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Evaluation of the Early Detection of Child Growth and Development Program (DDTK) at RA Bani Adam, Bekasi City: An Evaluation Study Using the CIPP Model

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Abstract
This study aims to evaluate the implementation of the Early Detection of Child Growth and Development Program (DDTK) at RA Bani Adam, Bekasi City using the CIPP model (context, input, process, product). The study used a descriptive qualitative approach with data sources from the principal, teachers, parents, activity observations, and program documentation. Data collection was conducted through in-depth interviews, participatory observation, and documentation studies, then analyzed using the Miles and Huberman model. The results of the study indicate that in the context aspect, the DDTK program was born from the institution's real need for objective data on child development and is aligned with the direction of SDIDTK, but is not yet supported by written SOPs. In the input aspect, the school has basic anthropometric tools and support from collaboration with the community health center, but the number of tools is limited, teachers have not received formal training, and screening instruments are not yet available independently. In the process aspect, physical measurements have been conducted monthly but not consistently across all classes, recording is still manual, and follow-up is not systematically scheduled. In the product aspect, the program helps detect delays, strengthens school-parent communication, and triggers early referrals, but longitudinal analysis and documentation of intervention results are not optimal. Overall, the DDTK program at RA Bani Adam is relevant and beneficial, but requires strengthening of standardization, teacher training, data integration, and sustainable follow-up to be more effective and sustainable.

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1. INTRODUCTION

Early childhood growth and development is a crucial foundation for the quality of future human resources. Between the ages of 0 and 6, children experience accelerated physical, language, cognitive, motor, and socio-emotional development, which requires appropriate monitoring and stimulation. When growth retardation or developmental delays are not detected early, opportunities for early intervention are limited and the risk of long-term impacts on a child's learning readiness increases.

In the Indonesian context, growth and development monitoring is not only related to nutritional status but also to the achievement of overall developmental aspects. The government is encouraging the implementation of Early Growth and Development Stimulation, Detection, and Intervention (SDIDTK) and the strengthening of Holistic and

Integrative Early Childhood Education (PAUD) services so that schools, families, and health facilities can work synergistically. However, program implementation in the field often faces challenges related to limited equipment, competency of implementers, parental participation, and the lack of integrated child development records.

RA Bani Adam Bekasi City has implemented the SDIDTK program for the past three years. Weight, height, and head circumference measurements are conducted regularly, while certain developmental checks are conducted in collaboration with the community health center (Puskesmas). However, initial observations revealed several significant issues: implementation was not consistently implemented every month, recording was still manual, analysis of results was not adequate, and non-physical developmental aspects were not consistently screened. This situation creates a gap between SDIDTK policy requirements and practices at the educational unit level.

Several previous studies have described the implementation of DDTK in early childhood education (PAUD), but they generally focused on technical aspects of implementation, practical benefits, or clinical screening activities. Khairunnisa et al. highlighted the implementation of SDIDTK in Magelang, Sulistyowati and Kayati discussed early detection of preschool children through anthropometric examinations, and Nesy and Pujaningsih demonstrated the importance of early detection in preschool-aged children. While these studies are important, evaluations that simultaneously examine the context of needs, resource readiness, process quality, and program outcomes are still relatively limited.

Based on this, this study offers a novel approach through the use of the CIPP (context, input, process, product) evaluation model to more comprehensively assess the DDTK program. This model allows researchers to assess not only whether the program is implemented but also whether it is truly needed, supported by adequate input, implemented consistently, and produces impacts that can be utilized by schools and parents.

This article is a re-arrangement of a thesis into a JISIP journal article format. The research objective is to evaluate the implementation of the DDTK Program at RA Bani Adam, Bekasi City, in terms of context, input, process, and product, while simultaneously formulating implications for program improvement at the institutional level.

Table 1. Summary of previous research and contributions of this research

No	Study	Focus/Method	Gap/Contribution
1	Khairunnisa et al. (2022)	Evaluation of SDIDTK implementation in Magelang	Demonstrates the importance of early detection, but focuses more descriptively on field implementation and has not systematically assessed all program components.
2	Sulistyowati & Kayati (2023)	Anthropometric examination and developmental screening of preschool children	Emphasizes clinical and operational aspects, but has not examined the institutional context, input readiness, and program sustainability.
3	Nesy & Pujaningsih (2023)	Early detection of growth and development of preschool children	Emphasizes the benefits of early detection for preschool children, but has not yet adopted a comprehensive program evaluation framework.

4	Tunik et al. (2022)	Empowerment of PAUD teachers in DDTK screening and stimulation	Focusing on socialization and training, has not evaluated the impact of program implementation on the institution as a whole.
5	This research	Evaluation of the DDTK program using the CIPP model at RA Bani Adam	Provides simultaneous evaluation of needs, resources, processes, results, and recommendations for program improvement based on field findings.

2. RESEARCH METHODS

This study used a descriptive qualitative approach with the CIPP evaluation model developed by Stufflebeam. This approach was chosen because it is suitable for examining the program in depth, from the relevance of program needs, resource readiness, implementation in the field, to the results obtained. The evaluation focuses on: context for program needs and relevance; input for teacher competency, instruments, and institutional support; process for consistency of implementation and recording; and product for program impact and utilization of detection results.

The research was conducted at RA Bani Adam, Jaka Setia Village, South Bekasi District, Bekasi City, from November to December 2025. Institutionally, RA Bani Adam has 8 classrooms, 1 hall, 1 open field, and 4 bathrooms. In the current academic year, there are 106 students spread across 8 classes, supported by 1 principal, 1 foundation head, 8 class teachers, 3 extracurricular teachers, and 2 school operators. These conditions make RA Bani Adam a relevant location to evaluate the DDTK program that has been running since the second semester of 2022.

The research data sources consisted of school principals, teachers, parents, activity observations, and program documents. Data were obtained through in-depth interviews, participant observation, and documentation studies. Interviews were used to explore program needs, institutional support, constraints, and utilization of results. Observations focused on anthropometric measurements, screening procedures, tool use, teacher and parent involvement, and referral mechanisms. Documentation included detection instruments, activity schedules, teacher administration books, referral forms, and documents related to collaboration with community health centers.

Data analysis was conducted using the Miles and Huberman model through data reduction, data presentation, and conclusion drawing. Data validity was maintained through source triangulation, technical triangulation, member checking with key informants, and recording an audit trail throughout the research process. Ethically, the research was conducted after obtaining institutional permission and parental consent; the identities of the children, parents, and teachers were anonymized in the reporting of the results.

Table 2. Research design based on the CIPP model

Component	Focus of evaluation	Data sources/techniques
Context	Program needs, urgency of DDTK, alignment with SDIDTK/PAUD HI	Interviews with principals, teachers, parents; document studies
Input	Teacher competency, measuring tools, screening instruments, institutional and community health center support	Interviews, facility observations, administrative reviews

Process	Consistency of schedule, measurement procedures, recording, communication of results, referrals	Observation of implementation, interviews, and documentation of results
Product	Impact on early detection, communication with parents, utilization of results, and follow-up	Interviews, documentation, review of intervention results

3. RESULTS AND DISCUSSION

Table 3. Profile of institutions and main program resources

Aspect	Description
Institutional status	RA Bani Adam, Jaka Setia Subdistrict, South Bekasi, Bekasi City
Learners	106 children in 8 classes (Playgroup, Group A, and Group B)
Educational staff	1 principal, 1 foundation head, 8 class teachers, 3 extracurricular teachers, 2 operators
Main facilities	8 classrooms, 1 hall, 1 open field, 4 bathrooms
Internal DDTK tools	2 scales, 2 height measuring tools, 2 head circumference measuring tools
Program partners	Jaka Setia area health center for semester check-ups and referrals

3.1. Evaluation of Context Aspects

The research results show that the DDTK Program at RA Bani Adam is no longer understood merely as an administrative obligation, but rather as a real institutional need. This awareness emerged when the school faced cases of weight changes, decreased concentration in learning, and suspected developmental delays that were difficult to communicate to parents without supporting objective data. The program subsequently developed into a vital tool for more systematic monitoring of children's conditions.

The program's need is also influenced by the incompleteness of health data collected during new student admissions. Many parents lack accurate information about their child's weight, height, immunization history, or health status. Therefore, the school has implemented routine weight, height, and head circumference measurements starting in the first semester of 2023, responding to internal needs and supporting the SDIDTK policy.

Despite the strong program context, RA Bani Adam does not yet have a written standard operating procedure (SOP) that outlines program objectives, implementation mechanisms, success indicators, and follow-up procedures. Dependence on the health center's visit schedule also remains high. These findings indicate that the program's urgency is well understood, but formal planning and internal standardization still need to be strengthened.

3.2. Evaluation of Input Aspects

In terms of input, RA Bani Adam already has the basic resources to implement DDTK. The school has two scales, two height measuring devices, and two head circumference measuring devices, as well as formal collaboration with the community health center through a memorandum of understanding. Teachers are also accustomed to conducting basic physical measurements and presenting the results in monthly evaluation meetings with the principal.

However, input readiness is not yet fully optimal. The number of devices required to serve eight classes leads to queues and delays in recording. The school lacks a dedicated screening room, so activities are conducted in classrooms or halls that are also used for other activities. Furthermore, teachers have not received formal training on using the KPSP, reading growth charts, or interpreting developmental screening results.

Observations during health worker visits also revealed that several logistical components of the SDIDTK program were not always available, such as growth charts, SDIDTK manuals, M-CHAT-R instruments, ADHD forms, hearing tests, vision tests, and flashlights for white pupil detection. Thus, basic inputs are available, but the availability of stand-alone instruments, teacher technical capacity, and documentation systems still requires strengthening.

3.3. Evaluation of Process Aspects

The process aspect shows that physical growth measurements have become a monthly routine, especially at the end of the month. Teachers weigh, measure height, and head circumference, then record the results in the class administration book. In practice, implementation is inconsistent. Some classes adhere to the schedule strictly, while others delay implementation due to other learning activities, student absences, or limited equipment.

Recording of results is still done manually and has not been analyzed for long-term trends. Teachers do not routinely compare measurement results with growth charts, so the data serves more as a numerical record than a basis for growth analysis. In non-physical aspects, identification of speech delays, concentration delays, or social-emotional issues relies more on daily teacher observations and community health center visits, not based on standardized instruments used regularly.

Community health center visits reinforce the process by bringing in doctors, nutritionists, and other healthcare professionals for follow-up screening. However, some procedures are incomplete. For example, nutritional status isn't always communicated due to the lack of growth charts, sensory testing isn't comprehensive, and post-referral re-evaluations aren't systematically scheduled. This means the program process is ongoing and producing concrete interventions, but it's not yet fully standardized and comprehensively documented.

3.4. Product Aspect Evaluation

In terms of product, the DDTK program provides direct benefits to schools, teachers, parents, and children. The most significant finding was the detection of several children requiring further referral, including those with speech delays. After receiving therapy and follow-up, the children showed improvements in language, concentration, and social interaction. These findings confirm that DDTK serves as a meaningful early detection mechanism, not simply an administrative exercise.

For teachers, measurement data and examination results help strengthen communication with parents and provide a more objective basis for adjusting classroom stimulation. Parents also feel more understanding of their child's condition because they receive a more concrete picture of growth and development. Furthermore, the program helps children become more accustomed to health checkups because the activities are conducted in a familiar and supportive school environment.

However, the program's results have not been fully utilized institutionally. Schools have not compiled annual analyses of student growth trends collectively, intervention outcomes have not been documented longitudinally, and the continuity of

community health center (Puskesmas) checkups remains volatile. In other words, while the program's outcomes have been visible in the form of early referrals and improved communication, data utilization for long-term program improvement remains limited.

Table 4. Summary of CIPP evaluation findings

Dimensions	Main strength	Issues that need to be fixed
Context	The program arose from the institution's real need to have objective data on child development, relevant to SDIDTK and PAUD HI.	There is no written SOP, the program objectives have not been formulated with clear success indicators.
Input	Basic anthropometric tools are available, support from the principal, collaboration with the community health center, and participation from some parents.	The number of tools is limited, teacher training is not yet available, screening instruments are incomplete, and recording is not yet digital.
Process	Physical measurements are carried out monthly, communication of results is quite effective, and early referrals have been made.	Implementation is not yet consistent in all classes, manual recording, growth charts are not always available, follow-up is not scheduled.
Product	The program helps detect delays, strengthens school–parent communication, and triggers early intervention.	Longitudinal analyses have not been conducted, documentation of intervention outcomes is limited, and program sustainability remains variable.

3.5. Discussion

The research findings confirm that the evaluation of the DDTK program must be understood as a comprehensive evaluation of the quality of PAUD services. In early childhood, growth and development are inseparable from learning experiences, health, and family support. Therefore, when RA Bani Adam made DDTK an institutional requirement, the school was actually expanding its service function beyond classroom instruction to a more holistic monitoring of child development.

From the perspective of the CIPP model, the program's primary strength lies in its context and relevance. Schools have identified real-world problems: incomplete child health data, the difficulty of communicating suspected delays without data, and the need for coordination with community health centers. These findings are important because programs that are relevant to field needs tend to be more readily accepted by teachers and parents. However, a strong context needs to be accompanied by strengthened input to prevent the program from relying solely on personal initiative.

In terms of input and process, research results indicate that program implementation has not yet fully moved from recording to analysis. Teachers have collected data, but they lack the technical skills to read growth charts, use screening instruments independently, and connect detection results to classroom stimulation strategies. Therefore, strengthening teacher capacity is a crucial prerequisite for DDTK to become more than just a measurement ritual and a basis for pedagogical and child health decisions.

The product aspect demonstrates that the DDTK program has a tangible impact, particularly on schools' ability to detect problems early and expedite referrals. Within the context of developmental theory, these benefits are crucial because delays in language, concentration, or social-emotional behavior in early childhood require rapid

response. Case findings of children who improved after therapy demonstrate that when detection results are followed up, the program can produce meaningful changes in children's development.

The practical implications of this research are the need for program standardization at the school level. RA Bani Adam requires written SOPs, a more consistent measurement schedule, the development of a simplified database, the provision of more comprehensive screening instruments, and a post-referral re-evaluation mechanism. With these steps, the DDTK program will not only benefit individual children but can also serve as a basis for planning more targeted health and learning services at the institutional level.

Table 5. Recommendations for program strengthening priorities

No	Recommendation	Expected contribution
1	Develop written SOPs for DDTK	Ensuring more consistent program objectives, schedules, indicators, referral flows, and reporting.
2	Teacher training related to SDIDTK/KPSP	Improving teacher capacity in measurement, interpretation of results, and follow-up stimulation.
3	Adding screening tools and instruments	Reduce tool queues, expand screening coverage, and improve service accuracy.
4	Simple digitalization of record keeping	Facilitates analysis of growth trends and longitudinal documentation of intervention results.
5	Regular communication forum with parents and health centers	Strengthening collaboration, referral follow-up, and program sustainability.

4. CONCLUSION

This study shows that the Early Child Development Detection Program (DDTK) at RA Bani Adam, Bekasi City, is relevant to the institution's needs and beneficial for monitoring child development. In terms of context, the program arose from the school's real need for objective child development data and supports SDIDTK policies, but does not yet have a written SOP. In terms of input, basic resources and partnership support are available, although the number of tools, instruments, and teacher training is still limited. In terms of process, physical measurements have been carried out monthly but are not consistent, recording is still manual, and follow-up is not structured. In terms of product, the program has been proven to help early detection, strengthen school-parent communication, and encourage faster referrals, but longitudinal analysis and documentation of intervention results are not optimal.

Thus, the DDTK program at RA Bani Adam can be considered quite effective as an initial growth and development monitoring service, but requires system strengthening to ensure sustainability. Priorities for improvement include program standardization through standard operating procedures (SOPs), improving teacher competency, providing more comprehensive instruments, strengthening coordination with community health centers (Puskesmas), and developing a recording system that facilitates data analysis over time.

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