Permohonan Persetujuan Perjanjian Kerjasama PEMDA Pandeglang - PCI.

Perjanjian kerjasama dimaksud memuat :

1. Perpanjangan Perjanjian antara Departemen Kesehatan Republik Indonesia dengan Project Concern International (PCI) Tahun 1999 - 2004 ;
2. Kerjasama difokuskan pada Program Kesehatan Masyarakat dan Gizi yang dijadwalkan mulai tahun 2004 – 2007 ;

Pada prinsipnya DPRD Kabupaten Pandeglang tidak keberatan dan dapat ***menyetujui*** Perjanjian Kerjasama Pemda Pandeglang dengan Project Concern International (PCI).

Dengan pertimbangan sebagai berikut :

1. Bahwa kerjasama tersebut diharapkan dapat memperbaiki dan meningkatkan Status Kesehatan dan Gizi khususnya kesehatan Perempuan Usia Subur dan Gizi Anak Balita ;
2. Agar perjanjian kerjasama ini menguntungkan semua pihak, terutama masyarakat yang membutuhkan program kesehatan dan gizi untuk melanjutkan kelangsungan hidupnya ;
3. Dalam pelaksanaan program dimaksud memuat prinsip – prinsip keterbukaan, memberdayakan masyarakat, kejelasan dan kepastian, keamanan, ekonomis, keadilan yang merata dan ketepatan waktu ;
4. Dapat meningkatkan akses masyarakat melalui pelayanan kesehatan dan gizi ;
5. Bahwa dalam kerjasama dimaksud mengacu kepada Peraturan Perundang – undangan yang berlaku ;

Demikian Persetujuan ini untuk dapat dipergunakan sebagaimana mestinya.

DEWAN PERWAKILAN RAKYAT DAERAH
KABUPATEN PANDEGLANG
Ketua,

Dedi Sumantri, S.Pd, M.Sc

Wakil Ketua,
H.A. Wadudi Nurhasan,BAc

Wakil Ketua,
Drs. H.M. Acang, MAg

Wakil Ketua,
Drs. Aat Supriawijaya, MBA

Annex 4

Project Hiring Status

Annex 4 – CHOICE Project Hiring Status
As of April 2004

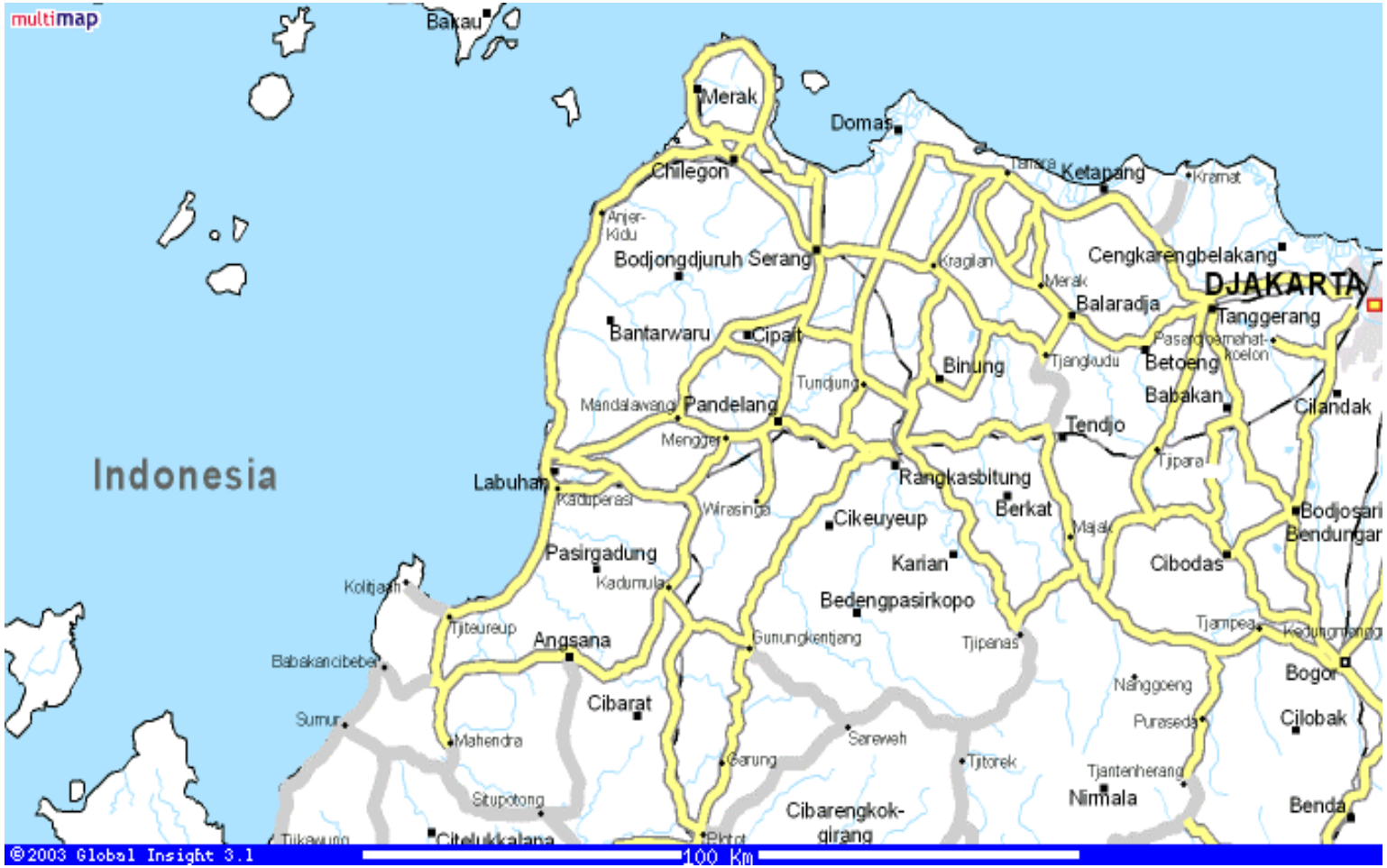
PCI
The Project Manager, Health and Nutrition Specialist, Community Development/Training Specialist and Finance Officer were hired in October 2003; the Administrative Assistant was hired in December 2003. All project staff have been hired on a yearly contractual basis. PCI/Indonesia's management team will conduct yearly performance reviews to determine contract renewal status.

YPSI
As of November 2003, four field supervisors were hired to assist with project start-up activities, including baseline survey and community preparation, relationship-building with stakeholders, DIP workshop planning, implementation, follow-up, etc). All four full-time field supervisors were hired until May 2004 and will be extended for a second year according to the results of a performance review to be conducted by YPSI and PCI. The Director of YPSI functions as part of a program management team (25 % of her salary is paid by PCI using CHOICE project funds). Once the second MOU is signed by both parties, YPSI will recruit 15 field facilitators to be placed in the 30 villages.

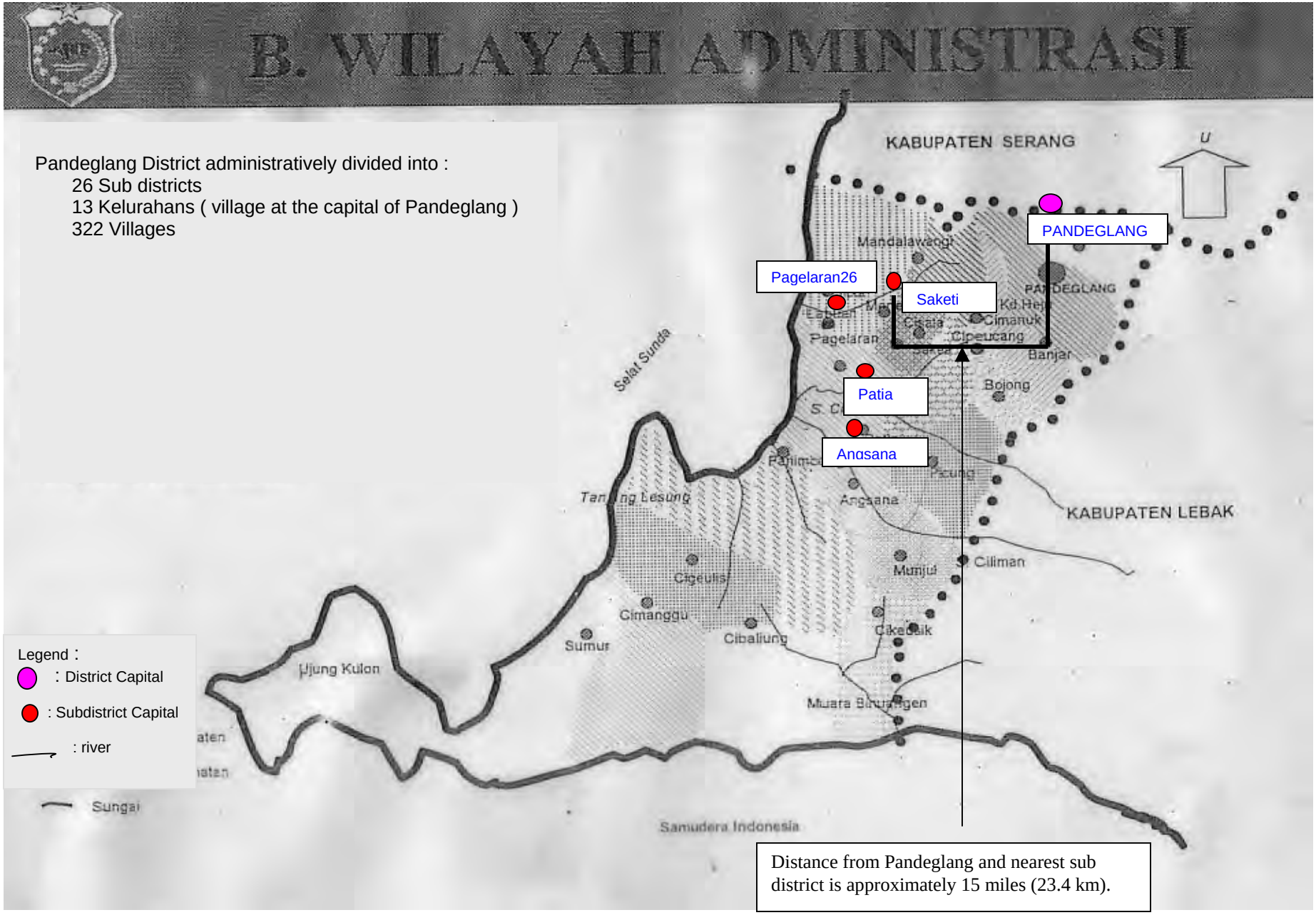
Annex 5A

Maps

WEST JAVA MAP



CHOICE PROJECT SITES



Annex 5B

Rapid CATCH Summary Data

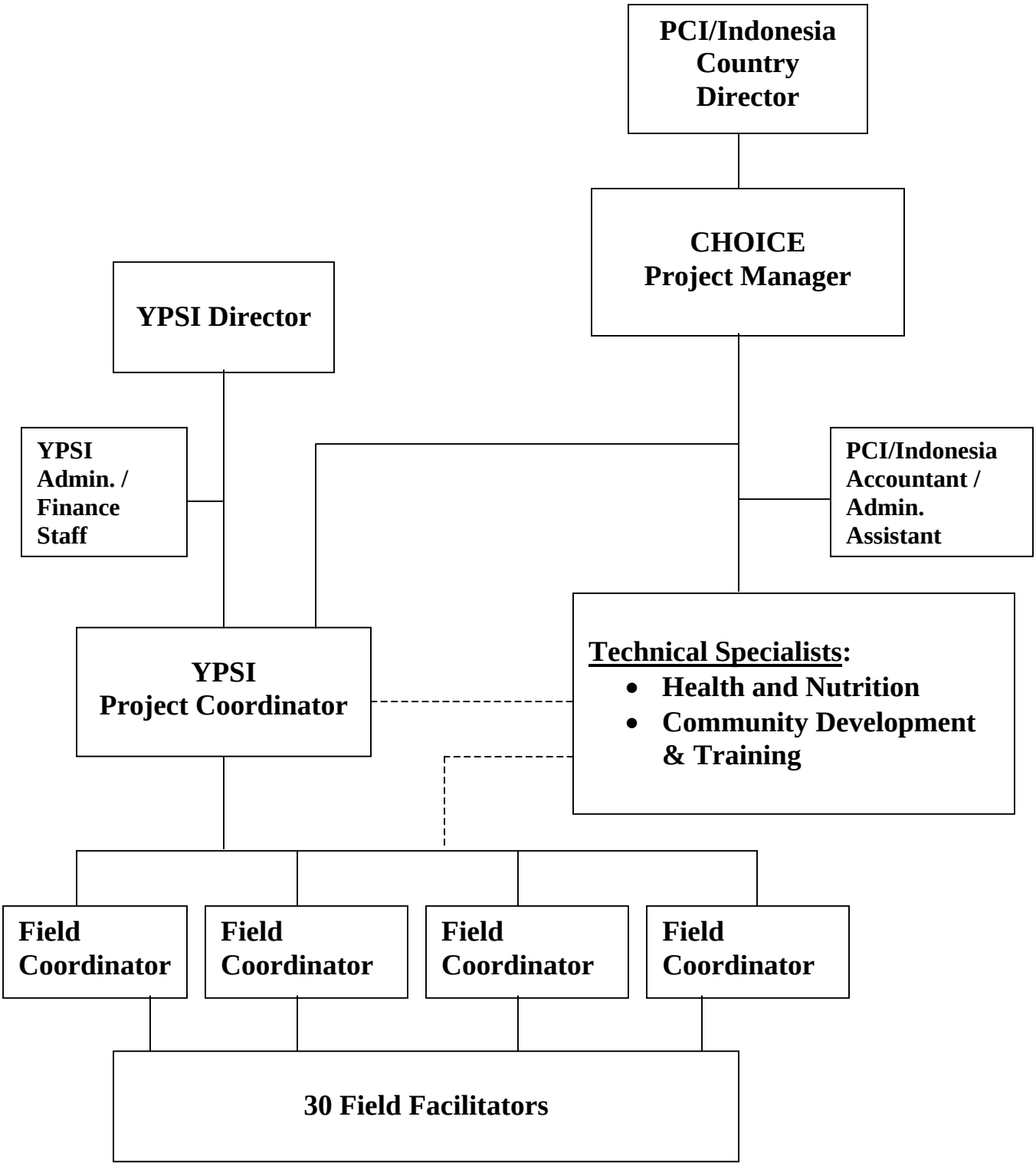
CATCH - PRIORITY CHILD HEALTH INDICATORS	**%'s**
1. Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**23.50%**
2. Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	**92.90%**
3. Percentage of children age 0–23 months whose births were attended by skilled health personnel	**15.80%**
4. Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**68.70%**
5. Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	**48.50%**
6. Percentage of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	**89.00%**
7. Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**51.10%**
8. Percentage of children age 12–23 months who received a measles vaccine	**61.70%**
9. Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night	**0%**
10. Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	NA
11. Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**1.30%**
12. Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	**28.70%**
13. Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	**73.40%**

Annex 5C

Organizational Structure

CHOICE

ORGANIZATIONAL STRUCTURE



Annex 5D

DIP Planning Workshop Report

Report on the Workshop for Developing CHOICE Program Activities Pandeglang District 24-26 February 2004

The workshop was carried out in two phases. The first was on February 24, 2004 aimed at exposing the results of the currently completed baseline survey and assessment of health facilities. The second phase was to (1)discuss the sustainability of maternal and child health program and (2) develop detail implementation plan of CHOICE Program.

PARTICIPANTS

Workshop participants were *stakeholders* of CHOICE Program included in KHPPIA (survival, development and protection for woman and child) Team, PCI's NGO partner (i.e., YPSI) and World Vision Indonesia. First phase workshop was attended by all stakeholders, i.e., representatives of Health Section, Regional Development Planning Board (BAPPEDA), District Government, Population Section, Family Planning and Civil Registration Office, Central Bureau of Statistics, Agriculture Section, Pandeglang District TP PKK (Family Welfare Movement Team) , Sub-District Heads (of 4 sub-districts), Puskesmas Heads (of 4 sub-districts), TP PKK (of 4 sub-districts) and representatives of World Vision. The total number of attendants was 36 participants. On the second and third days, all of the 18 participants invited were present.

FACILITATORS

Workshop facilitators were:

1. Dr. Agustini E. Raintung
2. Michel Pacque, MD,MPH,DTMH
3. Linda Morales, MA
4. Dr.Herty Herjati
5. Kuwat Karyadi
6. Titin Kustini

ORGANIZING COMMITTEE

General coordinator:

1. dr.Herty H.

Accommodation and logistics:

1. Sonny Aprichard
2. Bertha Dayantie

Minutes:

1. Otri Ramayani Dwiputri
2. Bertha Dayantie

Staff:

1. Solihin
2. Budi
3. Agung

VENUES

1. Exposure of the results of the baseline survey and assessment was held in the Operation Room III of Bappeda Office (24 February 2004 - 09.30 to 13.30)
2. Development of CHOICE Program detail implementation plan was carried out in Jayakarta Hotel of Anyer for two days (25 and 26 February 2004).

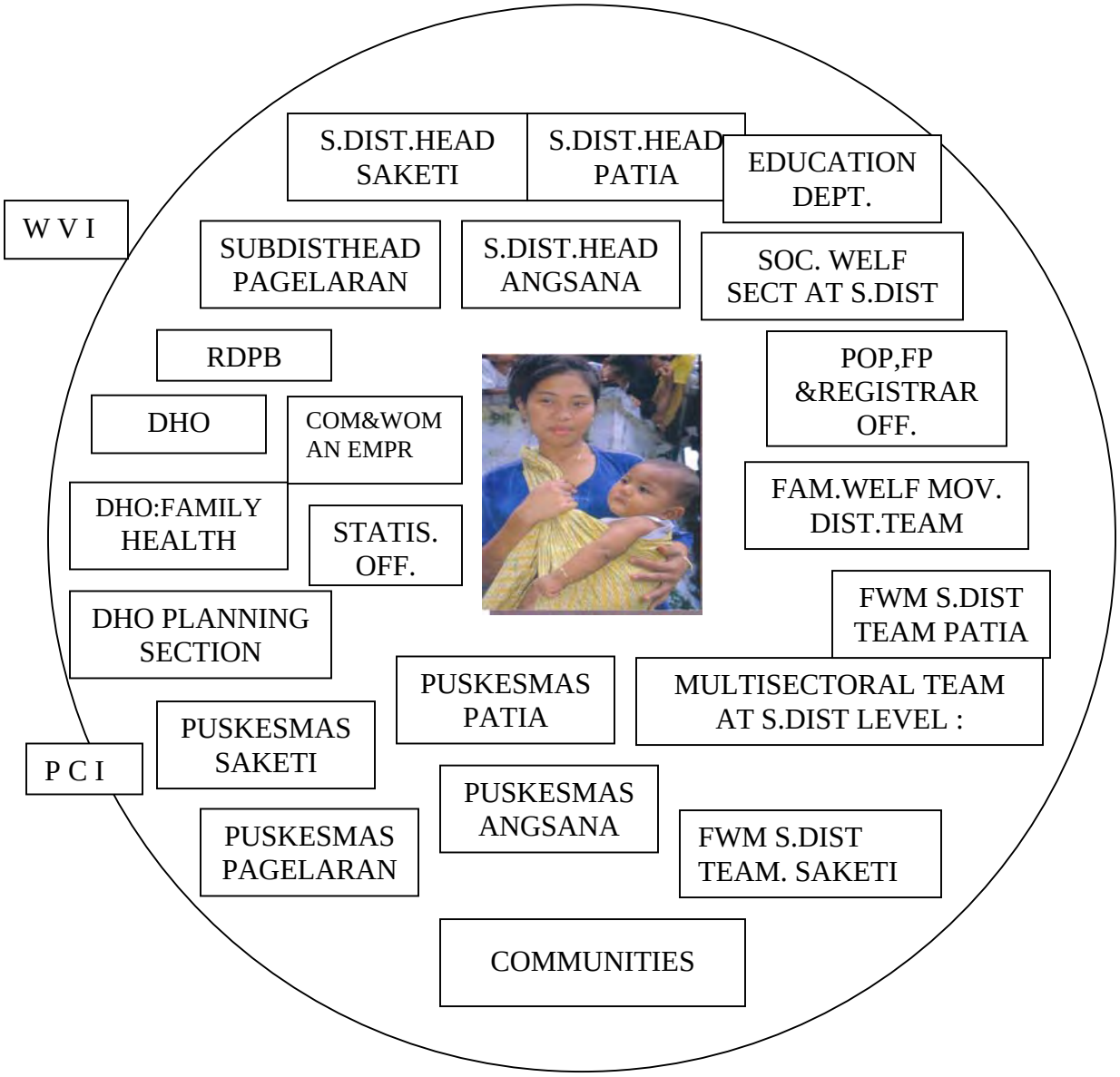
PROCESSES

1. **DAY I, 24 February 2004**:
   - Deputy Regent of Pandeglang district officially opened the workshop at 09:30.
   - PCI Country Director gave an opening speech emphasizing CHOICE's role as a development, rather than charity, program. The Country Director also expressed appreciation upon the presence of the Deputy Regent and supports provided for CHOICE Project to date.
   - Deputy Regent described problems faced by Pandeglang, such as lack of education and lack of information related to health and nutrition. Deputy Regent also stated that Pandeglang was less fortunate in terms of its geographical position in the region.

   - **Session 1** (09.30-11.50) was explanation of CHOICE Program; baseline survey; rapid assessment on water and sanitation, and concluded by a question and answer session.
     During the question and answer session, heads of sub-districts stated that more villages should be included in the program. They pointed out that many villages are in fact eligible. Two other points raised during the session were intention to get support for building water source facilities and need for more midwives according to the number of villages in their areas.
     The presenting panel explained that the 30 villages currently assigned under the program are the priority and selected through a process that involves various stakeholders. Any other problems existing can be addressed by other parties.

   - **Session II** (11.50-12.30) was a presentation by dr. Rulina Suradi DSAK on benefits of exclusive breastfeeding for child growth and development. At the end of the presentation, a question and answer session was also conducted.
     From the session, it was revealed that most participants were not aware of breastfeeding benefits. Lactation management was also a new issue for most participants.

   - **Session III** (12.30-13.30) was on program sustainability. The session was started by identification of roles played each stakeholder within CHOICE Program . All individuals/ organizations involved in CHOICE Program was asked to attach their name card on a piece of flipchart already prepared. A circle had been drawn on the flipchart. In the middle of the circle, a picture depicting a healthy mother and her child was attached to indicate the objective to reach by CHOICE Program. Cards put inside the circle indicated direct involvement to the program, while cards attached outside the circle indicated indirect involvement to the program. At the end of the activity, it was clear that most individuals/ organizations (except WVI) attached their names inside the circle. Participants learned that a program for improving health status of mothers and children was a multi-sectoral mission and should be the responsibility of various parties.



On the next activity, participants were asked to tell their 'dreams' about Pandeglang in the next 10 or 15 years. Each participant was to discuss his/her dreams with another participant nearby.

At the end of the session, Michel Pacque of ORC-MACRO USA talked about a program sustainability framework displayed in a three-dimensional triangle diagram: (dimension 1) on primary health goals of the local system; (dimension 2) on organizational capacity and viability; (dimension 3) on community and social ecological system that influences program sustainability. These three dimensions are interrelated to achieve program goals and, therefore, should be given appropriate and sufficient concern to guarantee achievement of 'dreams' of Pandeglang regarding health of mothers and children, even when CHOICE Program has been completed. This was in fact the first of the six-stage

participatory processes in program planning, i.e., defining the system to be assessed, its vision and goal.

At the end of the session, the moderator (Ms. Indah of Bappeda) presented a summary of the 'dreams' of the participants:

- Health status of mothers and children increased, indicated by reduce of maternal, infant and child mortality rates and reduce of malnutrition cases/rates on infants and children under five.
- Increased access of the people to mother and child services measured by percentage of people with access to health services (100 %); delivery by skilled birth attendants; immunization coverage (100 %); increased quality of contraception use; coverage of antenatal visits (K1/K4 (100 %) and increased coverage of neonatal visits (N/4).
- People understand the meaning of health and are aware of the importance of education and health: weigh taking coverage e is increased by 100 %; number of Posyandu and active cadres is increased; increased role of men in the health of mothers, infants, and children under five; people consume nutritious foods out of own lands/gardens.
- Realization of Pandeglang Healthy 2010, free from ignorance, poverty, and people understand the importance of health to reach a better future of the nation: healthy, bright, fair and prosperous.

Note: It was regretful that the legislative members invited to the workshop were not present.

- The workshop was officially closed at 13.30 by Head of Health District Office of Pandeglang district with the following conclusions:
  a. Community *development* programs are more complex/difficult to implement; however, their impacts are long lasting compared to charity programs.
  b. The results of survey revealed should be the guidelines for improving the conditions in Pandeglang, especially in the 30 villages involved in the program.
  c. Exclusive breastfeeding is very important for growth and development of children.
  d. The follow-up action is planning the future program framework.

- At 16.00, all participants departed to Anyer to join in the second phase workshop.

2. Day II, 25 February 2004

- **Introduction Session**: The session was started at 08.30. Through ball-throwing game facilitated by Kuwat Karyadi and YPSI Director (Titien Kustini), all participants introduced themselves. Later, the learning schedule and learning contract were discussed and agreed upon. All participants were also asked to tell their hopes towards CHOICE Program as well as their hopes towards the workshop they are now joining. Each participant was asked to trace both hands on a piece of paper and write their hopes on the drawings.

  Hopes towards CHOICE Program:
  1. That the program will be successful in the community's eyes beyond our wildest dreams.
  2. That the program can provide appropriate and effective information to people; become good workers; increase people's participation on health program; increase inter-sectoral roles in program; harmony agreement;
  3. That people are able to understand and apply knowledge or information on health of mothers and children; increase quality of community health for better future; children living in rural areas can grow and develop, be healthy and prosperous, same as those children in more developed areas; socialize healthy life practices to rural communities; increase people awareness on the importance of health.

4. That people know more about this foundation; that supports provided can be received by community; community will follow-up; reduce mortality rates; reduce poverty rate; reach people living in villages.
5. Very good; concerned about the conditions of the people; improve families/households; support government program; make future plan of action for 2004-2007.
6. Create supportive environment; reduce mortality; participatory; process oriented; community BSD.
7. Community participation; environment quality; increased nutrition status; increased access of people to mother and children health care and facilities; increased health status of mothers and children.
8. Reduce maternal mortality rate and infant mortality rate, increase health status of mothers and children, solid planning, children under five, pregnant mothers, breastfeeding mothers, healthy delivery practices, prosperous community.
9. Reduce maternal mortality rate and infant mortality rate, good and healthy life practices; increase participation to posyandu, reduce malnutrition; availability of clean water supply.
10. People awareness on exclusive breastfeeding, nutrition, healthy environment, health status, increased.
11. Health status of mothers and children increased
12. Quality services; health improvement; visible organizations; capable organizations; strong communities; sustainable development; community will be better able to manage the health of children and “mothers”.
13. Better health status achieved; health life practices; zero number of infant and children under five with malnutrition.
14. Health status of mothers and children increased, people access of quality health services for mothers and children increased; knowledge and skill of field health workers increased so to be better able to provide health services for children and mothers; collaboration network among community based institutions on health services formed and functioned; health program for mothers and children become priorities of local government.
15. Detail planning well developed
16. Independent community; community become more aware of health issues; solid supporting institutions; sufficient health funds; targets achieved and sustainable.
17. Children in the 4 sub-districts are healthy, bright, and good in character.
18. That program can be carried out in 4 sub-districts; good coordination among related institutions continuous monitoring and evaluation established; program socialization in four sub-districts; involvement of *stakeholders* in all stages.
19. Clear program direction; clear program activities; clear program goals and objectives; timely and for maximum achievement.
20. My Puskesmas should be happy sending me to this workshop as the knowledge obtained can be for betterment of our services to mothers and children.
21. Number of pregnant mothers with chronic energy deficiency in Pandeglang reduced; zero number of malnourished children under five and infants; healthy and clean environment.; people are willing to change bad health practices.
22. Posyandu cadres area active; village midwives come more frequently.
23. Planning; human resources mobilization; improving practices; service improvement; scope improvement.
24. Reducing maternal mortality rate; reducing infant mortality rate; reducing poverty; improve human resources, make Pandeglang more developed and independent.
25. Healthy mothers and children; healthy and bright children; increased motivation to build own village; working together; healthy environment.
26. Posyandu becomes more active; pregnant mothers are not reluctant to check their pregnancy to midwives; people wash their hands before eating foods.

Hopes towards the workshop

1. Work plan developed; Participation of *stakeholders* increased; Optimum results; Clear *follow up*; runs as planned.
2. Project plan for the next 4-5 years is agreed upon.
3. Mutual planning for responding problems related to health of mothers and children developed; Sustainable program developed; Plan for improving health status of mothers and children developed; Mutual interpretation and steps for sustainable program reached; Vision and mission for Pandeglang Health developed.
4. More knowledge; More friends; More developed vision; Interesting activities.
5. More experience for myself; More knowledge; More friends; Very advantageous for myself.
6. Good collaboration and strong, supportive work team developed; strong commitment for program.
7. What are the objectives of the workshop?; The results of the workshop should be able to benefit community; Knowing and understanding activities facilitated by PCI; good relationship between participants and facilitators developed; Solid and strong team established.
8. Results of workshop comprehended; Able to present the results to other colleagues at Puskesmas.
9. Safe and comfortable; Processes running well; Optimum achievements; Activities agreed upon; Future planning.
10. Able to concentrate in the workshop; objectives achieved and processes run well.
11. Information understood; work plan developed; get to know PCI more closely; Know more about the conditions in the 4 sub-districts under PCI program.
12. Workshop run well; program developed; Successful
13. Community awareness on nutrition increased;
14. Get motivated to improve health of mothers and children; Getting to know potential assessment techniques; Alternative problem solving understood.
15. Get more experienced and knowledgeable on issues related to health status of mothers and children; Socialize all information on health of mothers and children obtained to community members; get to know more colleagues concerned on health of mothers and children; Get information on how to maintain health of mothers and children
16. Increase participation of community in developing posyandu plus.
17. Community to be involved in empowerment program
18. Add mote experiences in event organizing; Transfer of knowledge; Friendship; Safe; be the best.
19. Learn conditions of people; define objectives; Propose detail plan; Develop program training strategy; Develop sustainable follow up planning.
20. Learning Together; Fun; Participatory; Understanding; Build Relations.
21. Define system; Identify elements; Choose Indicators; Measure/Map; Review result, propose interventions.
22. That project work plans will be detailed that they will fully exploit the resources (human, material, others) of the community to benefit all children and men .
23. That community participation can be enhanced through CHOICE Program, inter sectoral collaboration developed; Health status of mothers and children improved.

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- **Topic I Session:** baseline survey results were reviewed through matching game aimed at enabling participants to recognize key findings of the baseline survey/assessment.
  At the end of the session, the facilitator led the participants to make comparison between results obtained from the survey and dreams they had.

- **Topic II Session:** facilitated by Michel Pacque to further explain the program sustainability framework previously introduced in Day 1:
  1) Defining the system to be assessed, its visions and goals

2) Identification of element/general objective for the local system
3) Choosing indicators and performance criteria measuring progress on determined elements
4) Measuring and mapping the status of the indicators combining the appropriate evaluation tools
5) Combining the indicators and build indices as needed
6) Reviewing result and proposing programmatic intervention [specific project objective]

From the dialogue during the session, it was revealed that materials presented are still too abstract for most participants. It was also explained that those six participatory stages have actually been practiced by the participants in their daily routines. However, further guidance on implementation management and concrete procedures were needed.

- **Ice Breaker Session:** all participants were divided into several small groups. Each groups was asked to build a tower of straws. Best group was the one with the highest tower. Through the game, participants learned collaboration and supports for achieving mutual objectives. This game was very closely related to the explanation given by Michel Pacque on the six-stages participatory process.

- **Topic III Session** is aimed at developing vision. All statements on 'dreams' made by the participants were rethought and composed into a single statement. Participants were divided into 4 small groups and asked to make one vision statement. At the end of the process, 4 vision statements were submitted. The four statements were then discussed again to make the following single vision statement.

- **"HEALTHY PANDEGLANG 2010 THROUGH BEHAVIOR CHANGES USING AVAILABLE RESOURCES"**

The next activity was determining goals to achieve by reviewing all elements of the three dimensional triangle and determining the elements to which all CHOICE Program indicators are to be included.

The Child Survival Sustainability Assessment Framework (CSSA)

Process:
• locally-driven & participatory
• action-oriented
• focused on creating conditions for sustained child health gains

Those three elements include:

First Dimension: Primary health goals of the local system

(*Note*: local system refers to stakeholders and community who determine health vision and sustainable objectives, such as: local government (district to village level), community institutions at village level, Health Section, Puskesmas, Posyandu, KHPPIA Team, PKK, etc.)

- Element 1.1. *Population Health status* e.g.: morbidity and mortality rates, nutrition status, immunization scope, etc.)
- Element 1.2. *Health and social services approach and quality* influencing sustainability of every effort to improve health status, such as: competency of health workers, outreach, effectiveness, distribution, appropriateness and comfort of service.

Second Dimension: Organizational capacity and Viability

- Element 2.1. *Local organizational capacity,* referring to organization capacity of partners to sustain their working performance (technical expertise, management, administrative and logistic procedures, human resources management, financial management, etc.).
- Element 2.2. *Local organizational viability,* or dependency profile of each partner. Dependency does not only refer to financial matters, but also to other important supports enabling partners to continue their existences or carrying out their missions.

Third Dimension: Community and social ecological system

- Element 3.1. *Community competence/capacity* , this element refer to community capacity, and the overlapping elemnts of cultural acceptance and social cohesion.

- Element 3.2. *Ecological, human, economic, political and policy environment* refers to outside influencing factor, in its general meaning, that will influence a project such as national policy related to health and education, social and political situations, environment and human resources development, freedom to access information. These elements are often, although not always, beyond reach of project, however, they should not be ignored considering their possible connection and effects to program sustainability.

- **Ice Breaker Session:** participants played a game using seats and music facilitated by Linda Morales. The number of seats used in the game should be one less than the number of participants joining. It makes one participant left without a seat when the music for the game was stopped. He/she should then say loudly one *key family practice*. The game stops after all practices are already stated.

- **Topic III Session:** participants reviewed and discussed whether CHOICE Program framework has already been relevant to program sustainability framework, especially on the question whether all elements of the third dimension have already included.

RESULTS OF IDENTIFICATION OF CHOICE INDICATORS

Dimension 1	Element 1 (Population Health Status: Nutrition, KPC) 1. % under weight (weight/age <-2 SD) children aged 0-23 months in the 30 villages 2. % of mothers with chronic energy deficiency (MUAC of <22,5 cm). 3. % stunted (height/age < -2 SD) children aged 0--23 months, in the 30 villages % of mothers who wash their hands before food preparation, before infant/ child feeding, after defecation and after attending to a child	Element 2 (Health and social services approach and quality): 1. % of health workers in the project areas received at least one supervisory visit that included observation of case management in the last six or 12 months 2. % of health workers who perform assessment, treatment and

	who has defecated. 4. % of children aged 0 - 5 months who were fed breast milk only in the last 24 hours 5. Median duration of exclusive breastfeeding increased from 1.0 month to ….. months 6. % of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment 7. % of sick children aged 0-23 months who received increased fluids and continued feeding during the illness in the past two weeks. 8. % of children aged 0 - 23 months in the 30 villages with diarrhea in the last 2 weeks who received ORS and/or recommended home fluids 9. % of children aged 0-23 months who were breastfed within the first hour after birth	counseling correctly in the management of sick child 3. % midwives have been trained on safe and clean delivery and care of premature/ low birth weight neonates and lactation management. 4. % of health providers (midwives and paramedics) in the project areas have been trained in the management of child illness. 5. % of mothers with children aged 0-23 months received at least two tetanus toxoid injections before the birth of their youngest children. 6. % of children aged 0-23 months whose delivery was attended by a skilled health personnel. 7. % of children aged 12- 23 months who are fully vaccinated (against the five vaccine-preventable diseases before the first birthday. 8. % of children aged 12- 23 months who received a measles vaccine. % of children aged 0-23 months who were weighed in the last 4 months 9. % Posyandu attended by one health provider at least once/month
Dimension 2	Element 1 (Organizational capacity in key local partners): 1. % of assigned villages in which partner NGO have implemented activities according to PCI's community based health/nutrition development model. 2. All NGO- CHOICE project's staff have been trained/oriented in community mobilization, program management, technical skills, and other skills needed for program sustainability. 3. NGO partners have already have their own specialist for health, nutrition and training that included in their own organizational structure. 4. All training at community level organized, managed and facilitated by NGO partner without supervision from PCI technical persons	Element 2 (Organizational viability): 1. No. of proposals developed by partner NGO to expand their health /nutrition beyond the Choice's project areas and or beyond the health/nutrition issues to be proposed to other funding agencies. 2. No. of proposal accepted for funding by other funding agencies to continue support communities in the CHOICE project areas or beyond the areas 3. Collaboration/partnership between partner NGO and district authority continued beyond the CHOICE project period
Dimension 3	Element 1 (Community competence/capacity): 1. % villages conducted community-health provider regular meetings (at least 2 times/year) as a mechanism for improving the quality of maternal and child health services. 2. % Posyandu attended by one health provider at least	Element 2 (Social ecological environment): 1. No of village midwives/ village birth huts run by midwives) available in the project areas 2. No. of villages in or outside sub district project areas adopted

	once/month 3. % of registered TBAs been trained Ratio of active cadre/posyandu. 4. No. of Cadre's forum established in the project areas as a place for sharing experience and update skills and knowledge on neonatal care, lactation management and appropriate home care of sick child 5. % of parents/caregivers having children aged 0-59 months, in the project areas, are actively participate in parent/ caregiver education activities. 8. No. of parent/caregivers education session facilitated by trained cadres conducted regularly in the 30 villages. 9. No. of villages with high percentage of child's malnutrition (≥ 30 %) applied PD approach for improving the nutrition status of malnourished children. 10. % of underweight children aged 6-59 months participated in CBNERP/PD sessions rehabilitated (achieve normal weight) and sustain their normal status at least 3 months after recuperation, healthy growth and development 11.% villages conducted community-health provider regular meetings (at least 2 times/year) as a mechanism for improving the quality of maternal and child health services. 12.% of registered TBAs been trained Ratio of active cadre/posyandu. 13. No. of Cadre's forum established in the project areas as a place for sharing experience and update skills and knowledge on neonatal care, lactation management and appropriate home care of sick child 14.% of fathers/men of children aged 0-59 months actively involved in parent education/Posyandu activities	integrated Posyandu and NERP/PD models to promote child survival, healthy growth and development. 3. % of HHs in the 30 villages with safe drinking water from piped or covered well (available in all year long). 4. % of HHs in the 30 villages with access to flush toilet

- **Game Session:** participants were facilitated to p lay a game called bamboo bridge. The game is simulation of a problem solving work plan. In the evening session, each group presented the results of their bamboo bridge discussion and continued by a question and answer session.

3. **Day III, 26 February 2004**:
   - **Session I:** participants worked in small groups to discuss activities of each output and determine its monitoring and evaluation. Participants were divided into three groups. Each group worked on one intermediate objective (intermediate objective No. 1,2 and 3).

     Before the discussion started, Michel Pacque provided the participants with information on how to do measurement and mapping which are the fourth and fifth of the six-stage participatory process. Michel tried to describe the results of baseline survey by showing the status of each different indicator, e.g., nutrition status is put in a low rank, while exclusive breastfeeding into the lowest rank. The result of the activity does not reflect the general health condition in the district. For obtaining more through description, all indicators should be considered. A formula is provided to do the calculation and a graph is developed to show ranks of current health statuses. The Child Survival Technical

Support team has developed a model to measure health status of mothers and children using 13 Core Assessment Tool on Child Health indicators.

CATCH - PRIORITY CHILD HEALTH INDICATORS

	CATCH 1	CATCH 2-13
Strong	5% and below	90% and above
Promising	6%–15%	75%–89%
Intermediate	16%–30%	55%–74%
Emerging	31%–45%	35%–54%
Critical	46%–100%	0%–34%

- **Presentation Session: results of group discussion**
  Group 1 (discussion of the first intermediate objective)
  - *By the end of the second year,* all midwives in the program areas will have already been trained on APN, LSS, MTBS, Lactation management, KIP/K. Monitoring and evaluation will be done through direct observation, reassessment, and post training supervision; All posyandu will be routinely visited once a month; all traditional birth attendants in the program areas will have already been trained on home-base sick children care management.
  - *By the end of the third year* Audit Maternal and Perinatal (AMP) Social Forum will have already been established in all villages under CHOICE Program; by the end of the program, polindes attended by midwives will have already been available in at least 10 villages (financially supported by PEMDA)

  Group 2 (discussion of the second intermediate objective)
  - Output 1: the activities to be carried out are training for cadres; training for traditional birth attendants; routine meeting of village PKK; small workshop at village level; KMS form printing.
  - Output 2: health training at posyandu, majlis taklim, etc. KIA materials, immunization, nutrition, pregnancy and delivery, breast care, exclusive breastfeeding, post natal care, post partum care, and child growth and development.
  - Output 3: activities include problem identification; key family practice promotion , construction of pilot watsan facilities (1 package per neighborhood), providing seeds for family herbal plants, socialization of use of home yard for farming for own consumption.

Group 3 (discussion of the third intermediate objective)

- Training for Trainers (TOT) for field staff on health of mothers and children, nutrition, environmental health, prevention and treatment of diseases, and posyandu revitalization. By the end of the third year, NGO partners have already had staff specializing on health, nutrition, and training, reflected on the NPG partners' organizational structure.
- Training on communication, monitoring-evaluation and organizational management. Output expected is all staff has already been trained on community mobilization, program management, and technical skills according to each staff's field responsibilities to guarantee program sustainability. By the end of the third year, it is expected that all trainings at community level will already be organized, managed, and facilitated by NGO partners without PCI's supervision.
- Advocacy to the local government to ensure continuation of the collaboration between NGO partners and the local government even if CHOICE program has been completed.
- Proposal development: output --> before the program is completed, NGO partners have already secured funds from other organization to continue development programs in the villages currently under CHOICE program or beyond.
- Workshop to identify local NGO in Pandeglang district concerned on health and training for local NGO. Output --> before the program is completed, NGO partners have already built collaboration with 25% of the available local NGOs.

Closing Session, facilitated by dr. Agustini Raintung to make an emphasis on the need of further information from the community regarding their income, health expenditure, complains, health practices, as well as the techniques to collect that information.

Information to be obtained from the community:

1. Per kapita income
2. Health expenditure
3. Complains
4. General practices of mother and child care
5. Geographic conditions
6. Available human resources/key person
7. Census data

Sources of information/collection techniques:

1. Data from cadres
2. FGD/Survey
3. FGD/Survey
4. FGD/Survey
5. Village
6. Village
7. Census

Follow up planning

1. FGD/further survey
2. Data inventory and analysis
3. Prioritizing of activities to be conducted
4. Implementation
5. Monitoring and evaluation

Follow up meeting

1. Technical team meeting
2. Program orientation at district and sub district levels
3. Distributing meeting resumes

The workshop was officially closed by Ms. Indah, Head of Social and Cultural Section of RDPB, on 26 February 2004 at 15.00. After all participants were dismissed, the organizing committee (and facilitators) had a feedback session with PCI/IO's Technical Officer for Maternal and Child Health - Linda Morales and CSTS representative - Michel Pacque.

WORKSHOP EVALUATION BY PARTICIPANTS

Participants were asked to write their opinions on what they like and dislike about the workshop:

- Management of workshop and the materials presented were valuable and interesting
- Participants became more knowledgeable and their vision were enhanced
- A participant complained some activities started or finished not in accordance with the schedule.
- Two participants said that the reimbursement of their transportation expense was too small.

There was also a comment stating that the implementation plan of CHOICE Program is too ambitious and may not be applicable for Pandeglang district.

Attachment 1: Health Service Overview

The following picture provides an illustration of malaria. The hippopotamus is supposed to be the malaria cases. Only < 20 % cases are treated: <5 % patients are hospitalized and later die and about 15 % get medication from health facilities such as hospital or pharmacies, etc. The rest, > 80 % (the hippo part under the water) are treated at home by taking medicine bought at medicine stores.

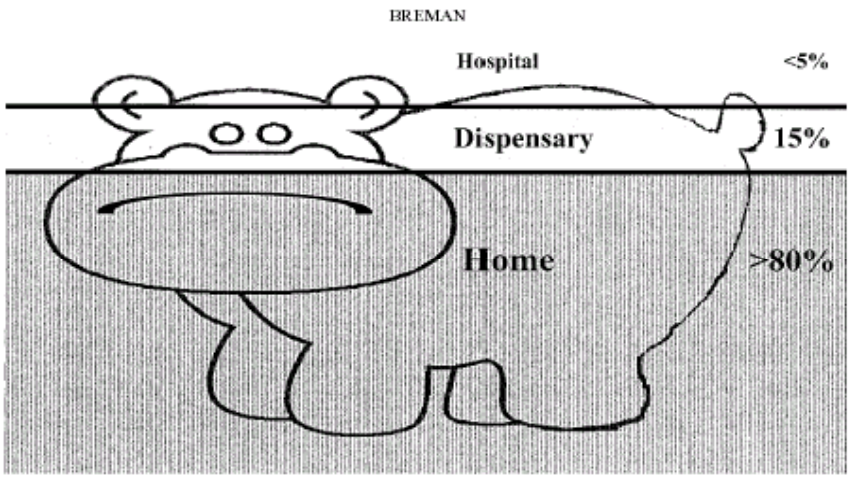
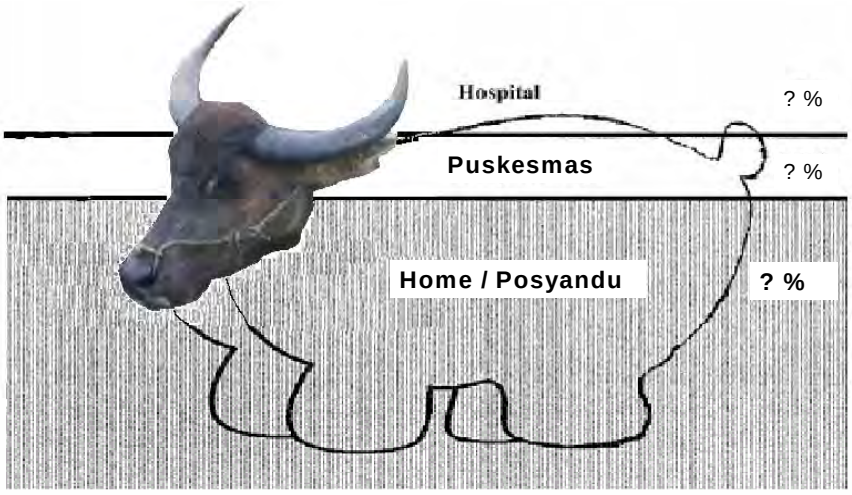


FIGURE 6. "The Ears of the Hippopotamus" where malaria patients are managed . . . and die.

In Indonesia, health problems may be illustrated using the following buffalo drawing. The question is: If children are sick, who will give treatment? How many percent of them will be taken to Puskesmas or hospital? And how many of them are treated at home?



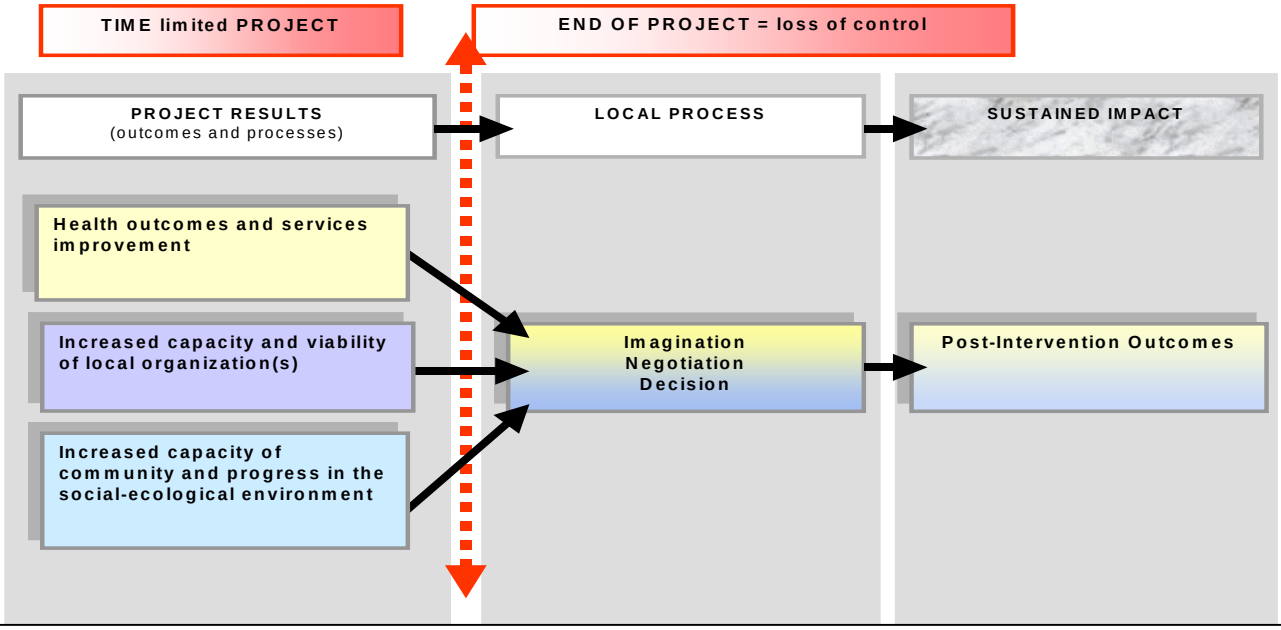
The horns of the buffalo: who takes care of our sick children?

Attachment 2: Steps in the Participatory Process of Evaluation Plan Development

STAGE 1 - Define the System to be assessed and its goals

1. Define the *level of the assessment* (who, where)
2. Develop a *vision* of sustainability with all stakeholders
3. Define *goals* that encapsulate the vision

A project contribution: improving the ***ability*** to ***sustain***



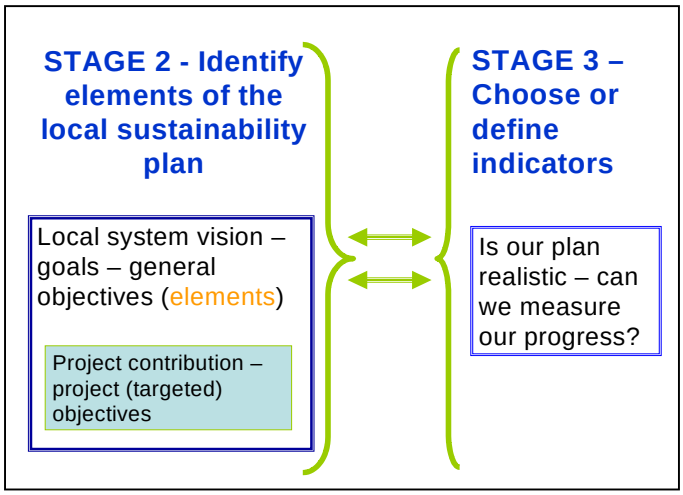
From the above chart, it can bee concluded that each project has a time limit which means that when the project ends, its continuity cannot be guaranteed. However, using the three-dimensional program sustainability framework that involves local processes, a program can be continued even when the time limit has ended.

Vision building:

Why building a common vision is important?
So that …:

- All plans are inter-connected and integrated.
- Sense of belonging can be built
- Working consensus is developed
- Direction is clear

Second and third stages:



- Second stage:
  Identifying elements of program work plan by relating program vision and goals and determining contribution made by the program.

- Third stage:
  Choosing or determining appropriate indicators. The question to ask: Is our plan realistic and able to measure the program achievement?

Fourth Stage: Measuring and mapping the indicators
The following is sample of measurement and mapping of indicators of child health priority obtained from KPC survey in 4 sub-districts in Pandeglang district.

CATCH - PRIORITY CHILD HEALTH INDICATORS

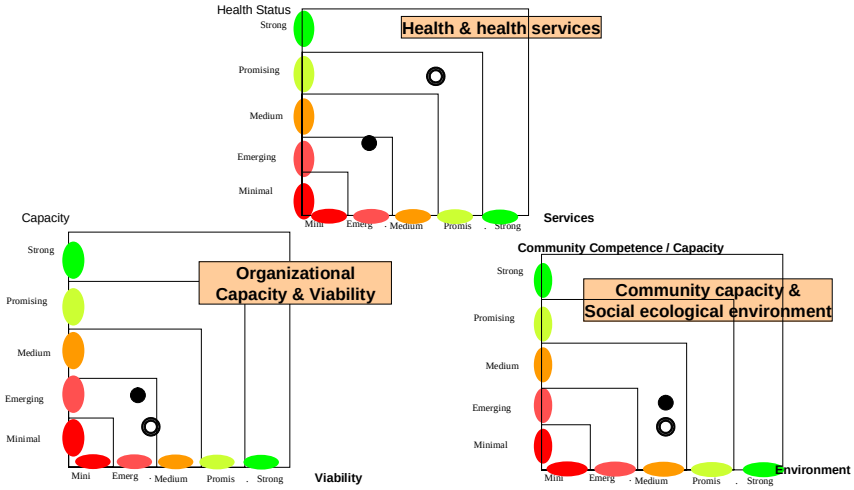
1. Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**23.50%**
2. Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	**92.90%**
3. Percentage of children age 0–23 months whose births were attended by skilled health personnel	**15.80%**
4. Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**68.70%**
5. Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	**48.50%**
6. Percentage of children age 6–9 months who received breast milk and complementary foods during the last 24 hours	**89.00%**
7. Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**51.10%**
8. Percentage of children age 12–23 months who received a measles vaccine	**61.70%**
9. Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night	**0%**
10. Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection	NA
11. Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defection, and after attending to a child who has defecated	**1.30%**
12. Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	**28.70%**

13. Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	**73.40%**

Fifth Stage:
Combining all indicators and mapping results to determine the indices.

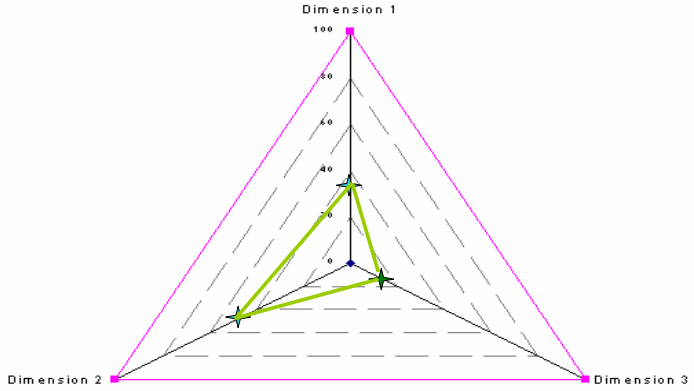
Communicating a complex question:

"how much progress are we making on sustainability?"



Identifying programmatic and policy questions strategically

"where are the fracture points?"
"who needs to do what about it?"



Information-Decision-Communication

13. Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks	73.40%
4. Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	68.70%
1. Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	23.50%

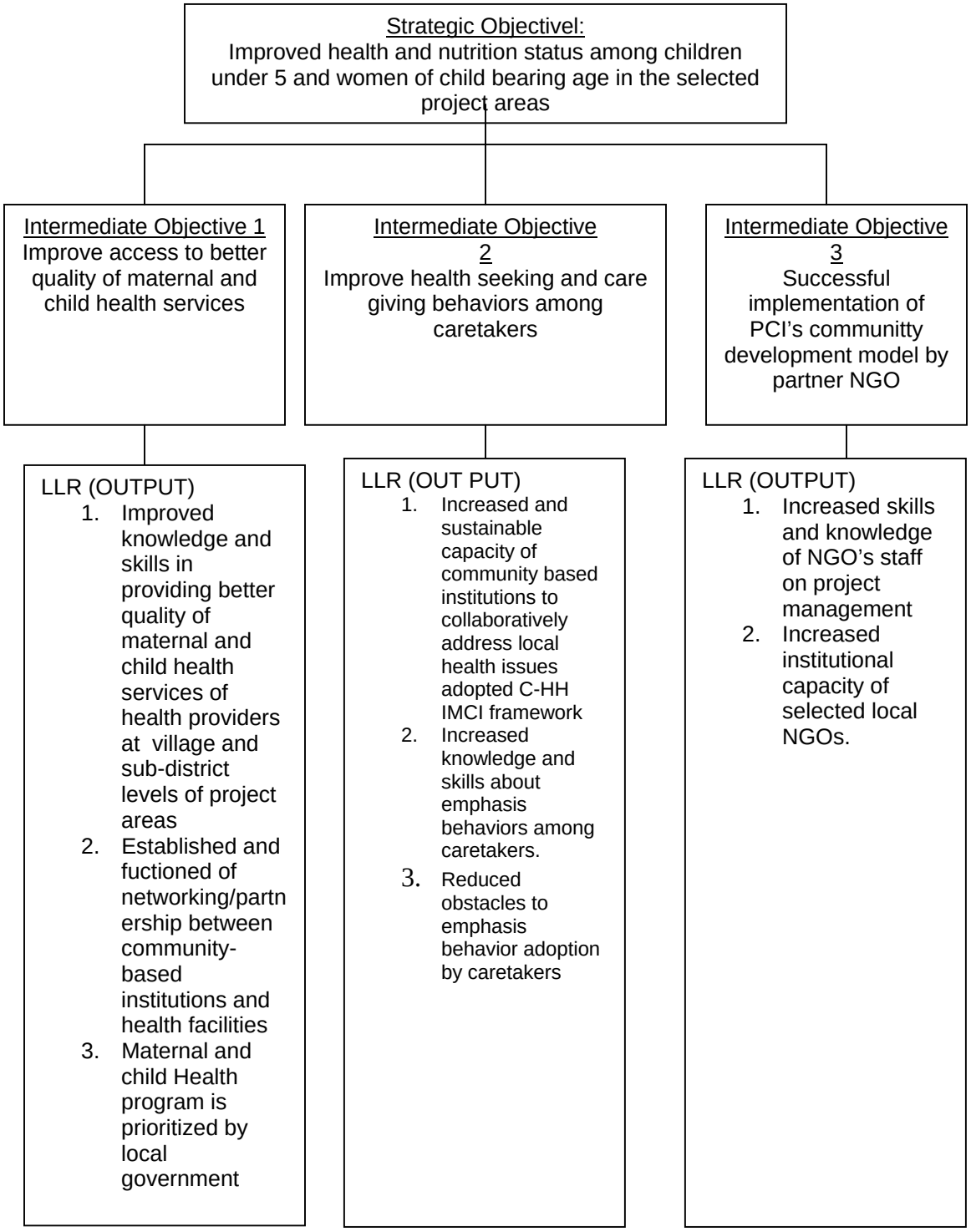
Composite measures	Specific indicators
Understandable data	Reliable data
Concise information "Big picture"	Detailed information
Strategic decisions	Tactical decisions
Communication	Analysis

Evaluation & Communication Tool

- **Evaluation = Information**
- **Information is made to be used:**
  - **Decision**
  - **Communication**
- **Present the information in the format that serves the purpose for which it will be used**

Sixth Stage:
Reviewing the results and planning program intervention to address problems.

Attachment 3: CHOICE Program Objectives



Attachment 4: Bamboo Bridge Game

Procedures:
- Participants are divided into 4 small groups. Grouping is done by throwing lots. Previously, the facilitator prepares lots as many as the number of the participants. The lots have been written with either *government, mother, midwives,* or *children*. Each participant gets one lot. Participants with the same lots form a group.
- Each group sends one of its member to pick a pair of pictures and listen to the facilitator's explanation. One picture is to be placed on 'Problem' and another one on 'Objective'. Each group is to discuss steps to take to solve the problem and achieve the objective using the available resources.

Results of discussion:

Group 'Mother' (1)
Problem: The child does not get exclusive breastfeeding

Steps	Resources
- Socialization of exclusive breastfeeding through a meeting at village levels attended by all related people. - Socialization of exclusive breastfeeding to cadres and traditional birth attendants - Socialization of exclusive breastfeeding to pregnant women - Demonstration of breast care for pregnant women (Antenatal Care) - Socialization of balance nutrition for pregnant women and breastfeeding mothers - Visit and observation to postpartum mothers and breastfeeding mothers	- Village Head and staff - Village or religion prominent people - Cadres - Traditional birth attendants - Village midwives - PPL - PKK - Breastfeeding mothers, Pregnant women, postpartum mothers - Suami Siaga (alert husband) - House yards - Papaya and katuk seeds - Posyandu center

Objective: The child get exclusive breastfeeding

Group 'Midwives' (2)
Problem: Ratio of posyandu to cadres: Saketi 1 posyandu to 3 cadres, Pagelaran 1 posyandu to 2 cadres, Patia 1 posyandu to 6 cadres, angsana 1 posyandu to 2 cadres

Steps	Resources
- Problem identification - Socialization of posyandu roles and support needed from cadres - Inventory and recruitment of new cadres - Training for new cadres and refreshing for senior - Facilitation, monitoring and evaluation	- Senior cadres - Village community - Village staff - Puskesmas, candidates of cadres, PKK, NGOs, community informal leaders - Health workers, related institutions

Objective: Active cadres is sufficiently available

Group 'Children' (3):
Problem: Children suffer from **marasmic** and **kwashiorkor**

Steps	Resources
1. Prevention a. Exclusive breastfeeding and breastfeeding till second year b. Use of house yards for fulfilling needs of nutritious foods for family c. Complete immunization d. Community participation in posyandu 2. Rehabilitation a. Case identification b. Referral c. Food supplement program d. Positive Deviance e. Management of malnutrition at Puskesmas or hospitals	- Health workers and cadres (as counselors and resource persons) - Land, seeds, fertilizers - Vaccine stock, immunization specialists, and posyandu - Health workers, cadres, posyandu, community, KMS, weighting equipment, etc. - Contraception, family planning personnel - Posyandu cadres, health workers, community and informal leaders. - Posyandu cadres, puskesmas - Food supplement program from government - Cadres, community, informal leaders, health workers, - Doctor, nurses, nutrition specialist, hospital/Puskesmas, received protocols

Objective: Healthy children

Attachment 5: DETAIL ACTIVITIES OF MOTHER AND CHILD HEALTH PROGRAM IN FOUR SUB-DISTRICTS UNDER CHOICE PROGRAM

Intermediate Result 1

1.1. By the end of the second year, 100% health workers (midwives and nurses) have already been trained on APN (11 people), LSS (13 people), MTBS (26 people), Lactation (26 people), KIP/K (17 people).

Data on the coverage of Training of Moternal and Child Health

Sub district	Midwives	Safe and clean delivery	LSS	IMCI	Lactation management	IPC /counseling	Notes
Saketi Pagelaran Patia/Perdana Angsana	10 5 8 3	6 0 7 2	5 0 0 3	0 0 0 0	0 0 0 0	2 1 4 2	Not all health workers have got training
Total	**26**	**15**	**13**	**0**	**0**	**9**	

[Output 1]

Steps:

1. Preparation of training (team meeting)
2. Implementation of training (APN 12 days, LSS 12 days, MTBS 14 days, KIK/K 6 days and lactation 14 days) including theory, laboratory, simulation, and field practice.

Monitoring and evaluation:

- Training for Midwives
- Direct observation
- Reassessment
- Post training supervision

1.2.1. All posyandu is routinely visited once a month by a health staff

Data on Number of Visits to Posyandu

Sub districts	Number of Midwives/ nurses	Number of Posyandu	Number of Cadres	Cumulative number of visits
Saketi Pagelaran Patia/Perdana Angsana	10 5 5 2	36 37 16 12	101 83 89 21	30 days 10 days 7 days 7 days

[Output 2]

Steps:

- To improve knowledge and skills of cadres in carrying out posyandu activities, a training (refresher training) needs to be organized.

Monitoring and evaluation

- Direct observation on number of visits made by cadres to their posyandu

1.2.2. 98 traditional birth attendants in 4 CHOICE Program working areas have received training on home-base sick children care management and on lactation management during the first month of the third year

Sub district	**Number of traditional birth attendants**	**Training already received**			**Number of traditional birth attendants untrained**		
		Lactation	**Care of newborns**	**Care of sick children at RM**	**Lactation**	**P.BBL**	**PBSR**
Saketi	26	0	20	0	26	6	26
Pagelaran	23	0	21	0	23	2	23
Patia	15	0	15	0	15	0	15
Angsana	24	0	24	0	24	0	24

[Output 3]

Steps:

- Training on home-base sick children care management
- Training on lactation management

Monitoring and evaluation:

- Direct observation
- Partnership between traditional birth attendants and midwives
- Delivery coverage scope

1.2.3. By the end of the third year AMP Social Forum will have already been established in 30 villages under CHOICE Program

[Output 4]

Steps:

Providing community information on:

- "4 too" and " 3 lates" as well as signs of risks during pregnancy, delivery and postpartum
- Case auditing (social autopsy)
- Establishing suami siaga ("alert" husband)
- Establishing warga siaga (alert community)
- Health promotion

Monitoring and evaluation:

- Direct observation of social autopsy
- Presenting the result of social autopsy

1.3. By the end of the third year polindes attended by midwives will be available in at least 10 villages (financially supported by local government)

[Output 5]

Steps:

Proposing to Pandeglang district government to provide:

- polindes in 30 villages (gradually through the year of 2007)

- 4 midwives to be stationed in villages currently without village midwives

Monitoring and evaluation:

- By existing local government team

Resources:

1. Local government at provincial and district levels.
2. Local government at sub district level
3. Local government at village level
4. Prominent female and male community and religious leaders
5. Families
6. Village youth union
7. Midwives and nurses
8. Cadres
9. Traditional birth attendants
10. Posyandu

Intermediate Result 2

[Output 1]

Activities:

- Training for cadres and Community Empowerment Institution members
- Training for traditional birth attendants
- Routine village PKK meeting
- Village administration workshop
- KMS printing

Resources:

- Community, village midwives, community and religious informal leaders, head of village, staff of village authority, village PKK members

Monitoring and evaluation:

- Sub district and district KHPPIA Team, once in three months

[Output 2]

Activities:

- Socialization at specific places such as posyandu or majelis taklim (religious activities) on health of mothers and children, immunization, nutrition, pregnancy and delivery, breast care, exclusive breastfeeding, neonatal care, postpartum care, and child growth and development

***Resources*:**

- Village midwives, community, village authority staff, existing local NGOs, informal leaders and cadres

Monitoring and evaluation:

- Sub district and district KPHIA Team, once in three months

[Output 3]

Activities:

- Problem identification
- Socialization of key family practices
- Construction of pilot watsan facilities (1 model per neighborhood)
- Providing seeds of herbal plants to community
- Promoting farming for family consumption

Resources:

- Community,
- Community self-help, seeds of medicine plants
- Farms, neighborhood health worker
- Cadres

Monitoring and evaluation:

- Sub district and district KHPPIA Team, once in three months
-

Intermediate Results 3

Resources	**Activities**	**Outputs**	**Monitoring and evaluation**
Staff of NGO partners and Health Section/Dept. of Health;	First Year TOT for NGO partners on - Health of mothers and children - nutrition - Environmental health - Prevention and eradication of diseases -BKB Kemas - Posyandu revitalization	**Output 3.1** By the end of the third year, NGO partners have already had staff specializing on health, nutrition, and training, reflected on the NPG partners organizational structure	Development of monitoring and evaluation tools for training process Development of monitoring and evaluation tools for follow up training
Instructors/ Consultants	Training on communication, monitoring and evaluation, organizational management	**Output 3.1** All staff have already been trained on community mobilization, program management, technical skills (according to each staff's field responsibilities) to guarantee program sustainability **OP.3.1** By the end of the third year, all trainings at community level will already be organized, managed, and facilitated by NGO partners without PCI's supervision	

Sub district and district KHPPIA Team NGP partner staff Professional organization PCI	Advocacy; year I, II, III Seminar I ;year IX Socialization I RTL IV	**Output 3.2** Before CHOICE program ends, collaboration between NGO partners and the local government is maintained for health and nutrition programs as well as for other programs concerning children and women	Project report, monthly, three-monthly, semester Yearly evaluation Midterm review
NGO Partners Community Cadres Stakeholders	Proposal development, year IV Assessment of local resources, III Workshop on resources management (Intern); IV	**Output 3.2** Before the program is completed, NGO partners have already secured funds from other organization to continue development programs in the villages currently under CHOICE program or beyond	End program review Developing instruments for monitoring and evaluation
NGO partners Local NGOs	Workshop Identification of local NGOs concerned about health Training of local NGOs	before the program is completed, NGO partners have already built collaboration with 25% of the available local NGOs	

Annex 5E

Terms of Reference Posyandu TKA

DRAFT
TERMS OF REFERENCE
INTEGRATED CHILD SURVIVAL, GROWTH AND DEVELOPMENT PROGRAM THROUGH POSYANDU TUMBUH KEMBANG (POSYANDU TKA)

I. Background

Survival, growth and development in the earliest years of life are fundamental for the future of every individual and for the future of the societies into which those individuals are born. The Convention on the Rights of the Child clearly states that every child has the right to : survival and development; an adequate standards of living; the highest attainable standards of health and effective health services and special care if she or he is disabled, that ensure dignity, promotes self reliance and facilitates active participation in the community. The article 24 of the CRC specifically defines the right of the child to health and health care, therefore the state parties should take appropriate measures to pursue the full implementation of these rights including : to diminish infant and child mortality,; ensure the provision of necessary medical assistance and health care to all children with emphasis on the development and primary health care; combat disease and malnutrition; and to ensure that .parents and children have access to education and are supported in the use of basic knowledge of child health and nutrition , the advantage of breastfeeding, hygiene and environmental sanitation, and the prevention of accidents.

In the mid 1970s, a community based program to address nutrition problems was launched in Indonesia and later, in 1984, has been transformed into Posyandu that provides basic preventive health to support the survival and optimum growth of the children, including family planning, antenatal and post natal cares, immunization, vitamin A supplementation, and growth monitoring. In 1989 the posyandu was implemented by almost every village in all 27 provinces in Indonesia (Sukirman et al, 1992), but it began decline in its coverage and attendance from early 1990s.

A dramatic decline in the last five years of posyandu service quality and utilization activities, was shown by the 2002 Indonesian Family Life Survey, with a child growth monitoring drop from 50 % to 36 % from 1997 to 2000 and the availability of supplies and instruments for

posyandu declined over the period; for example, availability of KMS (Growth Monitoring Cards) dropped by 24 %. . The Unicef/UNHAS evaluation of Posyandu performance and client satisfaction carried out in the West Sumatra, East Java and South Sulawesi in 1999/2000 showed a drop in posyandu services, utilization and quality. Their findings suggested limited standardization and quality assurance of training, competencies and performance of tasks by the volunteer community health worker (kaders) who work at Posyandu. In addition, only between 11 % to 27 % mothers reported receiving any orientation from the kaders or anyone else. These statistics confirm anecdotal reports of a significant decline in Posyandu quality and utilization over the last decade. Key elements appear to be a shift in consumer preferences, fewer villager residents being prepared to volunteer and general decline in quality. On the other hand, the addition of health and family planning services has increased medicalization that brought dependence on the Puskesmas and less ownership and control by community. These results confirm the CHOICE baseline survey conducted in the 30 villages, where each posyandu is only served by 2 kaders in average, with insufficient guidance from the Puskesmas staff to ensure their competence in providing posyandu services. Kaders and village leaders also reported that many of Posyandu in the project areas were collapse after leaving by the Puskesmas staff and mothers felt not necessary to take the children to posyandu if they come there only for weighing.

In 1998,UNICEF commenced a posyandu revitalization project with support from USAID. The activities included kader's training, provision of supplies and supplementary foods (e.g. Vitadelle). Andecdotal reports suggest that this had limited success and show that Posyandu is still appropriate in some places and need alternative approach for better results.

Rationale of developing Posyandu TKA model

Early years, at birth to 3 years are critical for the survival, growth and and development of the children. The children have different needs at different stages during the early years. During the first year of life the child is at the greatest risk of mortality. Mostly childhood illness are preventable and treatable . For examples, Child mortality can be reduced by over 20 % by improving intake of vitamin A through diet or supplementation, measles death can be prevented by immunization before the age of one year, the death caused by ARI can be avoided by timely

and appropriate care seeking combine with adequate treatment, child death caused by watery diarrhea can be prevented by correct home care applied by mothers/caregivers and improving hygiene practices.

During the late infancy or when complementary foods are introduced, and during the toddler period, the child is at greatest risk of growth faltering. As proven by some researches, malnutrition is associated with more than 50 % of child death. Improving breastfeeding alone could reduce the number of child death by more than 10 % .Improved complementary feeding prevent more than 10 % of death from diarrhea and ARI and reduce the prevalence of malnutrition by over 20 % and increase resistance to measles and other illnesses. Although lack of family resources may be a factor, in most places malnutrition is caused by feeding practices.

In term of brain development, researches on molecular biology have also indicated the important influences environmental or external factors can give to the development of human brain, far exceeding what has been known before.

a. Brain development during the first year of age is far more rapid and extensive than earlier estimated. The first months after birth are critical periods for brain maturity. During the period, number of sinaps – that enable human beings to learn – is growing 20 times more.
b. Environment or external factors such as nutrition, health condition, attention and stimulation are in fact more influential to the development of brain, especially during the first 18 months of life, than earlier estimated. Children born to a ‘poor’ environment may be posed to irrevocable deficiency conditions.
c. Impacts of environmental/external factors to the development of brain during early childhood will stay forever. Good nutrition, stimulation, and interaction experiences with other people during early childhood will give positive impacts to brain function.

Evidences have also revealed negative impacts of stress during early childhood to brain function. Stress on early childhood can pose risks to child cognitive, behavior, and emotional development.

In addition, underneath are several evidences showing the importance of an integrated intervention program (nutrition, basic preventive health, stimulation, interaction and education) for children during their early childhood periods.

a. Children brought up by parents/caregivers, who give their full attention and are able to develop meaningful interaction with their children, will be better fed and suffer less from diseases.
b. Investment made to early childhood programs through increasing nutrition and health status of children and providing opportunities to obtain stimulation, interaction and education during early childhood periods will provide future economic return for the children concerned and the community in general.
c. Loving relationship developed between parents/caregivers and their children since early childhood can give impacts to the ability of children to love and develop relationship with others in the future.
d. Longitudinal studies show that integrated intervention during early childhood period will give long term impacts to children' basic learning skills. This is observable in the increase of school attendance and performance besides the decrease of repetition rate in grade 1 and 2 and decrease of teenage delinquency and pregnancy.
e. **Education program for parents/caregivers will create a double impact: the benefits can be enjoyed by children currently under their care as well as by children born in the future.**

The above-explained evidences can pose a challenge for all related stakeholders to develop programs to support the realization of child rights and creation of quality and healthy human resources

Realizing that survival and growth because of good health and nutrition are necessary but not sufficient building blocks for the optimal development of children and refer to basic principle outlined in the WHO constitution stated that the healthy development of the child is of basic importance and health is a state of complete physical, mental and social well being and not merely the absence of disease infirmity, PCI is trying to combine basic preventive health intervention with the rehabilitation of malnourished children applying positive deviance

approach and stimulation of psychosocial and cognitive development in the Posyandu. While these combined nutrition and psychosocial interventions for earliest years (at birth to 3 years) has been proven had significant impact on both growth and development in every study that tested this relationship, PCI will prove the hypothesis that this model can also increase the utilization of posyandu, increase kader's competence and increase community ownership. Under the umbrella of Posyandu, the community will be intensively capacitated for sustainable behavior changing to support the survival, healthy growth and development of the children.

II. Program Strategy

Combined basic health preventive intervention with nutrition rehabilitation and child stimulation applying positive deviance approach developed by Project Concern International (PCI) is primarily aimed at ensuring child survival and optimum growth and development, especially during prenatal period and before the age of three. An assessment will be conducted prior to this intervention to analyze : good existing care giving practices and how they could be built upon, the contents of care giving messages should be emphasized and how best to communicate messages

There are two services planned to be delivered in this program:

1. Home-based services: to be performed by parents/caregivers within household environment.
2. Center-based services: offered in community based service centers (Posyandu TKA) by well-trained cadres in collaboration with parents.

The following are the implementation strategies designed to support optimum early childhood growth and development of children in PCI working areas:

1. Working with parents and caregivers

Learning from indigenous practice and local wisdom, each children need ASUH (caring), ASIH (loving) and ASAH (stimulating) Aspects of caring, loving and stimulating include:

Caring

- Fulfilling sufficient and balance nutritious foods (including exclusive breastfeeding and continued breast feeding until 2 years)
- Practicing and educating children on healthy and hygiene life practices
- Prenatal and post-partum care (including family planning) as well as new born care
- Providing protection from preventable diseases by immunization and creation of clean and healthy environment
- Recognizing signs of various diseases posing risks to children during their childhood (including prevention, seeking medical assistance, and caring sick children at home)

Loving

- Providing love, attention, affection, comfort, safety
- Protecting from physical and psychological abuses

Stimulating

- Helping and knowing grow and development delays on children
- Interacting with children and providing stimulation for children in order to help them developing their potentials (physical, mental, emotional, social and spiritual).
- Providing opportunities for children to socialize with others
- Providing opportunities for children to attain education to the highest level according to their abilities and interests.

Children between 0-3 years of age are usually taken care of by parents/caregivers in their own household environment. In this culture (Eastern culture), a child is looked after not only by his/her biological parents, but also by other members of his/her extended family, such as grandmother, grandfather, uncle, aunt and the older brother or sisters. For that reason, PCI believes that intervention should not only be directed to biological parents but also to other family members involved in childcare. Each parent/caregiver is expected to have sufficient knowledge and skills to apply proper caring patterns to ensure child survival and optimal growth and development. As used by UNICEF, the term “care” is defined as the integrated set of actions that ensure for the children the synergy of protection and supports for their health,

nutrition, psycho-social and cognitive aspect of development. Therefore "care" is one of the key factors in the promotion of children's survival, and optimal growth and development. Increase of knowledge and skills of parents/caregivers will give positive influences to their caring, loving and stimulating patterns and will be sustained not only for the existing children but also for the next children be born in the future.

This approach is aimed at increasing awareness and knowledge of parents and caregivers about child health, nutrition and development milestone and increased their capacity to support and stimulate child growth and development . Education for parents/caregivers of children under three will be carried out using "adult education approach", in a regular manner (such as once a week), in various settings/places, and in small groups under guidance of trained cadres. Three books have been developed and used by PCI- CHANCE's project and will be used by kadres as manuals to conduct the education program for parents/caregivers.

a. *Flip chart book series 1: Child's care for optimum growth and development (Buku Lembar Balik Asuhan Dini Tumbuh Kembang Anak Seri 1: Pengasuhan dan Perawatan Agar Anak Tumbuh dan Kembang dengan Sehat).*
b. *Flip chart book series 2 : Healthy behaviors and Safe and Clean Environment (Buku Lembar Balik Asuhan Dini Tumbuh Kembang Anak Seri 2: Perilaku serta Lingkungan yang Bersih Sehat dan Aman*.)
c. *Flip chart book series 3 : Parent/Caregiver's Role to Make Children Healthy, Active and Smart (Buku Asuhan Dini Tumbuh Kembang Anak Seri 3: Batita Sehat, Lincah dan Cerdas Berkat Bimbingan Orang Tua*t).

In addition to those books, the following relevant sources can also be used:

a. Maternal and child health book (Indonesian Ministry of Health and JICA).
b. *Child Health, series : manual for kader (Kesehatan Anak, Seri Pedoman Bagi Kader,* Indonesian Ministry of Health).
c. *Flip chart book : Staple Foods and Balance Nutrition (Lembar Balik : Makanan Pokok dan Gizi Seimban,* WVI and USAID)
d. *Poster card : Guidance to Better Health and Developmen t(Kartu Peraga : Panduan Menuju Kesehatan dan Perkembangan anak yang lebih baik*.(WVI and USAID).

e. Etc.

Through education/ sharing experience sessions, parent/caregivers gathering will have opportunity to learn new experiences, knowledge and skills from trained kaders, their peers and or other resource persons that is possible to be invited to share their experience and knowledge through this activity. Increased awareness, skills and knowledge in child care will increase parent/caregiver's demand for seeking proper health services for both prevention and treatment.

2. Integrated services

To achieve optimum growth and development, a child needs sufficient nutrition; hygiene, healthy and safe environment; protection from diseases and injury or accidents; protection from psychical and psychological abuses; care and love; stimulation and opportunity to interact with others. Therefore, an intervention must be integrated involving the following services:

- Health (especially basic preventive health) and Nutrition
- Mental/psychosocial stimulations

In addition, clean water supply and improvement of sanitation facilities will be encouraged to eliminate barrier for adopting key family practices related to hygiene and sanitation.

Services are provided in form of various activities under Posyandu (Posyandu TKA). Posyandu – expected to be "Child Growth and Development Center" – provides services including:

- Basic preventive health for mother and children : **growth monitoring (weigh taking), immunization, vitamin A supplementation, family planning and antenatal and post natal cares.** Growth monitoring will be done once a month, but the children who did not come at the date of weighing posyandu will give parents/caregiver opportunity to weigh the children in the date when the parent/caregiver education and stimulation activities is conducted. If possible the project will encourage the DHO to distribute UNISCALE that provided by UNICEF to be used in the CHOICE's pilot Posyandus. The easy use of this scale will enable parents/caregivers to weigh their children by themselves with or without kader's help. The project will encourage the village head and apparatus to coordinate meeting with kaders, Puskesmas staff, Women Welfare Movement Team, Village Representative

Board, Community Empowerment Institution, TBAs and community/religious leaders to develop plan for "village immunization weeks" at least 3 times a year to improve the immunization coverage for children and pregnant women.

- Nutrition rehabilitation for malnourished children using "positive deviance " approach. Each session will include a center based activity with active involvement of parents/caregiver under facilitation of trained kaders in 12 consecutive days and followed by 2 weeks home based implementation of new skills and behaviors.
- Development stimulation along with education for parents/caregivers on childcare as well as physical, mental, psychosocial stimulation (teaching, loving, caring) → especially directed to children aged 0 - 3 years. Parents/caregivers directly put into practice ways to interact with their children and perform stimulation activities for their children, such as washing hands, active feeding, baby massage, stimulate children to crawl, stand up and walking, playing together with their children, etc. under guidance of trained cadres. During the session, parents/caregivers can also share their own ideas and experiences with others. The short interval at least twice a month for this session hopefully can give great impact in parents/caregivers behavior's changing.
- De-worming medication every 6 months , started by the age of 4 months and supply of iron syrup for the anemic children. The project will strengthen partnership between Posyandu/community based institutions to enable them have easy access to anti-worm drug and iron supplementation. Kaders will also taught on how to identify anemic children through observing palmar pallor.
- Supply of iodine capsules in severe and mild goiter endemic areas.

To support these above services, Posyandu TKA is ideally equipped with stimulation facilities and aids, such as: education play equipments, materials for exercising fine and gross motorics, language abilities and intelligence.

These kinds of services hopefully attract parents/caregivers as well as the children to attend Posyandu activities and actively participate in the comprehensive services. Trained TBAs are also encouraged to participate in parent education, distribute iron supplementation for pregnant women and vitamin A for post partum women and if allowed by Puskesmas they can do

physical check up for pregnant women. As the services are mostly provided by trained community volunteers (kaders and TBAs), except for clinical based health services such as immunization and injectable contraceptive administration, the posyandu will no longer depend on the Puskesmas staff attendance.

3. Focusing on rural and urban 'poor' community groups

Integrated programs involving health, nutrition, mental/psychosocial services specifically directed to children under three (0-3 years) and early childhood education programs for pre-school children in Indonesia are not many. If available, those services can only be accessed by few children of upper or middle economic levels, usually the haves or village elites. As a consequence, rural children or children of the poor (in reality, these very children need the services most) stay marginalized. Both home-based and center-based services are designed to ensure those children "survive" and have opportunity to develop their physical, social, intellectual, and emotional capacities.

4. Strengthening existing community-based health service institutions

Posyandu is a popular form of community-based health service throughout this country. Initially designed and developed to be managed and owned by community, Posyandu has recently been perceived to belong to Puskesmas (Public Health Center) or health officers. The consequence is clear. Many Posyandu are now inactive because Puskesmas officers do not bother to make a visit or create activities. Furthermore, kadres are lack of self-confidence and capability to transfer their knowledge to parents/caregivers. So far, Posyandu is only for weighing children without parents/caregivers ever understood what taking weigh is for. Growth Monitoring Cards (KMS) that has been designed to monitor children growth cannot be used, as KMS is not distributed to parents/caregivers. Because of lack of knowledge or ignorance of community and field workers, many children with health, nutrition, or development problems cannot be appropriately and quickly served.

Community participation is the key for the success of this intervention. Efforts to empower community to be able to recognize problems, plan problem solving strategies, as well as mobilize, use and manage resources/funds should become the main focus to ensure program sustainability. Community will also be strengthened and capacitated to enable them implement this program. This process hopefully will build community ownership of this program. Once the community feel that the Posyandu TKA as their own program and has proven give great impact for their child health, growth and development, community will be motivated to self financing their project.

Series of trainings will be conducted for community volunteers/ Kaders as they must be first strengthened and capacitated to enable them to conduct education program for parents/caregivers A participatory training module for kadres has been developed and tried out in PCI working areas in West Sumatra and Jakarta. After the completion of training, kaders are expected to socialize this program to create demand and obtain support from parents, community members and leaders to initiate activities in the project areas. A competency based approach through formal and informal trainings will be implemented to ensure kader's competence and improve the quality of their services to the community.

The high competence of kader will improve the quality of their services in Posyandu TKA and will increase satisfaction and trust of the parents/caregivers and other posyandu's target group that will in turn will increase the utilization of Posyandus.

5. Involvement of all active stakeholders: district, sub-district, and village levels

Early childhood intervention should be carried out in integrated ways and become the responsibility of all stakeholders involved. Local government and other stakeholders should be made aware of the importance of early childhood intervention to improve the quality of human resources. PCI is to promote coordination among related institutions such as Health Department/Puskesmas; Family Welfare Movement Team (PKK); Education Department (Early Childhood Education Division); Population, Family Planning and Civilian Registrar Office,

Agriculture Department, *Badan Pemberdayaan Masyarakat* (*Community Empowerment Council*), etc. to help synergizing resources and funds to ensure sustainability of this program.

At the village level, Puskesmas staff is encouraged to take responsibility to examine the children with severely malnutrition and or the children who failed to gain significant weight in 2 consecutive months during nutrition recuperation.

III. Technical procedures for implementing Posyandu Plus Program

To enable children grow and develop optimally, parents/caregivers must possess ample knowledge and skills to apply caring, loving and teaching patterns correctly and appropriately. Therefore, "parent/caregiver education" should be a primary priority within Posyandu TKA program.

Design of activities

1. Session for education and nutrition improvement (special for malnourished children)

Activities	Time
1. Preparation of cadres, community, and other related stakeholders/sectors:` Focus Group Discussion/Participatory Rapid Appraisal, Positive Deviance Inquiry, training, program socialization, etc.	1 month Note: During the initial activities, cadres should be provided with an intensive coaching to enable them carry out program independently.
2. Providing de-worming medication (starting in the 4th month of age).	Prior to iron syrup treatment and to be repeated six monthly.
3. Providing iron syrup for children with anemia and malnourished children.	Certain dosage of iron syrup or tablet is given (in coordination with health officer) to anemia children aged 6-36 months for

	duration of 4 weeks. Notes: Health officers and Kadres may examine the pallor of child's palm to determine anemia. Children with very pale palm must be referred to a hospital for further treatment.
4. First session of education and nutrition improvement. Suggested topics for parents/caregivers during the first 12 days are: • *Children need caring, loving and teaching* • Essential nutrition for infants and children (Exclusive breast feeding; appropriate complementary feeding with continued breast feeding for 2 years; adequate nutritional care during illness and severe malnutrition; adequate vitamin A, iron and iodine intake; and nutrition for women). • Infant weighing, immunization and KMS.	12 days for 2 consecutive weeks and performed in the center (center-based), continued by home-based practices for additional 2 weeks. Cadres must make home visits to ensure family members are practicing new behaviors. Note: During the session, parents/caregivers are encouraged to: • Teach their children discipline and hygiene practices such as washing hands before and after eating foods, helping themselves eating, saying thank you upon receiving something from others, defeating or urinating in latrines, using garbage bins, etc. • Interact with their children, for example by asking names of foods being eaten, their tastes or colors, etc.
5. Education for parents/caregivers and physical development stimulation (fine and gross motorics), mental/ intelligence and social → children included in nutrition improvement program are mixed with well-nourished children (grouping is based on age	Weekly meeting Note: Knowledge and skills on teaching, loving, and caring patterns obtained during the education program are to be practiced at home.

group). The activity is carried out once in a week or at least every 2 weeks (see attached material for parent/caregiver education.	
6. Monitoring growth/weighing and other routine Posyandu activities.	Once a month at weighing date or parent/caregiver education sessions
7. Second session of PD/NERP. Suggested topics for parents/caregivers during the second 12 days are: • Danger signs of sick children and appropriate home care. • Healthy and hygiene practices (• Clean and healthy environment • Safe and comfortable environment for children.	12 days for 2 consecutive weeks and performed in the center (center-based), continued by home-based practices for additional 2 weeks. Kadres must make home visits to ensure that family members are practicing new behaviors in their households. Nutrition improvement program in a certain location is not intended to be a permanent project. The most important achievement is perpetual or continuous behavioral changes.

Important to note: although kadres perform their tasks voluntarily, their knowledge, skills, and efforts should be rewarded. A “reward system” needs to be developed to motivate kadres to continue their own development and work for others to improve health and quality of human resources in their own areas.

2. Session for parent/caregiver education and child development stimulation (all children aged 0-3 years)

AGE GROUP: 0-6 MONTHS

Meeting	Topics
First	- Each children need caring, loving and stimulating - Exclusive Breastfeeding .

	- Baby messaging (see video film and Guidance book for baby messaging)
Second	- Development characteristic of children at the age of 0-6 months - Caring since prenatal.
Third	- Caring for the newborns - Stimulate gross motoric, sensory, visual, tactile and auditory senses
Fourth	- Essential nutrition for lactating mothers - Stimulate gross and fine motoric, sensory, visual, tactile and auditory senses
Fifth	- Weighing infants, immunization and KMS. - Caring for babies with fever and cold and cough
Sixth	- Creating playing tools that stimulate sensory, visual, tactile, and auditory senses (using used materials available around the house)
Seventh	- Protecting children from preventable diseases - Baby messaging
Eighth	- Family planning and contraception methods

AGE GROUP: 7- 12 MONTHS

Meeting	Topics
First	- Each children need caring, loving and stimulating - Development characteristic of children at the age of 7- 12 months - Essential nutrition for children (breast feeding and complementary feedings
Second	- Infant weighing and KMS (enriched with practicing taking weight and filling in KMS).
Third	- Essential nutrition for children (viatmin A, iron and iodine) - Stimulate communication and language skills and introduce babies

	with environment
Fourth	- Healthy and hygienic practices . - Danger signs of sick children and appropriate home care.
Fifth	- Stimulate sensory, visual, tactile and auditory senses and communication. - Essential nutrition for children (nutrition for sick and severe malnourished children)
Sixth	- Inroducing babies with their environment and stimulate communication and gross motoric .
Seventh	- Healthy and clean environment - Caring infants with diarrhea (including preparing ORS).
Eighth	- Safe and comfortable environment for children - Family planning and contraception methods .
Ninth	- Creating playing tools that stimulate sensory, visual, tactile, and auditory senses and gross motoric
Tenth	- baby message (full)
Eleventh	- Malaria or Dengue Fever (spreading, prevention, appropriate home care and danger signs)
Twelfth	- Cooking and preparing complementary food for children age 7-12 months.

AGE GROUP: 1 – 2 YEARS

Meeting	Topics
First	- Each children need caring, loving and stimulating - Development characteristic of children at the age of 1- 2 years
Second	- Child stimulation. - Healthy and hygienic practices
Third	- Child stimulation
Fourth	- Danger signs of sick children and appropriate home care.

	- Essential nutrition (nutrition for sick children and severe malnutrition)
Fifth	- Healthy and hygienic practices . - Caring children with fever and cold and cough, measles and ear infection.
Sixth	- Creating playing tools using used materials available around the house
Seventh	- Healthy and clean environment - Caring children with diarrhea (including preparation of ORS/Oralit).
Eighth	- Child stimulation - Essential nutrition for children (vitamin A, iron and iodine)
Ninth	- Making playing tools using used materials - Child stimulation
Tenth	- Safe and comfortable environment for children - Family planning and contraception methods (*Buku Lembar Balik KB*).
Eleventh	- Demonstration and practice cooking nutritious snacks.
Twelfth	- Child stimulation.
Thirteenth	- Malaria and Dengue Fever (spreading, prevention, cure of sick children, warning)
Fourteenth	- TB prevention, symptoms, mode of transmission, place for checking up and treatment, and importance of complying TB cure

AGE GROUP: 2-3 YEARS

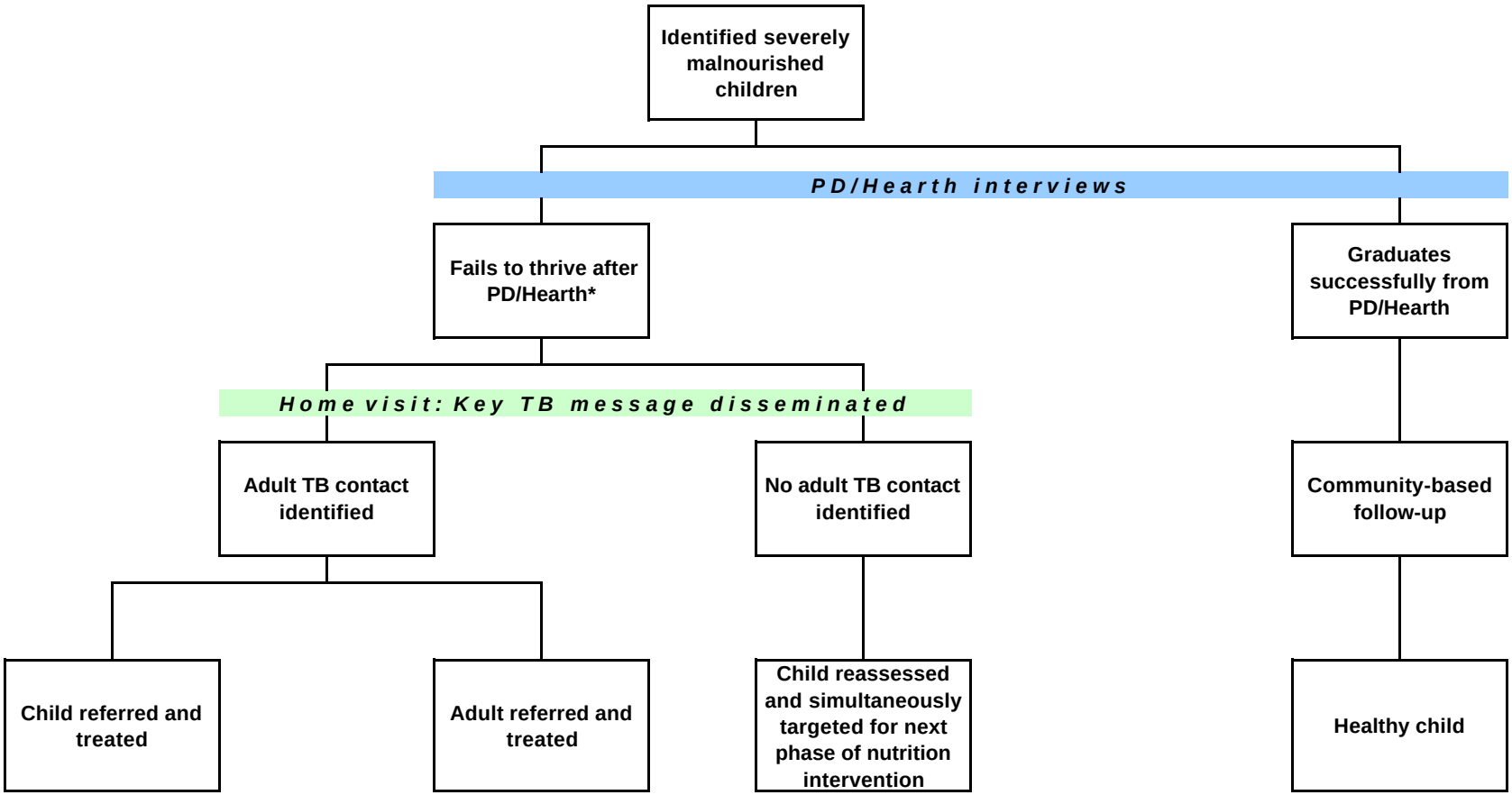
Meeting	Topics
First	- Each children need caring, loving and stimulating - Development characteristic of children at the age of 2- 3 years
Second	- Child stimulation
Third	- Malaria (spreading, prevention, cure of sick children, warning).

Fourth	- Child stimulation - TB prevention, symptoms, mode of transmission, place for checking up and treatment, and importance of complying TB cure.
Fifth	- Child stimulation and Making playing tools using used materials
Sixth	- Child stimulation
Seventh	- Demonstration and practice cooking nutritious snacks
Eighth	- Child stimulation and Making playing tools using used materials
Ninth	- Child stimulation
Tenth and so on	- Child stimulation and refresh of health and nutrition messages.

Annex 5F

Decision Tree

Decision Tree



Notes:

* Through IMCI at facilities and through C-IMCI

* Receives home visit by *Kader* (to identify adult TB contact person(s), to inform mothers and contact persons about key TB messages and to encourage them to seek treatment)

Annex 5G

Proposed TB Component for CHOICE

Proposed TB Component for CHOICE Project

PCI's CHOICE project intervention in Pandeglang District will cover 30 villages including 10 villages in Saketi Subdistrict, 10 villages in Pagelaran Subdistrict, 5 villages in Angsana Subdistrict and 5 villages in Patia Subdistrict. CHOICE will work closely with the *Puskesmas* in each of the Subdistricts.

In Pandeglang District, the TB infection rate is 115 persons per 100,000 population and it is estimated that every positive TB case will be transmitted to an additional 10-15 people/year. Although the majority of these cases are adults, this TB transmission will place children at risk, with malnourished children aged 0-5 being especially vulnerable. Child growth and development also suffers if parents are sick or die because of TB. Effective TB control requires properly functioning, well-managed health services with good diagnostic facilities, trained staff and available drugs. But these services will not be meaningful unless communities are educated about TB to reduce discrimination and encourage potential TB cases to seek diagnosis and comply fully with treatment.

Rationale for Change of Strategy from Original CHOICE Proposal

The original design of the CHOICE TB component involved the use of midwives. However, because midwives are already overloaded, the government is not supportive of the idea of midwives taking up additional responsibilities related to TB. PCI has also discovered that midwives are not present in most of the villages where the CHOICE project is to be implemented. Thus the original concept of using midwives as a major part of the strategy for community-based TB interventions has been modified. While increasing midwife knowledge about TB is still a worthwhile pursuit since they do play a major role in community-based health education and service delivery, this will not be a major part of the project's TB strategy. The project will also work with government and communities to advocate for midwives to be recruited and placed in villages where none are currently present.

Complementarity with KNCV TB Interventions in Pandeglang District

After consultations with Dr. Benson Hausman, National Project Director for KNCV, Dr. Lukman Siregar, the KNCV representative responsible for TB in Banten Province, Dr. Komarudin, the head of Disease Prevention and Environmental Sanitation of Banten Provincial Health Office, Pak Yudi, the TB Program Supervisor of the Pandeglang DHO (District Health Office), Dr. Sri Boediharjo, of the USAID mission in Jakarta, among others at the mission, PCI has revised its TB component to emphasize complementarity with KNCV/government activities in Pandeglang District. KNCV endorses this coordinated approach. It is important to note that PCI's approach is specifically designed to avoid creating a demand for TB services that are not yet available.

In Pandeglang District, Banten Province, KNCV is now working closely with the local government, the DHO, and all *Puskesmas* to combat TB by implementing the DOTS strategy focusing on adult pulmonary TB. KNCV, funded by CIDA and USAID, is focusing its assistance on increasing health facilities' capacity to tackle TB problems by

providing training, laboratory facilities, funding for quality control supervision and monitoring meetings, equipment and vehicles. KNCV is now supporting 24 out of 29 existing *Puskesmas* in the Pandeglang District, including two *Puskesmas* in 2 subdistricts within the CHOICE project area. Because CHOICE is working in these particular subdistricts, KNCV has indicated a willingness to give them particular attention, resulting in a stronger, complementary approach that will involve both community and health service elements. PCI will focus on supporting current TB efforts through a community awareness building and outreach approach that links community TB/nutrition efforts with KNCV's more health service delivery approach at the district and subdistrict levels. KNCV is keen to have PCI working at the community level to increase awareness about TB with an emphasis on 2 key messages: TB is treatable and TB treatment is free for all at TB-ready *Puskesmas*. PCI's approach will also involve working to ensure the support and involvement of both local and central government officials, as well as compliance with all relevant GOI policies and strategies.

Utilization of a Step-wise Approach

The integration of CHOICE TB interventions into CHOICE's Child Survival Project will be introduced in stages as *Puskesmas* become equipped and trained to competently manage TB in their subdistricts. This means that in the first year of project implementation (starting October 2004) the CHOICE project will prioritize its outreach and awareness raising interventions in the 10 villages of Pagelaran Subdistrict where the existing *Puskesmas* has already been strengthened through capacity building and through the provision of laboratory equipment and supplies by the KNCV project. This *Puskesmas* is currently functioning as a "self-help DOTS strategy implementer", called a "*Puskesmas* Pelaksana Mandiri" (the *Puskesmas* that can analyze sputum smears for diagnoses).

Malnourished children and adult TB patients who are living in the same house or surrounding the children's house are the main target group of TB intervention in CHOICE project areas. Every identified malnourished child or a child who failed to thrive should be suspected has had contact with adult TB patient. Home visits will be made by trained *Kaders* to detect contact person and to disseminate information on TB symptoms, transmission and appropriate place for seeking care . Once contact person is identified, *Kaders* will report their findings to the *Puskesmas* staff for follow-up action. The National TB Program has developed a guidelines for pediatric and adult TB diagnose and treatment and now is being used by *Puskesmas* for reference .

During this period, KNCV will provide financial support to the DHO for conducting regular supervision/monitoring visits to *Puskesmas*, and financial reward to the *Puskesmas* for the case findings. KNCV will conduct regular supervision visits and mentoring to the TB program managers/ implementer at the *Puskesmas* and DHO level. In adition, KNCV will also provide diagnostic supplies, as well as recording and reporting forms .

In the second year of project implementation, outreach and awareness raising interventions will be expanded to the 10 villages of Saketi Subdistrict, where the health providers of the existing Pusksemas have been trained on diagnostic technique and where the *Puskesmas* has been provided with laboratory equipment and supplies, but is not yet able to do laboratory diagnostics due to a lack of availability of laboratory staff. We understand that the local government has identified a budget and is in the process of recruiting the needed laboratory staff who will be trained by the KNCV supported provincial trainer team for TB..

During the second year of the project implementation, the interventions will also be expanded to the 5 villages in Patia sub-district and 5 villages in Angsana sub-district. As identified during the "*Puskesmas* Capacity Assessment" workshop conducted in May 2004, these two *Puskesmas* have also been completed with trained health providers. These persons have already been trained to identify suspected TB in adults and children, to properly process and refer sputum fixation and smears, and to manage TB cases as a satellite to the fully-staffed and equipped MR (Microscopic Reference) *Puskesmas* in Pandeglang District. Funded by the KNCV project, training was provided by the provincial trainer team which had been established and participants trained for improving the quality of TB services.

TB Component Objectives and Indicators

The CHOICE TB component falls primarily within the project's IR 2: Improved health seeking and care giving behavior among care takers, and LLR 2.2.: Increased knowledge and skill about key family practices that critical for child survival, growth and development among caretakers. Indicators to be used to measure intermediate results related to TB include:

- At least 80 % of identified severe malnourished children and the children who fail to thrive after participating PD/Hearth session visited by *Kaders* to identify TB contact persons, to inform mothers and contact persons on TB key messages and to encourage them for TB care seeking.
- Percentage of suspect TB cases referred to *Puskesmas* increased by 40 %

To measure the Lower Level Result 2.2. the project will use the following indicators :

- Proportion of target population (mothers of children aged 0-23 months) who are aware of at least 2 symptoms of TB.
- Proportion of target population (mothers of children aged 0-23 months) who know that TB is a curable disease

In addition, the project will measure progress through several process indicators that relate directly to the activities outlined below. These include:

- Number of *Kaders* and other health care workers trained on topics related to TB
- Number of home visits made
- Number of IEC materials developed and/or adapted
- Number of DOTS observers identified
- Number of village-level TB campaigns organized

CHOICE TB Activities

- Training for selected *Posyandu Kaders* (100), midwives (20 - if government assigns them all), TBAs (40) and *Puskesmas* staff (8 in Patia and Angsana subdistricts) on the transmission of TB, the symptoms of TB in adults and children, the correlation of severe malnutrition with TB in children, prevention, care-seeking and advocacy skills will be provided, in collaboration with the DHO and *Puskesmas*. (role of TBAs is still dominant in Pandeglang and this is recognized by government - this has been discussed and agreed to with district government)
- Trained *Kaders* will be encouraged to visit (400) families with severe malnourished children that they identify during *Posyandu* activities or through PD/Hearth sessions. Home visits will be made in order to identify TB contact persons, disseminate key messages by using an illustrated card (developed by KNCV), and encourage adult TB suspects to check their health status in the *Puskesmas*. The results of home visits will be reported by the *Kaders* to the *Puskesmas* staff for follow-up action.
- Locally acceptable IEC materials will be developed and/or adapted (in coordination with KNCV) for TB campaigns and health education sessions, and will be incorporated into the parent/caregiver education module. Key messages will include the fact that TB is not a genetic disease, that TB drugs are provided by *Puskesmas* free of charge, and that TB can be cured. Information on disease transmission mode, treatment schedule and steps, and the importance of drug observers to ensure patients' compliance with TB treatment will also be provided. CHOICE staff will work together with the KNCV, *Puskesmas*, *Kaders*, the Family Welfare Organization (PKK), and Community Empowerment Institution (CEI) members in developing a locally accepted orientation materials for TB campaign
- (120) appropriate and reliable treatment observers will be identified. During home visits to children's families, the *Kaders* or CEI members will interact with the patient, mothers of malnourished children, family members and respected/responsible neighbors, and select one person who is willing to help monitor the TB patient , escort the patient to Puskemas for health checking, together with the patient receive orientation about TB at the *Puskesmas*, conduct regular visits to the patient to ensure the compliance of TB patient to the TB drug regimen and to remind the patient about sputum rechecking at the *Puskesmas*. For TB in children, the mother will be the primary treatment observer.
- *Kaders*, PKK, CEI and village leaders will be facilitated in organizing (40) TB campaigns. PCI will coordinate advocacy and awareness building campaigns designed to minimize stigma and maximize appropriate behaviors. PCI will coordinate with the PPTI (Indonesian Tuberculosis Control Association) and others, building on their experiences and adapting materials for use in the target subdistricts.

ROLE OF SECTORS INVOLVED IN TB COMPONENT

Major Activities	**Sector' s Responsibility**		
	PCI	**KNCV**	**DHO/PHO**
A. Training			
1. Training for selected *Posyandu Kader*	Technical assistance (TA), training cost and facilitators	Training module	TA, facilitators, training cost
2. Training for midwives	TA, training cost & facilitators	Training module	TA, facilitators
3. Training for TBAs	TA, training cost & facilitators	Training module	TA, facilitators, monitoring
B. Case identification			
4. Home visits by *Kaders* to families with malnourished children or children who fail to thrive	TA, training, monitoring	Monitoring, TA	Drugs, TA, facilities for sputum check
5. Develop locally acceptable IEC materials	TA, training, printing cost	Printing cost, existing materials	TA, existing materials
6. Orientation for treatment observers	Facilitation, TA, monitoring	Orientation module, TA	Orientation cost, facilitators, TA, monitoring
7. TB campaign	Materials for campaign, TA	Existing materials, TA	TA, monitoring, materials for campaign