HELEN KELLER INTERNATIONAL

ASSESSMENT OF THE VITAMIN A TECHNICAL ASSISTANCE PROGRAM (VITAP)

ANNEX 6. INDONESIA COUNTRY REPORT

November 26 - December 11, 1992

Margaret Ferris-Morris, M.S.
Mary Ruth Horner, Ph.D.

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Helen Keller International
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EXECUTIVE SUMMARY

Indonesia is one of the countries selected by Helen Keller International, AID and collaborating Private Voluntary Organizations (PVOs) for inclusion in this assessment for a range of reasons: diversity of vitamin A dissemination activities, the number of Vitamin A Technical Assistance Program (VITAP) consultancies for PVO projects, complex service delivery to the numerous islands, and current stage of evolution of VITAP. Furthermore, Indonesia provides an example of the VITAP model operationalized with a full-time VITAP Coordinator in-country.

The team members chosen to assess VITAP activities in Indonesia were Ms. Margaret Ferris-Morris, MS, and Mary Ruth Horner, Ph.D., both nutritionists with extensive experience working with U.S. - based PVOs and non-governmental organizations (NGOs) in developing countries.

The team's assessment methodology included: review of documents, i.e. HKI/VITAP New York reports and in-country VITAP and PVO and NGO reports, interviews with HKI staff and the VITAP Coordinator, interviews with Ministry of Health staff in Jakarta and their field representatives in Lombok and Semarang; visits with VITAP collaborators in Jakarta including PATH, Fatayat NU, Muslimat NU, Project Concern International, and Planned Parenthood--IPPA/PKBI. Telephone interviews were held with ADRA, CARE, CRS, World Vision and Lembaga Bina Potensia (LBP). Field visits were made to the PATH program and CARE offices in Lombok, to IPPA/PKBI Bina Anaprasa (preschool center) in Salatiga, Central Java; and to Fatayat NU in Jakarta. Protocol questions, drawn up by the team before departure, were used when and where applicable.

Limitations on assessment activities included: inaccessibility of NGO project sites located in far provinces, and language barriers and other difficulties in collecting information from the VITAP Coordinator. As a result, some estimates of accomplishments may be low and some conclusions may be incomplete.

Factors which supported or enabled assessment activities included: a positive environment and time-frame for vitamin A programming, and positive responses from agencies collaborating with VITAP when faced with an unsolicited assessment from a peer agency. Assessment team visits typically renewed or reinforced NGO interest in vitamin A, and additional requests for TA and information were generated.

HKI began work in Indonesia in 1972, with VITAP activities commencing in the beginning of 1990. Previously, 60,000 children went blind each year due to nutritional insufficiency of vitamin A. As a result of interventions by the Ministry of Health (MOH), HKI, and PVOs and NGOs working with VITAP, that number has recently been drastically reduced. Each year the MOH distributes 40 million high dose capsules (200,000 IU) to an estimated 20 million children age 1-5. Social marketing is used to

help increase consumption of vitamin A capsules and will focus in the future on consumption of vitamin A-rich foods.

In February 1990, VITAP was introduced to the MOH and potential collaborators in a national workshop held in Jakarta. The workshop served both to encourage the MOH to work more closely with NGOs and to broaden the national vitamin A program. The initial workshop was followed by NGO submission of project proposals to VITAP. ADRA and Church World Services counterpart PELKESI requested and received training.

VITAP activities became more intensified when HKI hired a Coordinator in January 1991 to work full-time to achieve VITAP's goals. The new VITAP Coordinator hosted the second orientation of potential collaborators, stressing VITAP's role as provider of technical assistance and not as a funding agency. VITAP's first task has been to build awareness of the new understanding of vitamin A's role in child survival before any other technical assistance activities can be undertaken.

This evolution of activities has been hampered by a central deficiency in the planning: there was no country-specific strategy to convince NGOs of the necessity to integrate vitamin A programming into their child survival activities and develop the needed program components. Early misunderstandings among VITAP-Indonesia, VITAP collaborators and VITAP-New York appear to have hampered VITAP's efforts. These problems may have been avoided if a specific plan for implementing VITAP had been clearly communicated and agreed upon. Nonetheless, many positive results have been achieved and are summarized below.

VITAP ACCOMPLISHMENTS

The principle accomplishments attributable to VITAP in Indonesia include the following:

PVO, NGO, and MOH Collaborators

Development of Ministry of Health guidelines and policies for vitamin A:

- VITAP played a key role in the development of the Directorate of Nutrition's new policy regarding the role of NGOs in vitamin A deficiency (VAD) control and subsequent guidelines for NGO - assisted distribution of vitamin A capsules (the latter is currently in progress); and facilitated the change in climate within the GOI to work with NGOs and recognize their potential to enhance health service coverage.

- MOH gave permission for NGOs to distribute vitamin A capsules (VAC).

Increased number of agencies and development staff involved in vitamin A programming:

- Prior to VITAP, no other PVOs or NGOs were known to be involved in vitamin A activities. Now there are four US PVOs -- PATH, PCI, ADRA and World Vision -- and at least four local NGOs -- Fatayat NU, Muslimat NU, LBP and IPPA/PKBI, as well as other smaller NGOs involved in vitamin A deficiency prevention and control (VADPC).

- At least 7 US PVOs and 14 local agencies and 158 agency staff have been trained or received VITAP lectures. Currently nine collaborative projects are underway.

- Two agencies, ADRA and WVI, have proceeded to apply initial assistance from VITAP to the development of additional vitamin A activities and their integration into their health programs.

Increased number of proposals submitted and funded for vitamin A activities:

- VITAP assisted three NGO proposals in receiving funding for vitamin A programs: Lembaga Bina Potensia, Sintesa and Indonesian Planned Parenthood Association (total US $710,000).

Increased development agency linkages assisted by VITAP:

- Awareness-building of the role of vitamin A in child survival is being done through networking and professional meetings, for the development community and for medical personnel.

Increased development and adaptation of vitamin A materials in collaboration with NGOs:

- VITAP collaborative projects include development of a pre-school flip chart and model food toys with IPPA, and a module for training religious groups about vitamin A and nutrition with Fatayat NU.

- Four additional booklets were adapted and/or translated.

- The Philippines nutrition prescription pad will be adapted by Fatayat NU.

Development of in-house HKI resources and technical capabilities:

- Expertise previously provided by consultants is now provided in-house by the VITAP Coordinator.

Increased importance of VITAP as a key resource project for vitamin A:

- There is consolidation of VITAP's reputation among development agencies, the MOH, and others regarding VITAP as the key resource project for vitamin A; and increased awareness of VITAP's capabilities.

- There is consultation by agencies, international organizations and the MOH with VITAP for advice about iron and iodine (micronutrients) programs.

<u>Community Level</u>

Increased community level impact:

- At least 55 gardens have been planted in ADRA assisted areas, after receiving VITAP training and the VITAP gardens manual.

- A very limited increase in post-partum mothers receiving vitamin A has been observed. (These programs have only recently begun).

- Awareness of the role of vitamin A in child survival has increased in ADRA village health promoters and the mothers they have reached (est. population 25,000).

VITAP's impact on increasing delivery of VAC to the target population is difficult to measure, and drawing conclusions at this point may be premature. Many agencies are working to increase attendance at posyandus (village health posts) for a large variety of health reasons (EPI, growth monitoring, birth registration, etc.), and as attendance increases, it may be presumed that more beneficiaries will receive VACs as well.

In summary, VITAP has had a positive and major impact on changing the MOH vitamin A policy, and to a lesser extent, positive impact through awareness-raising, fund raising and support for proposals and programming on the development agencies with which it has collaborated. The VITAP model in Indonesia also appears to be more cost-effective mechanism for promoting and integrating vitamin A deficiency control into NGO activities than could have been achieved through separate consultancies. Technical assistance provided by the VITAP Coordinator can be expected to produce more field-level results but only after sufficient time is allowed for their evolution.

Recommendations

1. Develop a more comprehensive theoretical and operational *plan*. The current *modus operandi* is taken loosely from the global program. VITAP technical

assistance delivery should be focused and concentrated:

a) Review the current core group of agencies selected for collaboration and see if they can fulfill these purposes:

   1) develop models of more effective VAC delivery to children under five and post-partum mothers; and

   2) develop educational materials for their beneficiaries.

b) Redirect TA from central MOH and agency levels to target provincial and district levels.

c) Increase follow-up and maintain feedback. Initiate routine use of standardized forms for evaluation of TA and for requests for additional assistance.

d) Target urban populations by collaborating with an NGO working on a health-related urban project in which vitamin A education and VAC delivery models could be piloted.

2. Expand NGO-to-NGO and VITAP-to-VITAP linkages. Additional linkage activities might include:

   a) hosting a consultative workshop with NGOs presently involved in various aspects of vitamin A programming; and

   b) coordinating cross-visits by NGOs to each others' projects, and a VITAP-to-VITAP cross-visit to the Philippines.

3. Collaborate with USAID/Indonesia to have vitamin A included as a criterion for acceptance of programming in the Child Survival proposal review process for agencies working on Child Survival projects in areas with high VAD.

4. Address certain gaps in vitamin A programming using district models (trickle-up effect), e.g., provide delivery of vitamin A for measle cases, provide VACs 12 months a year for high-risk cases, and conduct training of trainers for core agencies.

5. Establish clearer reporting between budget line items and activities, and establish an individual line item for each NGO collaborative project.

6. Establish system for routine documentation of all activities, and file periodic written reports.

7. Give special attention to micronutrients and explore nutrition education techniques which may be more effective for changing behaviors than the more traditional educational paradigms currently in use.

8. Promote consumption of vitamin A-rich foods, including messages, materials, and channels (e.g., schools, mass media). Encourage collaboration of projects with Ministries of Religion and Agriculture.

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ACRONYMS

ADRA	Adventist Development and Relief Agency
CS	Child Survival
CRS	Catholic Relief Services
DON	Directorate of Nutrition
EPI	Expanded Program on Immunization
GOI	Government of Indonesia
HKI	Helen Keller International
IVACG	International Vitamin A Consultative Group
IPPA/PKBI	Indonesian Planned Parenthood Association
LBP	Lembaga Bina Potensia
MCH	Maternal and Child Health
MOH	Ministry of Health
MicroNET	HKI Micronutrient proposal
NOVIB	A Dutch funding agency
NGO	non-governmental organization
OPV	oral polio vaccine
PATH	Program for Appropriate Technologies in Health
PCI	Project Concern International
PKBI	Indonesian Planned Parenthood Association
PKK	The National Family Welfare Movement
PVO	private voluntary organization

SCF	Save the Children Federation
SDA	Seventh Day Adventist
SOMAVITA	Social Marketing for Vitamin A (HKI project)
TA	technical assistance
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
USAID/PVC	Bureau for Private Voluntary Cooperation
VAC	vitamin A capsule
VAD	vitamin A deficiency
VADPC	vitamin A deficiency, prevention and control
VITACS	Vitamin A Technical Assistance for Child Survival
VITAP	Vitamin A Technical Assistance Program
VPHC	Village Primary Health Care
WVRD	World Vision Relief and Development
WVI	World Vision International

I. COUNTRY INTRODUCTION

A. Overview

Indonesia is a culturally diverse country comprised of some 13,700 islands, of which approximately 7,000 are inhabited. Of the 180,000,000 population, 95% lives on six main islands: Java, Sumatra, Sulawesi, Kalimantan (Borneo), Bali, and Irian Jaya. The predominant religion is Islam (90%); however, there is freedom of expression for other faiths.

The government system is parliamentary based on the 1945 constitution. The highest authority is the People's Consultative Assembly which elects the President and Vice President and establishes the country's Five Year Plan. The country is divided into 27 provinces, which are further divided into districts (kabupaten), subdistricts (kecamatan), and villages (desa). Within a village, there may be many hamlets. There are approximately 66,700 urban and rural villages.

B. Ministry of Health (MOH)

Social and cultural diversity, as well as logistic complexities, present special challenges to health interventions in Indonesia. The centrally operated Ministry of Health supports the provision of primary health care services in two ways through community health centers (*puskesmas)* which are located in districts and subdistricts, and through the health posts (*posyandu*). Community health workers (*kader)* deliver village and hamlet based basic health services through the posyandu. In the more than 5,500 puskesmas, the district or subdistrict is served by a core team of at least one doctor and several trained health professionals: midwife, vaccinator, nurse and others. In some remote areas, the puskesmas may be up to 30 kms from a village, whereas in urban areas, they are more easily accessible.

Ideally, the puskesmas supports the posyandu with a doctor or nurse visit monthly and provides necessary basic medicines. One posyandu should service 100 children under five years of age, although only Bali and Yogyakarta have reached that target, the others have fallen short. Complete posyandu services include growth monitoring, distribution of vitamin A two times yearly, family planning, diarrheal disease control, immunization, maternal care, and counseling. However, in reality, many posts do not offer all services. The most common services are weighing of children under two, immunization and family planning. Furthermore, some remote areas do not have posyandus. The estimated complete coverage for immunization of children under one is 80 percent (1990), which reflects the general availability of health services. However, in areas such as the Maluku islands, Expanded Program on Immunization (EPI) coverage is estimated at 27 percent of infants. Maternal child health services reach approximately 50 percent of their target group.

Posyandus in regional areas are held once a month and last a morning or afternoon. Under professional supervision of the puskesmas, trained volunteer *kaders* (health care

workers) conduct weighing and immunizations. Kader personnel usually consist of: the village chief's wife (who is a member of the National Family Welfare Organization -- PKK), members appointed by the village chief representing non-governmental organizations (NGO)[1] such as Fatayat NU, and other appointed members. Each posyandu should have ten trained kader, of which four to six may be active. Clients visit five tables: 1) registration, 2) weighing, 3) weight recording, 4) counseling, and 5) other medical services, such as immunizations.

Locations of posyandus, typically held in houses, schools, or under a tree, vary from month to month. Kader must announce the date and place of posyandu ahead of time and mobilize mothers to bring their children. Typically children under two are brought to receive immunization, weighing and vitamin A. Children three to five years old often fail to receive health services, including the receipt of vitamin A. The great distances between some of the puskesmas and the posyandus also present difficulties for transport and supervision of services--hence the gap between the ideal and the actual delivery of services.

Recently, the Ministry of Health has recognized the role of NGOs in mobilization of mothers to come to the posyandu and to assist the kader in recording, counseling and other tasks at the posyandu. In the past, the MOH has restricted NGO's participation in posyandus. Advocacy of NGO involvement in enhancing health care coverage has been a key role of HKI, groundwork on which VITAP has been able to build.

C. Health and Nutrition

The estimate of infant mortality in Indonesia is 71 deaths/1000 live births, based on the 1985 Inter-censal Population Survey. The under-five child mortality rate is estimated at 100 deaths/1000 live births (UNICEF 1990). Leading causes of young child mortality include diarrheal disease, measles, diphtheria, pertussis, acute respiratory infections, and malaria.

Moderate and severe protein-energy malnutrition (PEM) is responsible for nearly 16 percent of the deaths in children aged one to four. Micronutrient deficiencies of iron and iodine are also significant problems in Indonesia. An estimated 70 percent of pregnant and lactating mothers are anemic, and goiter (iodine deficiency) affects more than 10 percent of newborns who suffer from endemic cretinism.

Vitamin A deficiency is the single most important nutritional deficiency after PEM. A national study conducted by the Government in 1977-1978 with technical assistance from HKI found levels of active corneal xerophthalmia and non-corneal xerophthalmia (2.7

[1] For the purposes of this report, the term "NGO" includes "PVO" except where there is a need to make an explicit distinction between the two.

and 32 per 1,000, respectively) to be of public health significance. Studies from Indonesia and other countries indicate that up to 35-50 percent or more of these cases are preventable by providing vitamin A supplementation (VAC).

II. HELEN KELLER INTERNATIONAL IN INDONESIA

Helen Keller International (HKI) has assisted the MOH in Indonesia since the early 1970's. The tireless efforts of Dr. H.A.P.C. Oomen, a Dutch physician nutritionist who had served in Indonesia for 20 years and during World War II, brought the plight of nutritional blindness in Indonesia to the attention of HKI, WHO, governments and other interested parties. HKI's point of entry with the Government of Indonesia (GOI) was to document their progress in controlling nutritional blindness so that other parts of the world could benefit from their research. Indonesia was selected for initial project work with vitamin A-related blindness prevention, because it was one country with the best documented need and with readiness for action. The MOH gave high priority to the prevention of vitamin A deficiency in children. They were the first to pilot test distribution of prophylactic doses of vitamin A (200,000 IU) and evaluate its effectiveness in reducing the amount and severity of nutritional blindness. HKI, under the direction of Dr. Susan Pettiss, assisted in the evaluation of capsule distribution with technical and financial support. The findings provided the basis for planning the future national program, and in 1974, the GOI made a commitment in their five-year plan to provide preventive measures. Dr. Pettiss was instrumental in all the early HKI technical assistance to Indonesia.

HKI-USAID-GOI collaboration on development of programs for prevention on nutritional blindness has been underway since 1973. Program efforts have included capsule distribution, fortification of MSG in particular, nutrition education, training and other support activities.

In 1979, HKI established an office in Jakarta. Historically, HKI has been one of few NGOs to work closely with the MOH at the central level. Throughout the 70's HKI's work was in many areas of eye care, (e.g., primary eye care and rehabilitation of the blind) including preventing blindness from vitamin A deficiency (VAD). HKI's efforts to combat VAD was through a series of grants involving assessment, VAC distribution, social marketing, and fortification. Social Marketing for Vitamin A, SOMAVITA, is an HKI project funded by US AID in Indonesia. SOMAVITA I and II have focused on increasing consumption of high-dose vitamin A capsules in a target population of children under five and post-partum women using social marketing techniques. SOMAVITA II will be implementing the marketing of vitamin A-rich foods in 1993.

HKI has an office and SOMAVITA representative in the MOH, working closely with the DON to enhance coverage of vitamin A capsules (VAC) and to promote feeding vitamin

A-rich foods to children under five via social marketing. Recently, post-partum mothers and children with measles have been added to the target group.

Of the 27 provinces of Indonesia, 13 are targeted by HKI for health intervention through SOMAVITA and VITAP programs. UNICEF supplies VAC for distribution throughout all of Indonesia, and supports some vitamin A activities in the other 14 non-targeted provinces. While xerophthalmia rates have been reduced in certain regions of the country because of government and international agency efforts, recent evidence indicates as many as 40 percent of preschool children in high risk areas may still suffer from significant, sub-clinical vitamin A deficiency.

Historical Highlights:

1971	MOH pilot tested high-dose VAC.
1972	The first contact was made by HKI and GOI about addressing nutritional blindness in Indonesia.
1972-1975	Another field test of high-dose VAC and evaluation was undertaken by HKI.
1973	HKI/USAID and GOI collaborative efforts commenced.
1974	Results of field test study were presented to USAID and WHO, and an action plan was developed.
1974	GOI drew up directives for nutritional blindness prevention in its five-year plan (1974-1979)
1976-1979	Dr. Alfred Sommer conducted a large longitudinal study on VAD in 24 provinces. Outcomes of study were many and varied contributing a wealth of data and new program directives, e.g. services to the blind, particularly in area of integrated education.
1979	HKI established an office in Indonesia.
1980	HKI began assisting GOI in development and evaluation of alternative VADPC programs.
1990	VITAP was introduced to Indonesia.

III. VITAP PROGRAM

A. Overview

VITAP was started in Indonesia in February of 1990. The charge of the VITAP program was to increase vitamin A consumption in vulnerable groups via provision of technical assistance to development agencies involved in child survival programming. The program goals and objectives outlined by the HKI Country Director, in accordance with the overall VITAP goals, are described below.

Program Goals:

1. Increase the number of NGOs implementing vitamin A activities and expand the number of such activities by each PVO.

2. Increase the number of NGOs with in-house capabilities in vitamin A programming and strengthen their existing skills.

Objectives:

1. Provide a consulting and advisory service for NGOs in vitamin A programming, including assisting to determine the most appropriate interventions and methodologies.

2. Establish a technical assistance personnel resource and consultant data bank.

3. Provide information and materials on vitamin A, including a data bank of vitamin A literature and institutional resources.

4. Provide human resources and technical materials for continuing education and in-country workshops in order to train NGO representatives in vitamin A interventions.

5. Provide for development of materials with local-based NGOs including design and development, field testing and reproduction and distribution.

6. Provide short-term consultancies (local and international) in specific technical areas, i.e. monitoring, assessment and social marketing and others.

7. Provide sub-grants to NGOs of up to 10 million rupiah (approx. US $5,000) for seed money to initiate pilot components with NGO field groups, i.e., problem assessment survey, focus groups, NGO-specific promotional or training materials.

8. Provide an HKI regional Coordinator for liaison with HKI headquarters and field offices, local management of activities and as a regional resource. [2]

(Source: Wilbur, S., Memorandum, February 2, 1990).

Structure:

A Steering Committee was established to maintain oversight and government liaison for this project and consists of members of the following organizations:[3]

1. Directorate of Nutrition
2. Health Education Center
3. Directorate of Community Participation
4. HKI
5. UNICEF

An orientation session was held at that time (February 1990) for US-based Private Voluntary Organizations (PVOs) including Adventist Relief and Development Agency (ADRA), Christian Children's Fund, Church World Service, Project Concern International (PCI), Project Hope, Save the Children Federation, and World Vision; and for local Indonesian NGOs. The general role of VITAP was described during this session: to provide technical assistance (TA); to provide assistance identifying project funding sources and applying for funds; and to provide some services and limited funding in specific collaborative projects where VITAP and NGO objectives intersect.

At the end of the workshop a call was issued for proposals from PVOs and NGOs for initial funding were made. Grant requests to VITAP from PVOs and NGOs were made submitted, but they did not conform to the expectations of VITAP-Indonesia concerning the operation of VITAP in Indonesia. The initial design of VITAP by Helen Keller International (HKI)-New York lacked specific strategies, objectives and evaluation components. Based on the information available to the evaluators, this design failure from both VITAP-New York and VITAP-Indonesia appeared to have caused difficulties for HKI-Indonesia in establishing a strategy for its VITAP operation that would be both effective and acceptable to USAID and VITAP-New York.

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[2] For a variety of reasons, the VITAP Coordinator position never expanded into regional coordinating responsibilities as originally planned.

[3] There was no PVO or NGO representation planned for this committee other than HKI itself.

B. Proposal Process and Relationships with Collaborators

VITAP Indonesia received nine proposals from organizations which attended the first orientation. However, because they were requesting funding support instead of TA, the newly established Steering Committee decided not to fund them. Six to eight months were spent trying to redefine the funding requests, but the perception had already been established that VITAP was an NGO funding project. The only TA requests met immediately were from ADRA for two trainings, and from CWS and ADRA for a gardens manual for sandy soil.

One year passed before a second orientation session was held in February 1991. Primarily local NGOs attended. NGOs were selected to participate based on the following criteria: size, eg. large membership and/or programs in many provinces; programs in provinces which are a high priority for vitamin A deficiency, prevention and control (VADPC); a history of collaboration with the SOMAVITA project (such as Muslimat NU); and rapport between the NGO representative and the VITAP representative. Application procedures for proposals were presented, and the role of VITAP was discussed; however, it is not apparent that proposals were submitted after the second session. Later, the VITAP Coordinator solicited two agencies to re-submit proposals (PKBI and Fatayat), which will be funded.[4]

Apparently confusion persisted concerning VITAP's charge. Some PVOs chose not to investigate VITAP's TA and low-cost implementation strategies since VITAP did not provide project funds. These uncertain initial steps made some agencies reluctant to collaborate with the VITAP program.

One major structural problem was the requirement that projects be funded only through US PVOs, in spite of the fact that local NGOs were involved in development programs with greater penetration, and that the GOI required foreign agencies to work through local counterparts. It was suggested that local NGOs access VITAP's TA through US PVOs. This presented practical difficulties, and although the obstacles were not insurmountable, this extra procedure was an affront to some local NGOs. With the exceptions of PATH and PCI, US PVOs in Indonesia were not selected for additional TA for reasons largely unexplained.

'BINGOs' (*big Indonesian NGOs*) such as Fatayat NU, Muslimat NU, and PKBI have been targeted for in-depth assistance from VITAP since they have both interest and funds. Lembaga Bina Potensia (LBP), also part of the core group, is a smaller local NGO which has a holistic development approach. LBP is testing delivery models

[4] Differing information has been provided about the proposal process from the first and second orientation workshops by all parties involved.

through TBAs to post-partum mothers, agriculture techniques to produce vitamin A rich foods, and development of educational materials for mothers and children. PATH and PCI/Sintesa will also receive more in-depth TA from VITAP for testing of VAC delivery models through TBAs to post-partum mothers. As VITAP has only begun working with these organizations, technical assistance will need to be more intensive and varied during the next year, to include development of DIPs, monitoring, follow-up, advice, and evaluation.

Although the original VITAP grant was designed for US PVOs, VITAP New York and Indonesia (among other countries) realized that USAID requirements would hamper VITAP's fulfilling its objectives unless local NGOs could be incorporated to receive technical assistance. In Indonesia, each US PVO program was encouraged to have an Indonesian counterpart to assure that local agencies would benefit, albeit indirectly. As this became a cumbersome process, VITAP-Indonesia decided to work directly with local organizations.

Limited technical assistance has been provided to US PVOs whenever they have requested it. Of the six US PVOs listed as possible core collaborators in the HKI quarterly report for Indonesia, October - December 1991, two have collaborative projects with VITAP (PATH and PCI), both for increasing consumption of vitamin A (via VAC) to new mothers.

C. Relationship of VITAP Field Office with VITAP-New York Office

After negotiations with HKI/NY, HKI-Indonesia was authorized in 1990 to hire a full-time VITAP Coordinator on an experimental basis. Unfortunately, it took another 10 months before a suitable candidate was hired. Dr. Roy Tjiong joined as VITAP Coordinator, in February 1991, one year after the commencement of the VITAP program in Indonesia. VITAP-New York provided some training and orientation for the new Coordinator, in the form of correspondence, a meeting in India, and a field visit by a VITAP-New York staff person, all in 1991.

VITAP-New York assisted the VITAP Coordinator in developing an outline for writing action plans for a core group of VITAP collaborators, delineating the ways that aspects of vitamin A programming would be integrated into their programs, clarifying what was expected from VITAP by the collaborators, and detailing what the shared funding responsibilities would be. However, confusion persisted between the New York and Indonesia offices of HKI over the issue of cost-sharing between VITAP and its collaborators, that is, the extent to which participating NGOs would cost-share some expenses while receiving others free, such as TA. VITAP-Indonesia expressed discomfort with the task of funding sub-grants to other agencies, but nevertheless proceeded with this plan. As a result, VITAP's collaborators developed the expectation that VITAP would provide start-up funds for their joint activities in addition to free technical assistance. Meanwhile, VITAP/NY called for more cost-sharing with

collaborators, claiming never to have endorsed a sub-granting model of implementation. This remained a point of contention for VITAP-Indonesia. Hence, the initial action plans were never developed, nor the outline for implementation followed as VITAP-New York had intended.

IV. VITAP COLLABORATION

The groups with which VITAP is collaborating in Indonesia include NGOs and US-based PVOs, the Ministry of Health and other programs of Helen Keller International itself. These groups are categorized according to the amount of technical assistance provided which ranges from greater intensity (Group 1) to lesser intensity (Group 3). Each agency is described in detail, including program accomplishments, potential for success and factors which support and confound program implementation.

Comments in this section are based on meetings in Jakarta with key officers of Fatayat NU and Muslimat NU, Fatayat representatives participating in pre-testing SOMAVITA promotional materials and UNICEF and MOH officials.

A. Introduction to PVO and NGO Collaborators

Group 1. Core Collaborators

1.a UNICEF Circle

In collaboration with the Ministries of Religion and Health, UNICEF has formed the UNICEF Circle. This group is comprised of religious-oriented Indonesian NGOs and is designed to facilitate the collaboration between UNICEF and NGOs in matters related to child survival. Even though their primary focus is religious activities, this group of women's organizations is also concerned with child survival. The UNICEF Circle has been selected by VITAP as having great potential for the promotion of vitamin A due to the members' interest in children's health and their extensive infrastructure throughout the country. The UNICEF Circle meets monthly, and in August 1991, the featured speaker was the VITAP Coordinator, who gave a presentation on vitamin A.

Two of the major organizations in the UNICEF Circle are Fatayat NU (which has local groups in 26 of Indonesia's 27 provinces) and Muslimat NU (local groups in 25 provinces). Members of the former are usually younger Muslim women who are unmarried, while members of the latter are typically married. Members of both groups, particularly Fatayat NU, may also serve as kaders in their villages or neighborhoods.

1.b Fatayat NU

The major collaboration between VITAP and Fatayat NU to date concerns the production of educational materials. The VITAP Coordinator translated a reference card, called Guidelines for the Prevention of Blindness due to Vitamin A Deficiency. Designed for use by posyandu personnel and village-level volunteer health motivator, this reference card serves health workers in the promotion of vitamin A-rich foods and distribution of vitamin A capsules twice a year. In addition, the VITAP Coordinator developed a manual for training health workers in the use of the card. This manual is tailored for use by religious groups, as it includes relevant scriptures from the Koran related to the importance of health. It also has potential widespread application as it can be reproduced for other groups with slight changes in the cover. Both the reference card and the manual are in the final stages of printing.

In addition, the VITAP Coordinator gave a presentation on vitamin A deficiency control and the use of social marketing during a Fatayat NU workshop on communication techniques held in August 1991. Thirty provincial representatives from Fatayat NU attended the session. During the assessment, there was an opportunity to discuss the vitamin A activities which six of the trainees had undertaken after the workshop.

Since they were not yet authorized to distribute VAC, these women concentrated on informing their neighbors about vitamin A and encouraging them to take their children to the posyandu during the months of VAC distribution. The majority of the interviewees lived in urban Jakarta and said that mothers were generally unaware of vitamin A. In addition, they expressed their frustration at not being allowed to distribute VAC, since a typical response from a mother whose awareness had just been raised was to request VAC on the spot. In the city, posyandus have the reputation of offering only one service, for weighing children and serving only poor clients as well. As a result, attendance is limited, even by those who could most benefit from the services provided.

This small group of interviewees was enthusiastic that Fatayat NU's members had taken the responsibility for distribution of VAC on a house-to-house basis, given the low coverage of the posyandu system in the city. However, they recognize that this type of activity must be sanctioned by the neighborhood governmental authorities, and that this is currently unlikely since these authorities do not want to relinquish their control over the posyandu.

1.c Muslimat NU

VITAP has been working with Muslimat NU, the other national women's religious NGO, for over one year in developing a proposal for incorporating vitamin A into their on-going activities. Of particular interest to VITAP is Muslimat's network of approximately 4,000 preschools and 49 Maternal and Child Health (MCH) clinics. The newest proposal, presented during the team's assessment, includes training activities for teachers

and paramedics for the purpose of motivating parents and children concerning VAC distribution and the consumption of vitamin A-rich foods. Muslimat NU proposed to take the responsibility for the direct distribution of VAC to all children attending its preschools. This proposal will now be reviewed by the VITAP Steering Committee for comment and action. If approved, actual allocation of any funds by VITAP is subject to their availability.

1.d Indonesian Planned Parenthood Association (PKBI)

Comments in this section are based on interviews with key PKBI officials in Jakarta, with the PKBI Board of Directors in Semarang and on a visit to a PKBI field site in East Java.

i. Organizational Overview

The Indonesian Planned Parenthood Association (PKBI) is one of the largest NGOs in the country, having 22 offices in 22 provinces. One of PKBI's strategies for promoting family planning is capturing the attention of parents through preschool education programs which their children attend. These PKBI-assisted preschools, called *Bina Anaprasa*, were started in East Java in 1979 and now comprise 108 preschools in 11 provinces. In addition to helping to establish the preschool, PKBI also assists in establishing a clinic for family planning and general health services.

The Bina Anaprasa program includes monthly meetings with the mothers of preschoolers, in which a variety of topics are discussed.

ii. VITAP Inputs

VITAP is collaborating with PKBI in developing a flipchart on vitamin A which can be used by trained speakers (e.g., the Bina Anaprasa teacher, health workers from the puskesmas and/or the local religious leaders) during this discussion period. This flipchart is ready to undergo its first pre-testing.

iii. NGO Outputs

VITAP is collaborating with PKBI in assessing the validity of the Bina Anaprasa network being involved in VAC distribution. The Bina Anaprasa framework, and all other preschools in Indonesia, provide an opportunity for the distribution of vitamin A capsules through the organizations which manage them. This model is actually in practice in one Bina Anaprasa preschool visited in this assessment located in the village of Gintan in East Java. In February and August, the midwife brings the VAC from the puskesmas to the school and the teacher is responsible for making sure that all children take them. If a child is absent on the delivery day, the teacher makes sure that the VAC is given as soon as the child returns to school. This delivery system for VAC appears to take into

account a number of crucial factors which make it a positive model encouraged for further promotion:

- The number of children involved is small, approximately 30-50 per preschool, thus facilitating distribution, record keeping and follow-up of those who are absent;

- The distribution takes place within an on-going system, i.e., by a teacher who works with the children every day, and who is very familiar with each child and can manage whatever follow-up is necessary;

- The vitamin A capsules are delivered to the school by the midwife, thus providing the necessary "transfer of authority" from the Directorate of Health to the operating NGO;

- The distribution of VAC is a separate, distinct and focused health activity for the preschool program, in comparison to the more typical situation at the posyandu where a variety of health-related activities are going on, only one of which is the distribution of VAC; and

- The number of preschools in Indonesia is large and growing, thus providing an important mechanism for reaching many at-risk children who have stopped attending the posyandu.

Despite the advantages mentioned above, delivery of VAC outside the posyandu system requires careful monitoring of individual children to prevent overlapping distribution in cases where a child enrolled in a Bina Anaprasa preschool also attends the posyandu. This issue is being addressed in VITAP's pilot project with PKBI.

iv. Future VITAP Activities

Future plans with PKBI include developing educational toys related to vitamin A which will be used to complement the collaborative activities already undertaken.

In addition to the activities described above in the Bina Anaprasa program, the VITAP Coordinator has also provided technical assistance to PKBI in the preparation of a proposal for a Food and Nutrition Project. This US $600,000 proposal has been accepted by NOVIB, a Dutch agency, and will be implemented in Irian Jaya, East Nusa Tenggara and South East Sulawesi. Through this grant, VITAP will be receiving some financial support for future technical assistance to PKBI to expand its vitamin A programming. Considered from the cost-benefit point of view, this one grant, developed and supported by the VITAP Coordinator, is more than six times the total two-year budget for VITAP itself.

1.e Lembaga Bina Potensia

i. Organizational Overview

Lembaga Bina Potensia (Institute to Develop Potential, LBP) is a local Indonesian non-governmental organization established in 1985. LBP works primarily in integrated community development, and has projects in two villages in the rural Hulu Sungai Tengah district in South Kalimantan. These villages have not been served directly with puskesmas or posyandu services. NOVIB has funded LBP for the past two years to enhance the project's health and nutrition components, a relatively new area for LBP. These components include growth monitoring, family planning, training of health kaders, provision of ORS and high-dose vitamin A, as well as provision of supplemental foods. Farming and kitchen gardening are also major aspects of their project.

ii. VITAP Inputs

The VITAP Coordinator assisted LBP's project in a number of ways. VITAP provided TA to help focus LBP's project directions and to include additional components important to child survival and vitamin A status, including promotion of colostrum, longer-term breastfeeding, and changes in maternal behavior to include giving vitamin-rich foods during early childhood. The objective to increase quality and quantity of food consumption is being addressed through improved farming techniques and seed selection for vitamin-rich crops. VITAP TA included giving advice concerning the detailed implementation plan (DIP) in the second two year period of the project, and performing a focus group survey and rapid village appraisal for the mid-term assessment. In addition, Indeco de Unie, NOVIB's local counterpart, has asked the VITAP Coordinator to be a technical advisor for the LBP project.

iii. NGO Outputs

LBP has written a new proposal and DIP which include additional vitamin A programming. NOVIB has funded LBP US $90,000 for 1993-94. The VITAP Coordinator provided advice on sections in the new proposal on the establishment and strengthening of new posyandus.

Village participation in the LBP project has been high. One village has built a health center so that a village trained MOH health professional will work at the center. At present they are focusing on social mobilization of mothers and children to go to the posyandu, where they are building links with the local MOH to bring basic health services to their target villages. Vitamin A is now included in the posyandu recording forms. Also, the local MOH now provides VAC to the LBP-served villages. LBP has recruited 10 kaders and conducted training for them. They will be the posyandu staff and potentially assist in VAC distribution to villages and village clinics. Midwives will receive VAC also.

LBP's first steps to encourage the community to diversify its food sources were using house-to-house extension work and introducing successful farming techniques from another Indonesian province. Ten West Javanese farmers and their families were invited to temporarily relocate to Kalimantan and work with LBP to exchange farming techniques and seeds. In turn, LBP is paying a small stipend for housing, and providing temporary land. The farmers from West Java plan to show how to plant more productive gardens, and to introduce new food preparation techniques and recipes. LBP will initially supply the village with seeds and fertilizer to prepare land for six-year crop rotations. During the second cropping session, seeds will be made available through a credit scheme so that villagers will not become dependent on handouts and project sustainability may be attained. Vegetable, peanut, and papaya seeds, and banana trees will be distributed initially.

iv. Finances

NOVIB has awarded LBP grants totaling US $152,000. During 1991-92 approximately 40 percent of the monies were spent, the remaining 60 percent (or $90,000) will be spent during this new proposal period 1993-94. The VITAP Coordinator provided assistance with the current grant, which allocated approximately 30 percent of the $90,000 for health and nutrition activities. Approximately $6,000 of the $90,000 is for gardening activities and another $3,500 for program development. Some of the grant monies support the West Javanese farmers in relocation, housing, etc. The assessment team was unable to obtain evaluation information about this project.

v. Future VITAP Activities

Thus far, LBP has been satisfied with VITAP assistance. They have requested more information, journals, leaflets and booklets, and wanted to become more familiar with the work of VITAP and HKI. LBP expressed an interest in an Indonesian VITAP newsletter (like that of Project MATA in the Philippines). LBP is interested in examining a tested model of vitamin A programming that has been integrated into an existing program, and would like VITAP to facilitate that cross-sharing.

From VITAP's point of view, the Coordinator would like to give LBP more TA in these areas: how to increase coverage and how to become sustainable, especially through income generation, in preparation for LBP withdrawal. Additional programming details and recommendations can be found in the Narrative Report HKI-Indonesia.

vi. Discussion

Lembaga Bina Potensia appears to have an innovative development approach, as it is willing to try different provincial farming techniques. The VITAP Coordinator has taken advantage of the opportunity to assist this agency with the integration of vitamin A components into the child survival program. Together with VITAP, with financial

backing from NOVIB, LBP's potential could be great for piloting vitamin A program components-- for example, 1) encouraging production of vitamin A-(and micronutrient Fe-I) rich foods, 2) testing a VAC delivery model for post-partum mothers, and 3) developing innovative techniques to mobilize mothers to attend posyandu. Although LBP may be relatively new at health interventions, they exhibit a desire to learn and try new promising methods.

Group 2. Collaborators Receiving Intermediate Levels of Assistance.

2.a Program for Appropriate Technologies in Health (PATH)

HKI-Indonesia participated from the beginning in PATH's involvement in vitamin A activities. PATH manages the Vitamin A for Child Survival (VITACS) Project, funded by AID/PVC, which identifies VITAP as a key source of technical assistance. The project's objectives are to expand the availability and consumption of vitamin A supplements through existing service delivery channels of the MOH and PVOs.

PATH is testing a number of different experimental models to increase the delivery of VAC through the posyandu system to reach infants under one year of age during EPI contacts. Another model being tried provides VAC for post-partum women through contacts made directly after birth.

The assessment team had the opportunity to visit the PATH project in Lombok and to observe the delivery of health services to two different mothers and their newborns. With the traditional birth attendant (TBA) present, the nurse from the local MOH clinic weighed the baby and administered a hepatitis B shot and a dose of oral polio vaccine-OPV (called "null" as it precedes the one which constitutes OPV-1). The mother received a tetanus toxoid shot, a VAC, a supply of iron tablets and information about care of the umbilical cord and breastfeeding.

This model, in which VAC is distributed to post-partum women by MOH personnel, appears to be functioning in PATH's project areas in Lombok. To take the next step to have VAC distributed by TBAs alone, as is being tested in North Sulawesi, requires the MOH to surrender the VAC to TBAs -- non-MOH personnel -- on a year-round basis. If TBAs can be trained to manage this intervention and if all necessary MOH levels will accept this transfer of authority, this model has potential for far-reaching impact. Not only would the amount of vitamin A consumption of mothers and infants be improved, but the door would be opened to better cooperation between MOH and NGOs, since the MOH would have proof that non-MOH personnel can effectively contribute to MOH goals.

VITAP has worked with PATH in designing and providing information and advice to support on-going activities. In the near future, VITAP and PATH will work together to develop the training program for TBAs involved with PCI's new project in the Maluku

Islands. Also, PATH and VITAP are in the process of developing strategies for training physicians in the treatment of measles with mega-doses of vitamin A.

2.b Project Concern International and Sintesa

i. Organizational Overview

Project Concern International (PCI) funds its health activities with USAID Child Survival grants. Its projects in Indonesia include expanding immunization coverage through increased posyandu attendance; diarrhea management and prevention; growth monitoring; and the training of traditional birth attendants (TBAs), kader, provincial and district health staff, village chiefs and members of religious organizations. They are also working to improve local data collection and increase effectiveness of posyandus. The aim of PCI's work is to create local agencies (*anak* or child agencies) and relinquish 90 percent of project operations within two to three years. Their programs are targeted to reach 50 percent of preschool children in Southeast Sulawesi, Sumatra (Riau Province), and to children and mothers in the Maluku Islands. The Maluku Islands is an area comprised of some 1,000 islands located in mid-eastern Indonesia. The Malukus have the lowest Expanded Program of Immunization (EPI) coverage rate of all 27 provinces. 21 percent of villages do not have posyandus and the overall average attendance is estimated at 38 percent. There is a 50 percent dropout rate of kaders.

Sintesa is a local organization created by PCI working in South East Sulawesi. PCI established Sintesa as their 'counterpart agency' in 1990, in conjunction with a three-year Child Survival project. Sintesa now handles 90 percent of PCI operations in immunizations, growth monitoring and training of TBA's; however, it has had to search for additional funding, as two years was too brief a time to establish financial independence from PCI.

ii. VITAP and NGO Inputs

Sintesa in Southeast Sulawesi was assisted by VITAP with TA to better incorporate vitamin A into programming. A child survival proposal for Canadian International Development Agency (CIDA) was awarded $US 20,000. In this project, the VITAP Coordinator has also encouraged the provision of mega-doses of vitamin A to post-partum mothers, distributed by TBAs. PCI collaboration with VITAP commenced at the vitamin A workshop in Bogor, February, 1990. Since 1991, PCI/Sintesa and the VITAP Coordinator have been discussing collaboration on a vitamin A program through TBAs in the Malukus. Particular difficulties related to VAC distribution include:

- organizing the logistics of delivery and supply to the 1,000-plus islands, some of which have never been reached by MOH services;

- providing training to culturally diverse ethnic groups and language barriers for both TBAs and mothers;
- establishing posyandu locations for delivery of VAC; and
- searching out alternative routes for distribution, eg. via the more developed infrastructure of schools.

iii. NGO Outputs

VITAP collaboration with PCI and Sintesa has been too recent to detect community-level impact. PCI has tried social marketing and new techniques to increase posyandu coverage and hence to increase VAC consumption. Social marketing by SOMAVITA has met with some success in the main city, Ambon, and less success in rural areas, as few island villages possess radios and television.

PCI has tried an innovative way to increase EPI coverage and VAC distribution via local schools. In one pilot project, a 16 week teacher-child-parent curriculum was developed, covering one topic weekly on health and motivating fourth- and fifth-grade children to encourage their mothers and their younger siblings to go to the posyandu. Prizes were given to school children to reward mothers' increased posyandu attendance. In Sumatra, high school students run the posyandus in the PCI project. These pilot projects reportedly have met with some success and were low cost. VITAP could have a role in promoting these models which resulted in increased coverage of VAC and other health services.

The VITAP Coordinator has provided technical assistance for the Child Survival grant baseline health survey (1991)[5], and Phase Two baseline, which included vitamin A coverage data recorded on the health card. They found that only two percent of 1-5-year-old children received VAC in 1992 in 24 subdistricts. Following a recent trip to visit the Malukus by the VITAP Coordinator, PCI expressed a commitment to become more active in promoting vitamin A, especially in remote areas, by providing VAC to children under five and post-partum mothers, and by conducting VAC sweeps along with the EPI program.

iv. Future VITAP Activities

In collaboration with VITAP, PCI will pilot integration of VAC delivery to post-partum mothers. The training for TBAs will be modified and updated to include information on the role of vitamin A in child survival simple monitoring. VITAP will provide support

[5] Phase One did not collect vitamin A coverage data, despite the recommendation of the VITAP Coordinator.

materials for VAC supplementation through TBAs (eg. revised VAC recording for health cards and handbook on vitamin A). PCI could include vitamin A in the next Child Survival grant; however their focus, and the focus of their counterpart organization, is to increase EPI coverage.

Group 3. Collaborators Receiving Low Levels of Assistance

3.a Adventist Development And Relief Agency (ADRA)

i. Organizational Overview

ADRA is the main non-sectarian, humanitarian development and relief agency of the Seventh Day Adventist Church (SDA). A full description of their organizational structure can be found in the Philippines country report. In Indonesia, ADRA is working in four locations--Alor, Timor, Manado, and Irian Jaya--with populations ranging from 10,000 to 15,000.

ii. VITAP Inputs

Two ADRA representatives attended the first 1990 VITAP orientation session. In April 1990, ADRA International requested a trainer's training for seven countries which was assisted by VITAP and held in Bali. An action plan was developed for ADRA Indonesia at that time. An additional two-day follow-up training was held by VITAP for ADRA the next month, with 44 ADRA project staff participating. Evaluation of the training was done shortly afterwards. However, after that evaluation, VITAP inputs ceased, and ADRA's vitamin A programming, which has become extensive, was not formally followed up by VITAP. During 1990, VITAP provided ADRA with the vitamin A social marketing radio spots and a copy of the HKI Home Gardens manual (from New York). It is important to point out that all of the VITAP inputs to ADRA were provided before the VITAP Coordinator was hired in Indonesia.

iii. PVO Outputs and Discussion

Overall, championing the role of vitamin A in child survival consorts well with the ADRA/SDA philosophy. Consumption of vitamin A-rich foods, and in particular dark green leafy vegetables (DGLVs), is promoted by their Health and Temperance Directors in programming via radio messages, gardening advice and education in the church and on the street (when a health message is delivered before a gospel message during street preaching).

ADRA has integrated an impressive amount of vitamin A program components into their activities. From the training, staff were expected to implement vitamin A education into their programs, especially in the area of home gardening. According to ADRA, the home garden manual given by VITAP was translated into Indonesian for their work. TA

was provided by VITAP/NY to adapt the garden manual for sandy soil areas. Each staff member has implemented home gardening, and ADRA set objectives for promoting garden plots for each of its communities. So far they have exceeded their objectives, and a total of 55 home and communal garden plots have been sown. ADRA provides seeds rich in vitamin A - spinach, carrots, tomatoes and kangkung (a dark green leafy vegetable). ADRA also conducted a home gardening workshop in Irian Jaya.

In the area of social marketing, VITAP provided ADRA with radio spots which were broadcast monthly for one year in Manado and Alor. Broadcasts ceased when the radio station went defunct.

Vitamin A programming has also penetrated the SDA church system. ADRA gave SDA all the information about vitamin A available from VITAP. However, the only feedback provided to the assessment team about this component was about one pastor who mentions that he gave talks about vitamin A in church.

In Manado, ADRA is training health promoters with the aim to train more than 500 by 1994. One hundred health promoters are already trained and are training communities to: a) conduct nutrition education, b) mobilize others to attend the posyandu, c) advise TBAs, d) conduct training in the mosque and e) encourage outreach with posyandu kaders.

In the training curriculum for health promoters, vitamin A is mentioned in components on feeding for under-fives, warning signs for VAD, and VAC capsule distribution months. Some of the materials given to health promoters were provided from VITAP. In conclusion, ADRA has been able to take VITAP assistance and integrate it into their programming cycle. Only the evaluation component appears to be weak. ADRA's enthusiasm for vitamin A should be exploited by VITAP, and at the very least, ADRA should share its work on gardening with other interested development agencies in a VITAP-sponsored workshop.

iv. Future VITAP Activities

ADRA would like more information from VITAP: a newsletter, updates on issues related to vitamin A, technical information on examination for VAD, and food fortification including techniques for fortifying MSG, ketchup, and soy sauce. ADRA is also interested in conducting a survey if provided with a dietary assessment tool.

ADRA has a CS grant (1991-94) with no line item specifically allocated to vitamin A, although they are interested in training for Health and Temperance directors. Their three hospitals and clinics are potential vehicles for promoting vitamin A. They plan to pilot test VAC distribution for post-partum women through TBAs.

3.b World Vision International (WVI)

i. Organizational Overview

World Vision International is an international Christian humanitarian development and relief agency operating worldwide. Its focus is targeting most vulnerable groups through integrated and sustainable development schemes. WVI is a child sponsorship agency, similar in structure to that of Save the Children Federation. In Indonesia, sponsorship programs are divided into three areas of operation: 1) Child Care projects that assist school children with school fees, supplies, health care, etc.; 2) family and welfare projects that assist low income families with vocational training, income generation, growth monitoring, supplementary feeding for children under age five, nutrition and adult education, and home gardening; and 3) Community Social Welfare Development projects, aimed at developing community life, especially in the area of marketing skills and income generation.

WVI currently works in 21 of 27 provinces of Indonesia. Child Survival and other projects related to vitamin A are located in primarily two areas: in two subdistricts of Sangal District, West Kalimantan, estimated 32,000 population; and in Irian Jaya with PROJECT WATCH funded by AIDAB, the Australian government's international funding agency. In all its projects, WVI must work with local partners; in health related projects, these are local MOH staff and posyandu kader.

ii. VITAP and PVO Inputs

WVI sent two representatives to the first 1990 VITAP orientation. The VITAP Coordinator has been involved in informal discussions and has provided requested materials, versus more in-depth technical assistance.

Upon advice from VITAP, WVI will revise its Sangal/Child Survival target group to provide vitamin A to all children under five years of age. In both Sangal and in PROJECT WATCH, the present target population is children under two years of age. The Sangal project is currently conducting a baseline survey and working closely with the MOH to develop their commitment to the project. WVI will attempt to enlarge posyandu coverage to include children under five. Even their programming for urban areas has a vitamin A program component, such as the family development project in Semarang.

iii. PVO Outputs

WVI will add vitamin A information as part of their education efforts for communities, and will work to mobilize mothers to attend posyandus especially during the months of vitamin A capsule distribution (February and August). In addition, in areas where few government health posts or where VAC is not available at the clinics, WVI will aid the

MOH to provide services to their project villages. WVI would like to assist the MOH in distributing VAC, especially to remote areas. WVI already provides finances for the transportation of goods and services to rural government health posts.

iv. Discussion

In its collaboration with the government, WVI found a unique approach in gaining support for their efforts from the local level Ministry of Health. Because health policies are centrally established and managed, local health personnel have little authority outside of that established national policy. WVI directs its efforts toward strengthening local health institutions and staff. When local levels must defer decisions to higher levels, WVI first initiates informal discussions of the issues at the local level, and then presents recommendations to provincial level authorities in order to obtain permissions or commitments. The provincial level MOH has more authority and can influence the district and subdistrict. Once an agreement is made at the provincial level, WVI staff prepare minutes of the meeting and send them with a memorandum. The written agreements are presented to the district and subdistrict levels for coordination and implementation. This approach has enabled WVI to cooperate successfully with MOH authorities in Kalimantan and Irian Jaya. In obtaining permission to distribute VAC, they will use this approach.

World Vision International in the USA has a solid understanding of the vitamin A in child survival. Where and when possible, it attempts to integrate the role of vitamin A in their programming. On the field level, TA in working out details of vitamin A programming would be useful and could be explored more fully by VITAP. With their well-developed institutional structure, WVI could have the capability of testing VAC delivery models and evaluating them.

v. Future VITAP Activities

WVI would like to orient development communication staff about vitamin A and train health boards at local levels. WVI is also interested in social marketing food sources of vitamin A, and in methods for guaranteeing sustainability of the local NGO project per se. WVI commented that VITAP should pay more attention to local partners -- even though NGOs may be small, they play an important role, as in the training of trainers.

Group 4. Collaborators Receiving Nominal or no Follow-up

These groups were introduced to VITAP and requested assistance, although not all have incorporated vitamin A into their programs.

Catholic Relief Services (CRS) attended the first VITAP orientation. CRS was one agency which openly took offense at the proposal process with VITAP, following the orientation session. As a consequence, CRS has not included extra vitamin A

programming except for the kader module on vitamin A and fortified food commodities distributed through their own Community Food and Nutrition Development Program. They have, however, sent information about vitamin A and VITAP to all their provincial offices.

CARE-Indonesia's projects include community water supply, health, agriculture and income generation projects and an AID/Washington Child Survival Village Primary Health Care (VPHC) project. The VPHC project is located in three provinces, East and West Java and West Nusa Tenggara, and serves approximately 335,000 women and children. CARE is supporting the posyandu by training kaders and religious leaders about basic health care and delivery of services. Presently CARE does not have any specific program goals concerning vitamin A. However, the Lombok Project staff were interested and willing to consider adding vitamin A components to programming if costs were nominal, and if the new components did not add significant amounts of preparation and delivery time to their on-going programs.

CARE-Indonesia's leadership had made a decision not to include vitamin A activities in their Child Survival program because they lacked additional funds and because vitamin A was not one of their original CS objectives. However, they could have benefitted from follow-up or increased TA from VITAP at a provincial level. In Lombok, CARE was participating in a UNICEF Circle project to develop a health book for religious leaders. Numerous health and child health issues were covered, with the notable absence of vitamin A -- its role in maintaining eyesight and child survival, food sources and VAC distribution. If CARE staff were informed about vitamin A, they could play influential roles in the design of such materials, and could piggy-back vitamin A-related training onto other training projects at little or no cost. In essence, there may be numerous 'spin off' activities that could be generated by staff who have expertise in the role of vitamin A in child survival. CARE's participation in training -- such as was done with ADRA -- could be a beneficial activity for other PVOs and NGOs collaborating with VITAP.

Save the Children's work with vitamin A is relatively small. Initially Fatayat NU was their local counterpart and received TA from VITAP in the areas of training to kaders in Lombok and Central Java, testing of a posyandu chart, and training 60 provincial mangers on vitamin A and social marketing. SCF has not had any direct TA from VITAP. The assessment team did not have the opportunity to talk with SCF staff during this visit, nor was the team led to believe that SCF was conducting any vitamin A activities.

Yayasan Kesehatan Bethesda Irian Jaya, a large religious agency for health activities, received technical assistance from the VITAP Coordinator. A message about vitamin A for an educational calendar was developed which Yayasan printed and used in a training program.

Other agencies, such as RSU Bethesda Serukam, have received technical assistance from VITAP; however, the assessment team was unable to follow-up on the activities of all of these NGOs. Therefore, it was impossible to document any programming additions or modifications or spin-off effects which have occurred within these agencies as a result of VITAP assistance. However, given the spin-off effects which were identified for ADRA and WVI, who received TA and then little or no follow-up once the VITAP Coordinator was hired, the assessment team concludes that the overall impact of VITAP in Indonesia may be significantly under-reported.

B. Role of Ministry of Health

The MOH plays a very powerful role in determining how VITAP works in Indonesia. Cooperation is absolutely essential, as the MOH controls the distribution of VAC, the single most powerful tool in the effort to combat vitamin A deficiency. The new MOH policy which accepts NGOs as collaborating partners in VAC distribution is a necessary but not sufficient condition for this collaboration ever to achieve success at the village level. To this end, VITAP is currently participating in the development of guidelines which will assist the MOH and NGOs to work together in VAC distribution.

In order for this policy change to have a real impact on programming, it must be disseminated, explained, understood, accepted, implemented, monitored and evaluated by the MOH and NGOs. The challenge now is to study specific examples of successful MOH collaboration with NGOs such as the efforts of World Vision and to determine how to apply those models on a wider scale. VITAP can play an essential role in helping to identify and highlight such models and disseminate them among NGOs and MOH staff.

To become empowered to make a contribution NGOs must, with leadership from VITAP, be willing to prod the MOH system to serve as intermediaries between different levels of the MOH provincial and district, district and sub-district. Whatever the situation requires, NGOs will have to be gently forceful and patient. They will need to be repeatedly willing to invest resources into sensitizing the MOH personnel and modifying MOH structures that have authority over their project areas. Making a special effort to include the MOH in planning and implementing new activities is one collaborative strategy which many NGOs have employed effectively to minimize conflict and misunderstanding.

Given that HKI and VITAP have had positive experiences working with the MOH and have earned an excellent reputation as collaborators, VITAP is now in a superior position to lead NGOs in finding appropriate, effective and satisfying roles in a concerted effort to distribute VAC. NGOs must learn how to become advocates for their own involvement in VAC distribution and how to overcome the MOH's resistance to change. Most likely, the focus of these efforts will now shift from discussions at the central MOH level to negotiations at provincial and district levels.

C. Role of SOMAVITA

Ever since 1982, HKI-Indonesia has been involved in large-scale projects to increase public awareness and use of VAC. HKI's current Social Marketing for Vitamin A (SOMAVITA) project employs social marketing strategies to increase the consumption of vitamin A in the form of VAC and vitamin A-rich foods. In its current three-year phase, the scope of work for SOMAVITA has been expanded to include objectives for collaborating with and encouraging local NGOs to become involved in VAC distribution. Given its national scope, SOMAVITA provides an umbrella for NGO involvement in vitamin A activities.

Over the past two years, SOMAVITA and VITAP have collaborated in various ways, both providing TA in project planning, training, materials development and funds to augment the participation of NGOs in trainings sponsored by SOMAVITA. All key members of the SOMAVITA staff provide assistance in support of the NGO activities which are being coordinated by VITAP.

Given that VITAP is designed to involve PVOs and NGOs in the promotion of vitamin A and that the SOMAVITA project now includes similar objectives, there is an understandable need for close collaboration between the two projects. Indeed, this collaboration is so close that HKI-Indonesia leadership and staff view VITAP as an integral component of SOMAVITA. The assessment team concluded that this perspective limits the potential of VITAP. That is, if VITAP uses the perspective of SOMAVITA when it identifies collaborators, develops the strategies for working with them and envisions expected results, then the resulting experience of both VITAP and its collaborators will be limited in breadth and depth.

The design of VITAP provides great flexibility for developing creative solutions to help NGOs become involved in vitamin A programming. While SOMAVITA is designed to collaborate with NGOs which have a broad geographical scope, VITAP is not limited by this criterion in its choice of potential partners. While the strategy of SOMAVITA is to use a social marketing approach, VITAP can select among many other approaches to help NGOs solve any problems which prevent them from becoming active partners in the effort to combat vitamin A deficiency.

An analogy may help to characterize the different capabilities of the two projects. While SOMAVITA can be likened to a professor who teaches a large group of students in a lecture hall with little chance of interaction with individuals, VITAP has the luxury of being the teacher who develops customized learning programs for pilot testing in a variety of non-traditional settings. These different conditions call for different teaching strategies and offer different experiences to be gained by each of the teachers, and all of this experience is indispensable in the overall effort to help students learn.

Without a doubt, the SOMAVITA and VITAP projects do share similar goals, i.e., to reduce blindness, morbidity and mortality due to vitamin A deficiency. However, within the limits of each project agreement, many different strategies should be evaluated, and a divergence of focus should be inevitable concerning primary collaborators and short-term objectives. To the extent that VITAP's resources are used to achieve SOMAVITA's ends (which are not primary objectives of VITAP), VITAP risks diluting and delaying its overall impact on NGOs. Collaboration with SOMAVITA is a desirable activity for VITAP, but such collaborative activities need to be undertaken only if they serve the special needs of VITAP.

For example, if VITAP provides funding for NGO representatives to attend a MOH-SOMAVITA training in nutrition and social marketing, plans should already be in place for long-term collaboration between VITAP and NGOs that participate in these activities. VITAP should help to select the trainees and design follow-up activities. If these NGOs are not partners in such a plan and if VITAP cannot follow-up on their activities in a serious manner, then their participation, though it may seem justified as an attempt to widen the impact of vitamin A education, does not justify the diversion of VITAP's limited funding away from more targeted uses.

Another example concerns VITAP's participation in the inter-agency provincial-level teams which SOMAVITA has formed for managing the promotion of VAC. Under the new MOH policy, representatives of NGOs have recently been added to these teams. The role that these NGOs assumes on these teams has direct relevance to VITAP and vice versa. It would be appropriate for VITAP to be directly involved in any one of these teams <u>if</u> one of VITAP's key NGO collaborators were participating <u>and</u> would then be following through with a plan of action which VITAP had helped to design. If this were not the case, then VITAP should remain informed about the NGOs on these teams, but should not invest time directly.

SOMAVITA and VITAP have learned much from each other and should continue to do so. However, due to its unlimited flexibility and to its limited resources, VITAP it should concentrate its efforts on carefully selected opportunities to collaborate with thoughtfully selected NGOs. Collaborative projects should be within a framework of shared responsibilities that are clearly delineated so that truly innovative solutions can be developed.

V. DISCUSSION AND CONCLUSIONS

VITAP-Indonesia operates within a framework established by goal statements which are the same as those for the worldwide VITAP program:

- Increase the number of NGOs implementing vitamin A activities and expand the number of such activities by each NGO; and
- Increase the number of NGOs with in-house capabilities in vitamin A programming and strengthen their existing skills.

Indicators for the overall evaluation of VITAP activities were identified in HKI New York's original project proposal and revised later in July 1992, expressed within a LogFrame. However, to date, there have been no quantitative targets, no qualitative indicators, no explicitly stated strategy nor any timeline established for VITAP in Indonesia.

This situation has its advantages, e.g., flexibility, but it also has disadvantages, e.g., operating in a void, not knowing how far or how well one is progressing. Under these conditions, the assessment team was left to pass judgement on the quantity and quality of VITAP's results using standards and criteria which the team brought to the task from other experiences. Some specific outputs, such as the development and production of materials, can easily be counted. However, with no targets, assessing overall achievement, even in gross quantitative terms, is difficult.

Besides the difficulties imposed by the absence of an overall action plan delineating indicators of progress and achievement, the team was hampered by its inability to obtain comprehensive information about VITAP in an organized manner. In particular, written documentation about the implementation of VITAP activities seemed to be scant. Understandably, there was more documentation available in Indonesian than in English; nevertheless, even brief periodic summaries of activities in English, to serve as references, would have greatly facilitated the discussions. This problem of access to information undoubtably has negatively affected the team's interpretation of the information available, most likely leading to an under appreciation of the full extent of the activities performed and successes achieved.

A. Supporting and Confounding Factors

To gain a better understanding of VITAP activities in Indonesia, it is important to describe the supporting and confounding factors into which VITAP was introduced. These in turn had impact on the successes and weakness of VITAP which are later described.

i. Supporting Factors

- HKI's relationship with the MOH has been a long and supportive one, assisting the Ministry to develop its vitamin A program, and to establish guidelines and policies for vitamin A distribution. Providing an HKI staff member with an office in the MOH has fostered good relationships and aided in strengthening institutional development.

- The MOH has a far-reaching health structure in place, so that even with its difficulties, there exists a structure through which VITAP can operate and expand vitamin A programming. In addition, the MOH has been alert to new opportunities, as in its recent decision to cooperate with NGOs in increasing coverage of VAC to children under five throughout the country.

- The varied experience of the HKI Director and the VITAP Coordinator enables them to play important supportive roles. The VITAP Coordinator's medical background and experience working with NGOs have not only promoted VITAPs' relationships with some NGOs but also have benefitted aspects of HKI's work with the Primary Eye Care Project and SOMAVITA. In addition, medical expertise has been necessary in order to work with the MOH to establish policy and guidelines regarding vitamin A.

- VITAP has benefitted from the work of SOMAVITA, both in the area of social marketing, and in facilitating work with NGOs and the MOH.

ii. Confounding Factors

Initial USAID and VITAP-New York philosophy and approaches:

- The initial USAID requirement that VITAP collaborate only with US PVOs showed a lack of understanding of the role that Indonesian NGOs play in vitamin A programming.

- The initial VITAP design lacked a detailed structural framework. Without a specific action plan, e.g., such as the Detailed Implementation Plans (DIPs) required for AID-funded Child Survival projects, effective evaluation of progress is difficult.

- VITAP is centrally managed from VITAP-New York, which can create awkwardness in communications and line of authority when there is an in-country VITAP Coordinator. Communication gaps between Indonesia and New York have also created confusion and generated differing opinions on program process and operations.

Pre-existing MOH philosophy and approaches:

- The MOH typically has been conservative in its approach to health care delivery, including VAC distribution. Vitamin A capsules are available at the posyandu level only during the VAC distribution months. Obtaining VAC outside of those months for measles outbreaks or for high risk cases poses difficulties.

- Although the MOH has run a VAD prevention and control program since 1972, it is just now beginning to allow NGOs to help increase coverage of VAC distribution. MOH policy decisions are largely dependent on the recommendations of World Health Organization, International Vitamin A Consultative Group (IVACG), and other major health organizations. Therefore, the MOH is slow to try innovative strategies such as administering vitamin A to children with measles and post-partum women.

- Until recently, VAC coverage has been overestimated in official reporting, creating a false sense of accomplishment and possible laxity in social mobilization efforts. Calculations of VACs distributed are based on registered posyandu children (primarily those under two years of age), and not on the entire eligible population of those children under age five.

Pre-existing delivery structures through MOH and NGOs:

- The posyandu system poses its special difficulties. Problems in the system are factors that influence VITAP work, but these factors are beyond VITAP's control or range of effective influence. These factors include inactive kaders, changing locations each month, and volunteer staff. Posyandus are dependent on the puskesmas for delivery of supplies. Only a handful of services are delivered routinely, servicing primarily children under two, and VAC is taken away after the brief half-day sweep. Many rural areas are not serviced by posyandus at all.

- The kader structure also poses challenges. Kaders receivetraining from the MOH; however, turnover can be 50 percent or higher in the first year. Many kaders, who are members of the quasi-governmental organization PKK, are viewed with suspicion by NGOs. Kaders are usually volunteers, and have many responsibilities and services to deliver to their communities. Additional tasks may be seen as burdensome for kaders, and delivery of effective counseling for health problems is rarely undertaken. Kaders have few incentives to expand their health services or VAC distribution to include all children under age five. Kaders also need more support: good supervision, refresher courses and supplies delivered on a regular basis.

Pre-existing VITAP philosophy and approaches:

- Given their limited budgets, there is a prevailing notion both at MOH and HKI-Indonesia that they must give priority to big NGOs over little NGOs and to local NGOs over US PVOs. The acronym BINGO and LINGO connote Big Indonesian and Little Indonesian NGO, respectively, and are widely used. The value of small NGOs' ability to experiment with models of service delivery, education techniques, or other aspects of integrating vitamin A into programs is often overlooked or neglected. The reason being that it may pose difficulties for country-wide expansion, or that population size reached by LINGOs is too negligible to be of value for replication.

- NGOs are not mandated to collaborate with VITAP, thus making the task of networking, relationship-building and follow-up extremely important. Any inadvertent neglect that these activities suffered has limited VITAP's effectiveness.

- HKI-Indonesia is relatively new to working with NGOs and US PVOs, and has dealt almost exclusively in the past with the MOH. It may have been this lack of experience that led to the NGOs' initial confusion with the proposal process after the first VITAP orientation and resultant hesitation to work with VITAP after the second orientation.

- The overlap in the roles of the two HKI projects, SOMAVITA and VITAP, has presented difficulties. Differentiation of tasks within the shared (overall) objective of increased vitamin A consumption has not been clarified between personnel of the two projects. This may have hampered the pace of development of VITAP programming with NGOs in Indonesia.

- The focus of VITAP's work in Indonesia has been VAC delivery, and not foods. A multi-pronged attack on VAD is needed to maximize impact.

Lastly, a recent confounding factor for vitamin A programs is the unexpected change in color of the prophylactic dose capsules, supplied by UNICEF - from golden to red. All previous posters and social marketing materials displayed the golden capsule. Red iron capsules are supplied to pregnant women, increasing the risk for confusion of vitamins and minerals.

The above supporting and confounding factors present the complexities facing VITAP in Indonesia, some as a result of HKI operations, others outside of VITAP's direct control.

B. Successes

The initiation of VITAP activities in Indonesia was very timely, since VITAP's involvement helped cause the change in government policy towards officially recognizing

NGOs and encouraging their active participation in VAC distribution. Even though HKI, through its SOMAVITA project, is also working with NGOs, VITAP can fill a separate, yet complementary, niche. The NGOs now collaborating with VITAP are quite a diverse group: some are old, and well-established, with a country-wide network, while others are very new, small and very parochial; some have long histories of working in health while others do not.

The complexity of the situation demands that VITAP's approach be creative and flexible. The VITAP Coordinator has shown that his role must vary from being a vitamin A specialist "on-call" when sought out for some NGOs, to being an advocate and taking an assertive posture with others to convince them about the importance of vitamin A and their potential role in fighting VAD.

Many of VITAP's achievements to date are clearly identifiable and contribute directly to VITAP's overall mission in Indonesia. While some of the accomplishments are evolving relatively slowly, it is imperative to remember that the work of VITAP is not independent: the VITAP Coordinator always functions as a member of a team comprised of representatives of several organizations.

The majority of results which the team was able to assess are characteristic of one phase of project development, i.e., direct interaction between VITAP and the collaborating NGO. In other words, they occur at the activity level in the project design, as a prerequisite for producing subsequent follow-on activities by the collaborator. In the future, these latter activities will be identified and quantified as contributing to the overall achievement of VITAP's objectives. Exceptions to this generalization are VITAP's effects on ADRA and WVI. Among VITAP's successes are, inter alia:

1. For the first time in Indonesia, involving PVOs and NGOs in the promotion of vitamin A. In two years, four major US-based PVOs (ADRA, PATH, PCI and WVI), four major Indonesian NGOs (Fatayat NU, Muslimat NU, LBP and PKBI), smaller NGOs and semi-professional groups have called on VITAP. Currently nine collaborative projects are in operation;

2. Causing a direct impact on ADRA and WVI, as these organizations proceeded on their own to apply initial assistance from VITAP to the development of additional vitamin A activities;

3. Finding creative opportunities to provide orientation sessions about vitamin A to a variety of groups;

4. Participating in the development of the Ministry of Health's new policy regarding the role of NGOs in vitamin A deficiency control and subsequent guidelines for NGO-assisted distribution of VAC (the latter is currently in progress);

5. Assisting three NGOs to develop proposals and obtain funding (total US $710,000 for activities related to vitamin A);

6. Collaborating with NGOs to produce materials which support vitamin A-related activities (e.g., Fatayat NU, manual; SOMAVITA, brochure for NGOs; PKBI, flipchart in progress) and publishing newspaper articles about vitamin A issues;

7. Assisting PATH and PCI to increase VAC coverage in their pilot areas (to include measles case management and VAC supplementation for post-partum women through TBAs);

8. Providing a more cost-effective mechanism for promoting and integrating vitamin A deficiency control into NGO activities than could be achieved through separate consultancies; and

9. Assisting in skills development of NGOs through orientations, training and on-the-job experience.

C. Weaknesses

Difficulties in obtaining information about VITAP's activities and impact has hampered the assessment team in its efforts to discern and diagnose weaknesses as well as successes.

A number of factors have impeded VITAP from achieving even greater accomplishments, in breadth and depth, than those summarized above. These factors fall into two groups: those which are out of VITAP's control, (considered earlier under Confounding Factors), and those which are not. The discussion below is limited to factors over which VITAP has some influence.

Given the diversity of the collaborating groups and the variety of potential activities which can be implemented with them, VITAP needs an overall project framework to guide the choice of collaborators, develop joint activities, and monitor progress along the way. VITAP-Indonesia adopted the same goals as the worldwide VITAP effort and identified proposed activities in February 1990 in preparation for the initial orientation. However, according to information gathered during the assessment, it is not clear if these initial design components were ever expanded to form a complete multi-year plan, nor whether such a comprehensive plan was ever requested by key parties in HKI-Indonesia or HKI-New York.

The absence of a readily apparent and long-term design for VITAP's efforts in Indonesia is the single overall weakness identified by the assessment team. The absence of such a complete design probably contributed to VITAP's slow and difficult start in Indonesia, some missed opportunities and prematurely aborted relationships. The early

misunderstandings between and among HKI-Indonesia, PVOs and NGOs in Indonesia and HKI-New York probably were a consequence, at least in part, of confusion concerning VITAP's charge and plan for implementation -- a plan that was either poorly communicated or never agreed upon.

The team sought information which would reflect such a plan, if not in writing, then at least in operation, looking for the following components:

WHO? Collaborating Organizations: How were they chosen? Some criteria appeared ad hoc; all relevant US-based PVOs do not seem to have been given equal consideration for their potential to meet VITAP objectives. Nevertheless, the current group of collaborators appears viable, albeit with differing levels of interest.

WHAT? Technical Assistance Interventions from VITAP: How were these chosen? Training the staff of other NGOs seems to have received undeserved low priority. In order for training to be appreciated for its full potential as a VITAP intervention, it must be part of an overall plan reflecting commitment between VITAP and the NGO. The design must not only include the actual training event, but a detailed follow-up plan for the NGO, describing activities, dates, staffing patterns, resources, indicators of progress and dissemination of results. NGOs come to VITAP with a proposal for collaboration which includes training, and VITAP's response is to help them look for funding. An alternative is to seize the moment and their interest, and try to do something on a low-cost pilot basis. Then, depending on the results, VITAP could help the NGO expand its activities.

WHERE? Shift in Locale of Activities as VITAP Evolves: A comprehensive project design would include indicators of achievement at various levels of effort, e.g., in the collaborating organizations, at the field level of their organizations and at the community level. Indicators which VITAP would monitor would change with each phase of implementation, as project activities produced a rippling of impact through various layers ultimately to reach high-risk children. As VITAP is currently being implemented, focus is unduly concentrated on central level activities, with limited expression of plans to move from this locale.

HOW? Implementation Strategy: Different NGOs require very different implementation strategies. NGOs that are new to involvement in health activities and which have never been exposed to vitamin A programming need a variety of interventions (including everything from orientation and focused training to materials) and require more intensive follow-up than groups which have already focused on health issues and have field-level experience (e.g., US-based PVOs with Child Survival grants). In addition, care must be taken that all implementation strategies include an overall plan for project evaluation, comprised of the baseline survey, indicators, monitoring of activities and eventual evaluation of objectives.

VI. RECOMMENDATIONS

1. Develop a more comprehensive theoretical and operational plan for VITAP. The current modus operandi in Indonesia is taken from the global program in VITAP Phase I. VITAP midterm recommendations and the indicators from the Logframe in the revised DIP should now be applied to the Indonesian situation. VITAP's technical assistance should be focused and concentrated:

   a) Provide more intense technical assistance to the core group of VITAP collaborators for these purposes: developing models of effective VAC delivery to children under five, post-partum mothers, and urban populations; developing educational materials for religious groups, mothers, health workers, schools, and illiterate or neo-literate ethnic populations. In addition, promotion of vitamin A-rich foods should be coordinated with government ministries other than the MOH, e.g. Ministry of Agriculture.

   b) Redirect TA presently aimed at central MOH and agency levels to provincial and district levels. Follow-up activities with NGOs who have received TA in the past. Provide more TA to core NGOs who need institutional development to support effective vitamin A programming. Maintain contact with and support US PVOs involved in vitamin A programming. Promote collaboration and cooperation.

   c) Increase follow-up and maintain feedback. Use the VITAP standardized forms for evaluation of TA requests for additional assistance.

   d) Include an NGO working on a health related urban project where vitamin A education and VAC delivery models could be tested.

   e) Allocate more of the VITAP Coordinator's time to concentrate efforts on a core group of PVOs and NGOs.

2. Expand NGO-to-NGO and VITAP-to-VITAP linkages. Currently, the VITAP Coordinator is involved in a number of networking and NGO linkage activities. The assessment team proposes these additional linkage activities to promote and augment vitamin A programming through:

   a) hosting a consultative workshop with NGOs presently involved in various aspects of vitamin A programming; to include: PCI sharing expertise on teacher-child-parent vitamin A promotion and VAC through the schools; ADRA sharing expertise in home garden promotion; Fatayat and SCF

sharing expertise in house-to-house nutrition education; and PCI and PATH sharing models of VAC delivery via TBAs to post-partum mothers;

b) facilitating cross-visits by NGOs to each others' projects, coordinated through VITAP; and

c) arranging a cross-visit of VITAP Coordinator to the proposed consultative workshop in the Philippines to compare experiences.

3. Collaborate with USAID/Indonesia to have vitamin A programming included in the Child Survival proposal review process for agencies working on Child Survival projects in areas with high VAD.

4. Develop strategies with the MOH to address certain gaps in vitamin A programming using district models (trickle-up effect), e.g., for providing delivery of vitamin A for measle cases, for providing VACs 12 months a year for high-risk cases, and for conducting training of trainers for core agencies.

5. Establish budgetary line items which are more directly associated with VITAP's activities, such as is done in the Philippines. Establish a line item for each activity with each collaborator and similarly with work with SOMAVITA. Develop an action plan and budget for the remaining year (1993).

6. Establish system for routine documentation of all activities, and file periodic written reports.

7. Give special attention be given to micronutrients and exploring nutrition education techniques which may be more effective than the traditional educational paradigms for changing behaviors.

8. Promote consumption of vitamin A-rich foods, including messages, materials, and channels (e.g., schools, mass media). Encourage collaboration of projects with Ministries of Religion and Agriculture.

Future Activities

VITAP should assess the potential to enhance VAC coverage to urban populations. In Indonesia and the Philippines, surveys indicate that urban vitamin A deficiency may actually be higher than in some rural areas - due to price of vegetables, lack of garden space, lower breastfeeding rates, low incomes, etc. In Indonesia, over one quarter of the total population lives in urban areas (26%; 1985 figures) and of that, approximately one quarter lives below the poverty level as defined by UNICEF (Situation Analysis 1989) or around 10 million people. Indeed, there is the need and justification for expanding urban models of vitamin A programming through VITAP.

As a final note, VITAP should pay close attention to its potential role in providing technical assistance for micronutrients. Scientists and health programmers worldwide are now turning their attention in nutrition to the triad of micronutrient deficiencies, adding iodine and iron deficiency to that of vitamin A. While the roles of these nutrients are different in the body, as well as the etiologies of their deficiencies, decision-makers nevertheless look to those persons and organizations which already have expertise in vitamin A to take a role in addressing the other two. The assessment team was told that this was the case in Indonesia. Helen Keller International needs to articulate its position and develop policies vis-a-vis programming in iodine and iron. Whatever the outcomes, these positions and policies need to take HKI's experience and current programs into account in each country.

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UNICEF. Situation Analysis of Children and Women in Indonesia, Revised April 1989 Ed.

UNICEF. The State of the World's Children. 1991.

VITAP Interoffice Memoranda (1990-1992)

VITAP Memoranda (1990-1992)

SUPPORTING DOCUMENTS

I. Narrative Report, VITAP Indonesia, 1992, LBP Section

II. PATH Project Proposal

III. WVI Project Proposal

ITINERARY: VITAP ASSESSMENT TEAM TO INDONESIA

Date	Activity
25 Nov.	Arr. Jakarta
26 Nov.	Thanksgiving
27 Nov.	HKI discussions PATH Indonesia IPPA/PKBI
28 Nov.	Fatayat NU Pre-test leaflet (interview with ex orientation session participants - KAP).
29 Nov.	Week end
30 Nov.	MoH (Directorate of Nutrition) PCI Indonesia HKI Anne Palmer, Roy, Steve briefings
1 Dec.	Mission USAID Depart for Lombok
2 Dec.	Meeting with CARE Representatives Lombok Meeting with Dr. Agus Sutanta Provincial MOH Representative
3 Dec.	Meeting with PATH Representative Puskesmas Representatives/Lombok Region Puskesmas Representatives/Subdistrict Field visit to PATH project hamlet
5/6 Dec.	Week end (travel to Semarang)
7 Dec.	Site visit to Salatiga (IPPA/PKBI) Telephone contacts with WVI, ADRA CARE, Lembaga Bina Potensia

8 Dec.	Visit with HKI field office Rep. University Diponegoro, Semarang PKK Representatives Fatayat NU, Semarang
9 Dec.	UNICEF
10 Dec.	Debriefing with HKI

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CARE

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Mr. Sri Widodo, Assistant Chief Representative

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Mr. Slamet Riyadi, Project Officer
Mr. Subari, Project Officer

CRS

Kristanto Sinandang, HRD & Material Resource Manager
(also former staff-Linawati Nasrif)

FATAYAT NU

Representatives from Jakarta Area

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Anne Palmer, SOMAVITA Project Manager
Asmira Sukaton, SOMAVITA Consultant
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Dr. Wiadnyana
Mr. Herno, Nutrition Directorate

Lombok:
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Preventive Medical Care Director

District & Subdistrict Labuati MOH representatives:
Posyandu Kader
Hamlet Chief
TBA - trained
Post-partum mothers

PKBI - Semarang

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Soreyatmo Pedro Hc, Executive Director, IPPA, Central Java
Farid Husni, Assistant Director for Program, IPPA of Central Java
Dr. R.A. Soemiani Sosrohadikoesoemo, Board member, IPPA, Central Java

Pesantren Bina Anaprasa
Gintan, Salatiga

Mrs. Muawanah - Teacher
Sarwo Hutomo - Mandri, PKBI Clinic
Mrs. Munawaroh - Nyai, Gintan Pesantren
Mr. Mubaroh - Kiai, Gintan Pesantren

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Farida S. Wahid - General Secretary
Izmiaty Marwin - 2nd Treasurer
Atikah Murtadlo, Head of Social Affairs Division

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Heather Lynch, PCI Maluku Intern
Syul Sopacua, PCI Maluku, Social Marketing Director

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