

# THE EVALUATION OF THE OFFICIAL DEVELOPMENT ASSISTANCE PROGRAMME FROM JICA ON THE MATERNAL AND CHILD HEALTH HANDBOOK AT THE TELOGO ASRI VILLAGE, CENTRAL JAVA

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## Abstrak

Artikel ini menguraikan salah satu bentuk program bantuan pembangunan antar pemerintah (*Official Development Assistance*) dari *the Japan International Cooperation Agency* (JICA) yang diberikan pada pemerintah Indonesia guna meningkatkan kondisi kesehatan Ibu dan Anak di seluruh Indonesia melalui pemasyarakatan Buku Kesehatan Ibu dan Anak (KIA). Program Buku KIA telah dilaksanakan selama sepuluh (10) tahun dan telah menunjukkan berbagai hasil yang berbeda di berbagai wilayah di Indonesia. Artikel ini akan menyoroti efek dari pemasyarakatan buku KIA terhadap perilaku kesehatan ibu dan anak di salah satu desa di Jawa Tengah (untuk menunjang aspek kerahasiaan nama desa dan informan dalam penelitian ini adalah nama samaran). Desa Telogo Asri dipilih sebagai kasus dalam evaluasi ini, karena desa ini telah terlibat dalam program pemasyarakatan buku KIA selama kurang lebih Sembilan (9) tahun.

## Abstract

This article will describe one of the Official Development Assistance (ODA) programme which had been introduced by the Japan International Cooperation Agency to increase the health condition of mother and children in such areas in Indonesia. The Maternal and Child Health (MCH) handbook programme had been undertaken for about 10 years and has shown different results in many different areas in Indonesia. This article will show the effect of the MCH handbook programme to the mother's child health behaviour in one village in Central Java (for confidentiality, the name of village and informants used are pseudo names). The Telogo Asri village was chosen because of their involvement in the MCH handbook programme for about the last 9 years.

*Keywords: Maternal and Child Health, Child Welfare*

## 1. General Background

According to Wood (in Efendy, 1997) <sup>1</sup>, health education is a body of experience whose impact is beneficial to habit, attitude, and knowledge related to individual, societal, and national health. Health education (WHO, 1988) <sup>2</sup>, basically is a process of educating individuals/communities so as to enable them to solve health problems they face. Such a health education process consists of both input and output, which means that the behaviour of users of both health facilities and health officials is transformed using certain techniques of education in order to produce output in the form of changed community's health behaviour based on a set of expectations and goals. The goals of health education, according to Wood (in Efendy, 1997) <sup>1</sup> are, among others:

- (1) to make changes in individual, family, and society's behaviour in fostering and maintaining healthy behaviour and environment and to actively involve in achieving an optimum degree of health;
- (2) to shape healthy behaviour on individuals, families, and society in line with the concept of healthy physical, mental, and social life.

Health education (Glanz, Lewis and Rimer: 1996)<sup>3</sup>, can be carried out either formally or informally by the government, professional groups, health officials, community leaders, NGOs, etc. Moreover, the health education process could be in the form of counselling, training, advocacy, consultation, and policy research. Efforts of changing society's behaviour through the provision of education, in addition to enhancing society's knowledge and skills, can also increase participation in all kinds of activities towards development, for without participation the goals and targets of such a change can not be achieved.

Indonesia's Ministry of Health currently adopts a health paradigm oriented towards a public health approach in each of the action it takes to address any health issues. Health paradigm stresses on the attempts of health promotion, prevention, maintenance and healing, as well as rehabilitation. Thus, health development that is based on health paradigm prioritises activities of promotion, prevention, healing, and rehabilitation.

Since 1993 the Ministry of Health has worked together with JICA (Watanabe and Osaki, 1997)<sup>4</sup> to develop a handbook on Maternal-and-Child Health, initiated in the province of Central Java. Currently, according to Azwar (2003)<sup>5</sup>, the handbook has been distributed in all the 27 provinces. As a means of educating mothers and children, the handbook contains ways of maintaining healthy pregnancy, taking care of a baby, monitoring baby and infant's growth and development, handling a baby/infant suffering from diarrhoea, and acute upper respiratory infection. The handbook is used by health officials as the standard of health service and counselling. Besides, the MCH handbook could also serve as a medium of communication between mothers and health officials.

## **2. Research Method**

The research uses two types of research methods, i.e. the rapid survey and the in-depth interviewing. These two types of research comes from different approaches. The the rapid survey comes from the quantitative approach, and the in-depth interviewing more qualitative in nature.

### **1. The Rapid Survey**

This type of research falls into the quantitative category. And, it is used to draw a map of MCH situation at the Telogo Asri Village.

The rapid survey is done by distributing a questioner to a number of selected respondents. It is called rapid survey considering that the number of questions listed on the questioner is limited, and so is the research period. From the rapid survey we try to obtain a general picture of some success indicators commonly used for evaluating the success of the maternal and child health handbook distribution, such as the loss rate, filling rate, and coverage of the MCH handbook distribution.

### **2. The In-Depth Interviewing**

Through this approach, various responses of informants can be acquired. In addition, this type of research will also give some benefits to further in-depth research by exploring all aspects related to maternal and child health behaviour. Furthermore, facts that hitherto would have been unthinkable can now be made available.

Data collection for the research is done through in-depth interviews based on the semi-structured interview guidance, in which information gathering from informants is done orally on the basis of a certain guidance or note (interview guidelines) containing items or key points related to questions that will be asked during the interview.

Informants for the research come from all the fourteen RWs at Telogo Asri Village, disregarding the number of informants from each RW because, in accordance with the nature of the qualitative approach, information can be collected based on the width of the range of information.

The selection of the informants are done based on the following criteria:

- The active group, i.e., pregnant mothers and mothers with children under five years old who possess the MCH handbook and actively use it in a sense that they read the MCH handbook as a source of knowledge of maternal and child health and apply what they get from reading on their maternal and child health behaviour.

- The passive group, i.e., pregnant mothers and mothers with children under five years old who do not possess the MCH handbook and who possess it but never read or apply what they get from the MCH handbook.
- All health cadres in each RW at Telogo Asri Village. These Medics and paramedics, such as midwives living at Telogo Asri Village, medics and paramedics in charge of health promotion, and doctors at the Puskesmas.
- Formal and informal community leaders who keep up with health development at Telogo Asri Village before and after the introduction of the MCH handbook.

### 3. Data Analysis and Data Interpretation

#### 3.1. The Coverage of the MCH Handbook

Most of the respondents, 82.2 % of 180 respondents, stated that they still have the MCH handbook published by the Ministry of Health in co-operation with JICA (MCH-JICA handbook). Around 17.7% of respondents claimed that they did not have the MCH-JICA handbook. Further details are as follows Table 1.

**Table 1.**  
**Ownership of the MCH-JICA Handbook Based on the Living Area of Respondents**

Area Where Respondents Lived	Ownership of the MCH-JICA Handbook		Total
	Yes	No	
RW 1	14 (93.3%)	2 (6.7%)	15 (100%)
RW 2	13 (86.7%)	2 (13.3%)	15 (100%)
RW 3	12 (80%)	3 (20%)	15 (100%)
RW 4	15 (100%)	-	15 (100%)
RW 5	15 (100%)	-	15 (100%)
RW 6	15 (100%)	-	15 (100%)
RW 7	12 (80%)	3 (20%)	15 (100%)
RW 8	13 (80%)	2 (20%)	15 (100%)
RW 9	7 (46.7%)	8 (53.3%)	15 (100%)
RW 10	11 (73.3%)	4 (26.7%)	15 (100%)
RW 11	8 (53.3%)	7 (46.7%)	15 (100%)
RW 12	13 (86.7%)	2 (13.3%)	15 (100%)
Total	148 (82.2%)	32 (17.7%)	180 (100%)

Although in general they still had the MCH-JICA handbook, there were certain areas with only few people possessing the MCH-JICA handbook. This occurred, among others, in housing estates in RW 9 (53.3%), as well as in RW 11, with 46.7% of the respondents having no MCH handbook yet. Based on this, in RW 9 and RW 11, which were relatively "luxurious", the number of the MCH handbook's ownership was still below those of the other neighbourhood areas.

This result actually was not a disappointing one since at least ten years after its distribution the coverage of the MCH handbook had reached above 80% of the target community.

Apart from the distribution aspect of the MCH handbook, indicators often used in assessing the success of the dissemination of MCH handbook is:

- The average loss rate;
- the average bringing rate of the MCH handbook to the Puskesmas; and
- the average filling rate.

Based on the number of MCH handbook lost from those who had had the MCH-JICA handbook (156 respondents), there were 14% of them who had lost the handbook. This figure is not a poor one as around 85.9% turned out to never lose their MCH-JICA handbook. This is presented in the following Table 2.

Having said that, it does not mean that the handbook had already been evenly distributed since the MCH-JICA handbook generally was given to those who were assisted by midwives during delivery or had their pregnancy examined at the Puskesmas. Meanwhile, those who had their pregnancy examined by a general practitioner or hospital usually did not receive the handbook. This group made up of those who usually lived in a housing complex, such as RW 9, RW 10 or RW 11. Therefore, the figures in the Table above are more like a total number, while the details of each area of settlement reflect the differences between one area and another.

From the figure of the average bringing rate of those who still had the MCH handbook, it is clear that there was a quite satisfactory result, as presented in details in the following Table 2.

From the above Table, it shows that around 82.4% of the respondents who still had the MCH handbook basically always brought the handbook with them each time they have their babies weighed at the Posyandu. Nevertheless, there were more than 17% of the target group who did not always bring the handbook when they have their babies weighed.

The high number of people who had the MCH handbook and brought it with them is one of the indicators needed for assessing the success of the MCH handbook socialisation. However, how the MCH handbook was utilised must also be assessed, among others, by considering how complete the record of the whole development of the mother's pregnancy period and the child's growth after being born is. That is why, completeness of record in the table on the development of child's weight is still another indicator of success in disseminating the MCH handbook in the community.

In Table 4 below it is clear that out of 148 respondents who had the MCH-JICA handbook, 81.1% filled in the table on weight development for the first year

**Table 2.**  
**Average Loss Rate of the MCH Handbook**

	<b>Frequency</b>
Had Lost	22 (14.10%)
Never Lost	134 (85.90%)
Total	156 (100%)

**Table 3.**  
**Average Bringing Rate of the MCH Handbook to the Posyandu**

	<b>Frequency</b>
Always brought the handbook	122 (82.4%)
Not always brought the handbook	26 (17.6%)
Total	148 (100%)

**Table 4.**  
**Average Filling Rate of Weight**

	<b>Frequency</b>
Completely filled in	120 (81.1%)
Incomplete	28 (18.9%)
Total	148 (100%)

**Table 5.**  
**Average Filling Rate of the Whole MCH-JICA Handbook**

	<b>Frequency</b>
Completely filled in	0 (100%)
Incomplete	148 (100%)
Total	148 (100%)

completely. Meanwhile, the remaining 18.9% did not fill it in completely. In this regard, it is clear that cadres had already done their best to fill in the table on child's weight development. That the percentage for this aspect reached more than 80% reveals the adequate efforts made by cadres to socialise the MCH-JICA handbook. The details can be seen in the following Table 4.

Conversely, a different result will show up if it is concerned with whether cadres or paramedics filled in the MCH-JICA handbook completely. From the result in Table 5 below, it is clear that generally cadres only filled in the table on child's weight development.

Needless to say, such a situation is not desirable. All of the components of the whole MCH handbook, starting from the mother's pregnancy period to postnatal period, and even to the complete record of child's growth and development, as well as immunisation record, are equally important in improving the community's health quality.

Notwithstanding, certainly there were reasons that they gave with regard to why they did not fill it in completely. Some of them were the fact that they had not been taught how to do it by health cadres, or midwives in charge of filling in the pregnancy data forgot to do it, or instead of recording the data in the MCH handbook, they put them in their own case record. From some of the in-depth interviews conducted, it is also found that there was a possibility of miscommunication between health officials at the central level and cadres at the regional level. For instance, the table on waist line was not filled in, or there were midwives who did not take the postnatal care record of pregnant mothers, such as expressed by the cadre below:

"No, just want to weigh the baby". (Cadre, RW 5, August 2003)

The informant responded when asked what part of the MCH handbook they were expected to fill in. The respondent produced such an answer because she thought it was the part she was supposed to fill in and not the other parts.

### 3.2. The Impact of the Introduction of the MCH Handbook on the Health Behaviour of the Target Group

The most significant impact felt by mothers having infants from the introduction of the MCH handbook or the KMS card was that they could routinely have their children's weight growth examined. Whereas, information on the maternal and child's health itself could also be obtained from the MCH handbook. However, sources of information, such as health officials, parents, other members of the family, as well as the mass-media could also be primary sources of information. This is due to, among others, the limited amount of information provided by the MCH handbook, so in order to get further information, they relied on other sources of information, such as:

#### 1. Health literature

"From texthandbooks, magazines, handbooks available in handbookstores, there are many (Active 23, active user, RW 12, August 2003)

"...From handbooks, there are handbooks about health" (Passive 06, passive user, RW 5, August 2003)

#### 2. Print and electronic media

"Well, that's it, tv, tv also, right? Yes, tv is the same as reading a handbook or magazine, something like that, *Ayah Bunda*. No, I borrowed from a neighbour. I wouldn't be able to afford it as it's expensive". (Active 01, active user, RW 3, January 2003)

**Table 6.**  
**General Benefit Of Using The MCH-JICA Handbook**

	Frequency
Benefits directly related to mothers and children's health	121 (81.8%)
Benefits indirectly related to mothers and children's health	22 (14.9%)
No benefit	5 (3.4%)

Total	148 (100%)
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### 3. Family

"Well, from parents, from parent-in-laws" (Active 12, active user, RW 4, August 2003)

### 4. Health officials and cadres

"Well, if not from a midwife, then it's from that guidance, mam, and also from cadres". (Active 16, active user, RW 3, January 2003)

The heterogeneous sources of information illustrate that, in addition to the MCH handbook, there were actually many other sources used by the mothers. Those other sources of information generally also provided more input than the MCH handbook, so there was a complementary relationship between the information coming from the MCH handbook and that from other sources.

In terms of the utilisation of the MCH-JICA handbook, there were diverse viewpoints in assessing the benefits offered by the MCH-JICA handbook. Of those who had the MCH-JICA handbook, 81.8% stated that there was a direct benefit obtained from the MCH handbook on mothers and children's health. This group, among others, viewed that the MCH handbook was beneficial as it served as a prerequisite for a person to get into the elementary education. On the other hand, there were around 35% of those who had the MCH handbook saying that the MCH handbook was totally useless. This can be seen from the Table 6.

In terms of the benefits offered by the MCH handbook, there were some responses that complemented each other, such as:

1. Those who enjoyed the benefits, such as cadres and some mothers who actively used the MCH handbook.  
"To monitor her health, her weight, her eating habit. So, we'll be able to know whether it is improving or not" (Cadre 9, RW 12, January 2003)
2. Those who said it was beneficial but did not use it as a source of information.  
"Talking about infant, this is my second one. Perhaps I basically don't need new information badly. However, to other mothers who just get one child the handbook may be very important to have as it gives a lot of information on how to bring up an infant". (Passive 05, RW 9, July 2003)
3. Those who did not get any benefit from the MCH handbook  
"Well, (the knowledge) improves. ...so I know more, if I may say so. Well, very useful, for everytime we go to the Posyandu and bring the handbook, we know how far the child's weight increases..." (Active 01, active user, RW 5, January 2003)

However, at upper-middle class housing estates, the frequency of visit was lower, so the benefits of the MCH handbook were less strongly felt.

"Here? Here it doesn't seem to be too beneficial, I think. Perhaps because it's a housing estate, and then some of their family members are health officials themselves. The mothers are also lazy..." (Cadre 1, RW 9, January 2003)

Only about 11.5% said they applied the material in the MCH-JICA handbook, and there had been some changes in their behaviour, such as:

#### 1. Changes during pregnancy and postnatal

"There is (benefit). See, the diet is better. Now there are more vegetables. Yes...when I was pregnant, I took care of my health... to stay healthy". (Active 02, active user, RW 5, January 2003)

#### 2. Skills in preparing supplements

"Yes, I can make supplements, such as porridge... then my 13-month-old baby has not begun to walk, and I an check it in the handbook. I have benefited a lot from the handbook". (Active 14, active user, RW 1, August 2003)

Meanwhile, of those who stated that the MCH-JICA handbook brought no direct benefit to mothers and children's health took record for the sake of an obligation they had to carry out. In this group there was no indication that the benefits of the MCH-JICA handbook was felt, and they considered the recording process a matter of obligation they had to bear.

Whereas, in terms of its impact on everyday behaviour, it seems that the respondents and informants of this research tried to combine information coming from different sources. For instance, although they go to the Posyandu for weighing, traditional medicines and treatments were still applied for daily health care, as revealed by an informant below:

"When it was heavily raining, I intentionally told him to go out and play in the rain, 1 hour, 1.5 hour. So, once or twice a week when it was raining, I told him to play out with a bucket or anything...but no umbrella. Now when everybody or myself or my husband gets a bad cold, he is the only one who stays healthy. His anti body has grown strong. I think if we are too protective over our child, he will grow weak." (Passive 02, passive user, RW 9, January 2003)

This occurred, among others, because they believed in the information conveyed by their parents or relatives, even more so when those traditional medicines and treatments have been practiced for generations.

Although there was a knowledge improvement through different sources of information, including print and electronic media on various personal hygiene issues, the community's health behaviour has not shown any improvement yet. For instance, in terms of 'toilet' behaviour, there were still people who liked to do it in the river or at a water closet built in the yard despite the fact that they knew it is not a healthy habit. There were other factors that made them keep on practicing such behaviour.

It is clear that changes in the cognitive aspect (knowledge) have to be supported by various other factors in order to make the desirable kind of behaviour materialised. An individual's cognitive aspect tends to lean on predisposed factors in the form of covert behaviour, while overt behaviour needs support from reinforcing factors, such as friends, family, or health officials), as well as enabling factors, such as the availability of adequate sanitary facilities and water sources. This explains why the dissemination of information to target groups/communities was not effective enough in changing the community behaviour towards the expected behaviour.

From the observation of the lower class economic group, it was found that their toilet behaviour has yet to show changes, although the MCH handbook contains ways to prevent diarrhoea, for instance, by using a toilet bowl and keep it clean, as well as by disposing a child's secretion in a proper place. However, in practice some people still made use of poorly maintained toilet bowls or disposed secretion in the river or in the yard.

In relation to clean water utilisation, among a certain group of people-usually that which belongs to the low economic group-there was a bath and washing habit which made use of a source of water that was relatively unclean, especially in the dry season. Even though most housing estates or brick houses generally have a facility for bath and washing, in some other areas the facility could be very limited.

From the observation to some areas of the village, it was found that there are several murky water used as a source of water by inhabitants for bath and washing clothes. These water sources were still used by some inhabitants coming from very poor families or poor families, and they were located in two different neighbourhood areas. However, the poor condition of the bath and washing facility was not peculiar of these two neighbourhood areas only as it could also be commonly found in some other neighbourhood areas. This is especially true in more economically-deprived areas compared to those whose economic condition is better.

#### **4. Conclusion**

In Macro perspectives, JICA's effort in introducing the MCH handbook has shown big success. The MCH handbook has been promoted nation-wide by JICA in cooperation with the Ministry of Health and some related institutions has shown an encouraging progress in the last ten years. The MCH handbook initially was distributed in Central Java. Up to the beginning of 2004 it has been adopted by 27 provinces and more than 200 regencies/cities, which is a promising achievement with regard to its national scope of coverage. Whereas, for the research conducted at the local level, the following conclusions can be drawn:

- 1) Locally speaking, at the Telogo Asri village around 82.2% of the target community had ever had the MCH handbook, and around 82.2% still had the MCH handbook up to the point of the research.
- 2) Meanwhile, from the perspective of the target community adopting the MCH handbook, it is clear that those living in relatively 'better-off' housing estates generally had a lower rate of ownership of the MCH handbook compared to those living in ordinary housing estates. In the former, such as housing estates in RW 9 or RW 11, generally

pregnant mothers would have themselves examined by a general practitioner or hospital rather than at the Puskesmas or a midwife which would have given them the MCH handbook.

- 3) Based on the points above, the changes felt by those using the MCH handbook would be more apparent among them whose monthly expenditures were between Rp 500,000 (\$50) and Rp 1,000,000 (\$100). Generally, they were neither part of the upper-middle class economy nor did they belong to the lower-class economy, and usually they were mothers with only one child. This is the group by which the benefits of the MCH handbook would be strongly felt. At the low-class economy, even basic needs for daily life could not be fully met, so in order to meet the needs for food in accordance with the food pyramid contained in the MCH handbook, some of them still faced difficulties. Whereas, those who were more educated, such as those living in relatively 'better-off' (luxurious) housing estates, generally felt that the information available in the MCH handbook was much too simple. Likewise, those with several children generally had already had the necessary knowledge, and they thought they did not need information from the handbook. Therefore, they tended to use the MCH handbook the way they used a KMS card, that is, only for the sake of taking record.
- 4) The use of the MCH handbook as a medium of taking record of the child's growth (in this case, the child's weight) was also strengthened by cadres' perception that still also perceived the MCH handbook as a KMS card. Nevertheless, the MCH handbook was considered very helpful by both medical officials and cadres. The benefits were especially felt by cadres as the existence of the handbook for them had made additional knowledge about health available, which in turn could be disseminated to the community whenever there were any inquiries from users of the services. Consequently, in this regard the benefits of the MCH handbook were more strongly felt by health service providers, which in this case acted as the reinforcing factor in changing the community's behaviour. On the other hand, the MCH handbook itself did not really have much influence on the predisposed factor at the grass-root level or the enabling factor of the community's health behaviour.
- 5) Related to the dissemination of the idea of maternal and child's health, the MCH handbook has to be viewed as part of the health service delivery that needs to be further equipped with community education at the grass-root level. Without community education (which is more than just counselling), it would be very difficult to expect changes in the community's fundamental behaviour, let alone changes in the predisposed factor and community's behaviour.

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