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International Nutrition Communication Service  
(INCS)

CONSULTANT REPORT  
for  
INDONESIA

(February 9 - March 1, 1981)

(Strategy for nutrition education intervention component  
of the vitamin A deficiency control project)

BY

Marcia Griffiths - Manoff International

(Through subcontract to  
Manoff International  
1511 K. St., NW, Washington, DC 20005)

Submitted by  
Education Development Center  
55 Chapel Street, Newton, MA 02160  
To United States Agency for International Development  
Washington, DC

*This project has been conducted under Contract A.I.D./DSAN-C-0209, Office of Nutrition,  
Development Support Bureau, Agency for International Development, Washington, DC.*

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CONSULTANT REPORT FOR INDONESIA

Helen Keller International (HKI) is a private voluntary organization currently focusing on problems of vitamin A deficiency in developing countries. Heretofore HKI has concentrated most of its efforts on capsule distribution programs and health professional training in an attempt to cure and/or prevent xerophthalmia in areas of the world where it is prevalent. In July of 1980, the International Nutrition Communication Service (INCS) sponsored a workshop in nutrition education for staff and associates of HKI. As a result, HKI made a decision to develop a multi-sectoral educational strategy as part of its Indonesian vitamin A deficiency control project. That strategy is outlined by Marcia Griffiths in the following report.

Ron Israel  
Project Manager, INCS

March, 1981

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## Summary and Recommendations for Further INCS Involvement

The overall strategy recommended for the vitamin A deficiency prevention project involves activities in four areas: motivation, training, community education and for the capsule distribution program. For each of these areas target audiences, appropriate materials for each audience and a plan of operation with specific outputs are outlined. Additionally, a time table establishing the relationship between the activities of each area has been elaborated in a sequence that will assure that the program grows from the materials developed for the communities. The initial program activities are examined in detail. Recommendations include the following:

1. Hold an intersectoral meeting to agree upon and obtain a commitment to a strategy for the vitamin A education intervention.
2. Employ a full time person with experience in communications to oversee the implementation of the strategy.
3. Agree upon behavior change objectives and messages for community education, specifying those with priority for development in the first year.
4. Review all existing materials selecting for dissemination those which support the agreed upon messages.
5. Effect a community materials development workshop to draft the basic materials package for the first year of operations. The workshop would involve provincial people interested in education and community members in the geographic area of the workshop.

The strategy was designed with those responsible for its implementation. It is ambitious, but one which can be accomplished. For the best results, intersectoral involvement, coordinated by the Nutri-

Directorate is essential. The potential problems at this date are ones of personnel and money for materials. Hopefully, these can be resolved given the enthusiasm of people from various agencies on the prospect of a unified approach to vitamin A nutrition education. More specifically, the points in the plan which need close attention at this time include: 1) Finding a full time person to oversee the education activities. Presently, there are few candidates who have the desired qualifications. However, more inquiries will be made. Given the workload of people already employed it is recommended that this person not have responsibilities to another project, but concentrate full attention on the vitamin A activities and the necessary intersectoral collaboration.

2) The present budget for the education component does not include enough money for the materials development workshop proposed or for duplication of materials in the quantity needed for the fifteen high prevalence provinces. If the money for materials reproduction could be secured from the groups which will use the materials, then other donor agencies would be more inclined to fund the materials development workshop or atleast offer money for development of materials in the field.

#### Recommendations for Further INCS Involvement:

During the next few months informal contact should be continued with Bob Tilden, HKI Program Officer in Jakarta and with Dr. Susan Pettiss. Letters inquiring about the progress of the education component and the decisions taken by the ad hoc committee should be addressed to dr. Mantra and Dr. Tarwotjo.

Active involvement by INCS will depend in large part on the decisions taken by the intersectoral ad hoc vitamin A education committee at a meeting to be held in March or early April. If the

V

committee elects to follow a plan resembling the one proposed in the report, then the following involvement is recommended:

1) assistance in planning and implementing a community materials development workshop. The request would be for workshop costs and INCS staff time (preparation and follow-up days, plus two weeks for the workshop). The workshop is tentatively scheduled for the first two weeks in June. The INCS staff person would spend three to four days with workshop organizers and trainers before the workshop reviewing each step of the two week workshop, unifying approaches. The INCS person would be available throughout the workshop and would assist with plans for further pretesting of the materials after the workshop. If the special staff person has been hired by the Government of Indonesia to oversee the education intervention activities then some extra days should be scheduled for consultation with this person on the other aspects of the strategy.

2) six to eight months after distribution of the community education materials, towards the end of the monitoring and assessment period (January-March 1982) additional assistance may be useful to help evaluate progress and plan next steps for the second year of operations and possibly help with a follow-up workshop for participants of the first materials development workshop.

## I. ORIENTATION

The terms of reference for the three week assignment were:  
To help the Government of Indonesia and Helen Keller International:

A. develop a long range overall strategy for a vitamin A communications program that includes an implementation plan and administrative framework for the next year or operation.

B. develop or improve the health education components of the different vitamin A intervention programs, recommending:

- priority areas for education
- specific behavior change objectives
- basic messages
- media and communication channels
- areas for further concept testing

The plan outlined in this report was developed in collaboration with Dr. Mantra, Dr. Tarwotjo, Dr. Tilden and Dr. Pettiss. However, many other people were consulted (see Appendix A) and their ideas are also reflected in the report.

During these consultations it was obvious that people have long recognized and given considerable thought to the need for vitamin A education materials. The time is perfect to enlist the support and commitment of groups which should have a role in the control of Xerophthalmia. This report is intended to serve as a point of departure for intersectorial discussions. The only way the plan can be carried out is if all programs from the different sectors commit to the activities, calling on their staff in all administrative levels.

## II. STRATEGY

### A. Background

On-going nutrition education programs in Indonesia particularly the Nutrition Education Project (N.E.)\* and the Family Nutrition Improvement Program (UPGK) have had vitamin A education as part of their program. However, a decision was taken to strengthen interventions in the vitamin A area after reviewing the results of the Government of Indonesia (GOI) - Helen Keller International (HKI) vitamin A prevalence study. This report called for a strong education program, recommending specific priorities:

- increase the frequency and amount of green leafy vegetables consumed by preschool children
- encourage breastfeeding and consumption of fruits by those below two years
- increase consumption of fat by young children
- create awareness about capsules, especially for those high risk children
- encourage innovative screening programs using school children to detect younger children who might be night-blind

Work already undertaken by the N.E. project and Manoff International provides the basic information necessary to turn these recommendations into a strategy for community vitamin A education. In this work particular behavior changes relating to the consumption of vitamin A rich foods were explored with village mothers resulting in a series of behavior change objectives and messages which reflect

\* All abbreviations for programs are defined in Appendix II.

the ideas expressed by village women who must effect these practices, (The behavior change objectives and messages are outlined in Section IIIC of this report).

While this work provides the basis for a strategy beginning with community education, other considerations are important to make the strategy comprehensive. Some of these considerations were outlined at a two day workshop sponsored by HKI with the International Nutrition Communications Service (INCS) in August, 1980.\*

Recommendations from this meeting for program priorities include:

- encouraging nutrition education activities that seek to prevent Xerophthalmia rather than preventing blindness
- supporting village level activities and community oriented education material
- encouraging the inclusion of Xerophthalmia prevention modules in the training curricula and materials for village level health workers,
- encouraging the teaching of communication skills and participatory techniques to village level health workers;
- encouraging direct participation by mothers in diagnosing problems and designing programatic solutions;
- emphasizing the relationship between vitamin A and eye health in addition to the need for more green leafy vegetables
- encouraging mass media support;
- developing programs to sensitize policy makers
- support for feeding habit studies with behavioral trial

\* This workshop was held in New York. A report is available upon request from Ron Israel, Project Manager, INCS.

components that explore existing practices and what is feasible for change.

The strategy which follows is based on the guidelines established by the above work, consultations held in Indonesia and the goals of the Indonesia Vitamin A Deficiency Control Project. The long and shorter range strategy overviews for education (not for the entire project) were approved at a vitamin A Task Force meeting\* 21 February 1981.

B. Long Range Goal:

The control of vitamin A deficiency (70% reduction by the year 2000) through a change in dietary patterns, especially for young children is the anticipated program goal. The changes would include giving the newborn child colostrum, breast-feeding the child for 2 years, beginning to introduce vitamin A and carotene-rich foods with the child's porridge at 5 months. Additionally, the pregnant and lactating woman would include sufficient quantities of vitamin A and carotene-rich foods in her diet.

Long Range Strategy:

Through an intersectoral forum and their channels, coordinated by the Nutrition Directorate of GOI/MOH control of vitamin A deficiency will be achieved by strengthening the following components of the overall nutrition improvement program:

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\* Task Force meeting participants: Suwarna, MCH program; Wati UNICEF; Imam, vitamin A project; Tito, Nutrition Directorate; Entarsih, BKKBN; representative of Health Center Planning Unit; Tarwotjo, Nutrition Directorate; Mantra, Nutrition Education; Susan Pettiss, HKI; Bob Tilden, HKI and Marcia Griffiths, INCS-Manoff International.

1. the training of the health care providers to seek solutions to the problems in terms of local and household actions that improve the vitamin A status as well as general nutritional status of the population,
2. the support materials and the communication skills needed to help the mother reach her own solution to the problem of low dietary intake of vitamin A by the family members.
3. the resources available to make community and home gardens.

C. Short Range Goal: (to be accomplished by the end of Repelita III, March 1984)

The decrease in blinding Xerophthalmia by 50% by the end of Repelita III will be accomplished through a variety of intervention programs including:

- The distribution of vitamin A capsules to women immediately after delivery and semi-annually to children between one and six years;
- education on changing dietary patterns to increase the consumption of vitamin A rich foods;
- increasing home production of vitamin A and carotene rich foods, especially green leafy vegetables;
- the increased use of the Health Center in cases of eye problems and severe illness.

Short Range Strategy:

Through an intersectoral forum and the communication channels of each member, the Nutrition Directorate of GOI/MOH will coordinate the provision of vitamin A related education interventions and the mechanism for monitoring and supervision to maintain a high level of interest and activity. The interventions would include:

1. Motivation:
  - increase the awareness of people at all administrative levels throughout the government as well as in the

private sector about the vitamin A problem and the available solutions.

2. Training of health care providers, village workers, teachers and school children;
  - develop the capability to detect nightblindness and xerophthalmia and an explanation of appropriate actions
  - develop a package of critical information tailored for each worker's job;
  - begin to develop the communication skills which will allow for the dissemination of information as well as engage the mother in the decision making process concerning the desired behavioral changes.
3. Information for the community and village family that is integrated into on-going programs:
  - develop a series of standard messages for adoption by all programs with a village education component
  - develop materials useful for the village family using a process which will allow for community input.
4. Reinforcement of vitamin A capsule distribution activities
  - develop a campaign approach for trial in one province with wider usage after testing, to offer information about giving the capsule, the capsule itself and at the same time about dietary improvements.

#### D. Details for Proposed Interventions:

For planning purposes each area needing education input within the overall intervention strategy will be examined. However it must be remembered that the activities and materials from each component build on and reinforce each other to create a unified approach and the greatest impact.

##### 1. Motivation

- a. The goal of these activities is to create an awareness of the vitamin A deficiency problem in Indonesia, its causes and the available solutions
- b. The target audiences would be segmented into:
  - 1) those political officials from the President and

BAPPENAS to the Camat who should know about the problem to effect appropriate programs within their jurisdiction. The "provider system" includes workers in the Departments of Health, Family Planning, Agriculture, Religion, Women's Affairs, Education, Information, and the Non-Government Organizations and is also part of this segment. This system would include workers from all levels, through the subdistrict (Kecamatan) level.

- 2) the rural community including political leaders, providers of services (kader) and school teachers as well as the families of the village
- 3) the urban communities.

c. The materials would be tailored to the audience.

- 1) For planners, decision makers and program implementators an audiovisual material (slides, movie or video, presentation time 10-15 minutes) would be useful if it emphasized the cost of blindness to the country vs. the cost of prevention and leaves these people motivated to undertake activities. This presentation while appropriate for meetings could also be used for non-formal training sessions and informal education settings.

At the time of the audiovisual presentation a print material highlighting the available solutions and enlisting a commitment to undertake a

specific activity would be distributed, being utilized to stimulate discussion after the presentation.

Additionally, newsletters printed by different programs that go to this target audience should carry a short motivational piece encouraging commitment to the intervention strategies (The Family Planning Bureau/BKKBN, UPGK and N.E., all have newsletters for program staff).

2 and 3) Although urban and rural audiences may need different materials, it is possible that a general audio-visual presentation (movie, slide-sound, video) could be developed for the "community". The presentation should be short (15 minutes) and relate to the problem solving process within a community to combat the vitamin A problem. The audio-visual presentation would be appropriate for community meetings, meetings of village or Kampung leaders (lurah), training sessions for village or kampung workers (kader), and could be aired on television or even as a short in the movie theater,

Additionally, support materials for the audio-visual presentation need development. This could include an open ended story, or other discussion starters for use at trainings or community

meetings. Also a print material for use with village or kampung program implementers to help them plan village activities could be developed.

In some instances a poster would be desirable.

d. Process for developing this package of motivational materials would include:

- identify priority groups for motivation and specify what should happen after the group is motivated;
- evaluate resources available for materials development and reproductions and how the material would be used;
- decision on media and material;
- identify motivational factors within the intended audience that would help stimulate desired decisions or activities;
- Outline script or story sequence depending on the choice of audio-visual presentation;
- Pretest with all segments of intended audience;
- Produce audio visual presentation and support materials;
- Obtain approval for reproduction;
- Reproduction;
- Distribution of materials or information about materials and how to obtain them through channels appropriate for the audience:
  - Political system - Ministry of Internal Affairs

and Department of Information

- "Provider System" - through the Nutrition Management team in the Nutrition Directorate to all government and non-government agencies with community programs
  - Public Access - through Department of Information
- e. The outputs of the process would be:
- Audio visual presentation for two audiences
  - Support print materials summarizing the presentation and possible follow-up activities
  - Discussion starters: open ended story or games
  - Articles for newsletters
  - A poster
- f. Production of a movie was mentioned for one of the audio-visual, motivational presentations since money is available. If the decision is made to make a movie, footage shot in Indonesia for the HKI movie Miracle Workers could be made available through HKI in New York. However, in making the decision, consideration should be given to the cost of film (high production and duplication costs) as well as the purpose and target audience for the film. If only one film is made it should be targeted to stimulate action, not only provide information.

## 2. Training

- a. The goal is to design training modules which will include not only the presentation of necessary information relating to vitamin A deficiency (diagnosis/detection, warning signs, treatment or referral,

dietary changes) but also a communications component. This component would include ideas and exercises to improve training and teaching skills and to open a dialogue with community members to incorporate their ideas into the on-going education program. The skills to emphasize include: asking questions, listening and formulating a response.

b. The audience would be segmented

- 1) Doctors from central, provincial or Kabupaten levels would diagnose and treat xerophthalmia and who are responsible for training Kecamatan level personnel.
- 2) Puskesmas (Health Center) staff and others at the kecamatan level like the PPL, agricultural extension workers and the PKKBD from the Family Planning Bureau would need some of the same materials developed for the doctors but also materials relevant to training and supervising village Kader and working with the village family. Additionally specific training relating to the responsibilities of each worker may be needed.
- 3) Village workers including UPGK, N.E., PKMD (primary health care) and PKK (women's group) Kader, traditional midwives and BUTSI workers need training for their job in detection, capsule distribution and dietary change (community and individual education).
- 4) School teachers and school children

- 5) The village families. Materials for their "training" will be considered under education materials for on-going programs.
- c. The training curriculum and the support materials would be tailored to the audience. The responsibility of the education component is not to design the technical content or curriculum related to eye disease but to develop support materials and ideas for the training process. Presently, the design of curriculum for Puskesmas staff is being considered by the vitamin A unit within the Nutrition Directorate.
- 1) For doctors visual materials and a handout should be available for the technical eye disease detection training. A visual which examines differential diagnosis (compares signs of Xerophthalmia to other common eye problems) would be particularly relevant. Additionally, a module should be developed related to community education and the basic messages.
  - 2) Puskesmas level staff and others at kecamatan level could benefit from visual materials stressing differential diagnosis. Additionally a handout readily available for reference is important. These people also need practical training in community education. A training module should include the techniques of asking questions, listening and responding. Practice in how to train village workers, mothers and how to use any community level materials or games de-

veloped for children is crucial. Part of the staff training would include a village visit to enquire about attitudes towards capsules, green leafy vegetables, giving colostrum, etc.

- 3) The village workers need a strong vitamin A component in all materials. In their training some visuals with pictures of eyes would be useful, but emphasis should be on how to detect nightblindness, how and when to give the capsule, where to refer children and how to educate to prevent nightblindness. Stress should be placed on practicing how to use the education materials with the families and how to ask questions, listen and respond. Activity sheets to help with role playing or materials for interviews with mothers should be developed to encourage active participation by the trainees. Additionally cooking sessions using local foods to prepare recommended recipes should be included in the training modules.
- 4) School teachers could benefit from some visual materials which show the eye signs of vitamin A deficiency. Additionally they need to know games for children which create awareness about blindness and which will allow school children to carry out simple games for detecting nightblindness in younger brothers and sisters. The need for

capsules and the importance of diet should also be stressed through demonstrations at school. The school children should practice the activities, be engaged in a "survey-game" to find nightblind children and to report consumption of vegetables in the home.

d. Process:

- 1) Beginning with the knowledge, attitude and behavior change objectives for the community, identify instructional objectives for community workers, then for their trainers at the Puskesmas level and for their trainers from the kabupaten, province and central levels. In addition to instructional objectives, knowledge and skill objectives should be established for each target audience.
- 2) Check objectives with existing technical training, working in collaboration with others to fill-in the communication content of the course.
- 3) Identify key areas for support materials and activities to reinforce each lesson. Activities which provide practical experience (cooking demonstrations, eye exams, designing a course for kader) are the best. However each activity may need its own instructions or materials.
- 4) Pretest ideas in a course, asking for continual

evaluation by the participants.

- 5) Adapt curriculum modules and support materials.
- 6) Attempt to unify training at all levels through approval of intersectoral forum.
- 7) Produce and duplicate different materials
- 8) Distribute materials through each program's channels with incorporation of the modules into existing manuals. Important channels are Health, Family Planning, Agriculture, Women's Affairs and Education.
- 9) Inform all groups of the existence of the modules and training support materials.

e. Outputs:

- Visual materials for doctors - slides
- Visual materials for Puskesmas level -- slides
- Visual materials for village -- slides or photographs
- Print material with differential diagnosis
- Module for doctors on community education
- Module on community education for Puskesmas level containing suggestions for a village investigation and practice of communication techniques.
- Module on kader training for Puskesmas level
- Modules in all Kader manuals on community education with ideas for demonstrations of

foods high in vitamin A for different age groups and games for detection of nightblindness.

- Special module for traditional midwives
- Activity sheets with games to play with children for detection of nightblindness
- Module for teachers on eye health.

f. Review of the list of outputs and the list of existing materials (see Section IIIC) indicates that many of the support materials, slides and color photographs of eyes have been developed by HKI. The task, within this strategy, would be to determine if adaptations are necessary regarding differential diagnosis and community education. Then a local source for the slide sets should be identified and the scripts translated to Indonesian.

Soon HKI will finish a prototype manual for use by health center staff. By field testing this manual and by making appropriate adaptations rather than designing an original training module and manual some time will be saved.

Additionally excellent materials exist for the school teacher which can easily be reproduced or modified for the children. The nightblindness detection games developed by HKI are available and the chapter "Eye Health" in the Pedoman Kesehatan Sekolah dan Masyarakat (School and Community Health

Manual) is excellent.

3. Community Education

- a. The goal for this component is to create materials to teach villagers as well as for the villagers themselves to use. The materials would be developed with input from the community and would contain information about dietary changes suitable for their realities. The materials would also be designed in such a way as to involve the village in making a decision or in some kind of activity.
- b. The target audience in this case is the village family, the mother or child care-taker in most instances. However, all village workers need to have the community materials plus support materials because they have the most important contact with the families.
- c. The materials for the family are varied. They include radio spots, cassette messages, action posters, comic books, songs, recipes, and leaflets. What is important is that the message is specific, action oriented and appropriate. The materials should be designed with community participation.  
Teaching materials used with families by either the village worker or the Health Center staff should complement the family materials with identical objectives, style, tone and stress. Additionally, all teaching materials should have open-ended questions or in some way involve the family members in the decision about new dietary practices.

Those responsible for discussing the particular behavior changes with the village family will need a reminder of all the basic messages and the rationale behind them. This information can easily be placed in all manuals. .

d. The process:

- 1) Select relevant behavior change objectives
- 2) Based on these objectives make messages which contain both an information and motivation component
- 3) Make a decision about messages with highest priority to use in the first materials and distribute the list of messages to all agencies.
- 4) Review existing education material
- 5) Organize a workshop/training in a province where field staff will develop materials together with a few communities through consultation and pre-testing with village mothers.
- 6) Once draft materials are ready, pretesting can take place in different areas.
- 7) Decision on materials and finalization
- 8) Printing
- 9) Distribute materials through the channels of each agency to their village workers. Inform all programs of existence of materials. Radio spots are distributed through provincial and kabupatens stations.

10) Use for a year and evaluate distribution procedure as well as effectiveness of material. Throughout the year supervision in the provinces is continual.

e. Outputs

- Radio spots, songs
- Action posters
- Comic book/leaflet/story
- recipes (especially weaning foods & snacks)
- ideas for cooking demonstrations
- open ended stories
- flip chart
- summary of basic messages

f. Although a workshop is being proposed for materials development, there may be other alternatives. Whatever else is considered it is strongly recommended that the process take place in the field where the ideas can be checked with community people. Additionally, what ever process is chosen it should be intersectoral and at some time involve people from different administrative levels. (A description of the proposed workshop is found in Section IIIC)

4. Capsule distribution

a. The goal of the education associated with the capsule distribution is to give higher visibility to the capsule distribution activity to assure that all

women receive a capsule immediately after delivery and that children between 1 and 6 years, especially those at high risk also receive a capsule every six months. Additionally, the opportunity for education about dietary changes at the time of capsule distribution should not be overlooked.

b. The target audiences for this information are:

- 1) The decision makers and program implementators at all administrative levels.
- 2) All health workers involved in capsule distribution at the central, provincial, kabupaten, kecamatan and village levels including the kader, traditional midwives, special vitamin A worker and BUTSI workers.
- 3) The families in rural and urban areas.

c. The materials are specific for the target audience

- 1) For the decision makers and program implementators information about the capsule, the distribution program, and the basic community messages can be conveyed in a newsletter. It is important that any actions expected on the part of these officials are stated clearly, accompanied by specific instructions for reporting.
- 2) In addition to information about the capsule, which is included in training materials and manuals for all health workers involved in capsule distribution, a small booklet or card should be made

which provides information about the capsule, the dosage schedule and the messages for the family. Any forms which are made for administrative purposes need to be accompanied by carefully designed instructions. A mechanism for informing the distributors about their progress would keep morale high for this activity.

- 3) For the urban and rural families radio messages, banners, mobile units, and leaflets could be designed to encourage the mother to bring her child for a capsule and to reinforce the education done by the capsule distributor.

d. Process

- 1) Review the delivery plans for the capsule in different areas and the needs of different programs and workers for information.
- 2) Design the information needed by the decision makers and program implementators. After approval by the intersectoral forum distribute for each program's newsletter to print.
- 3) Develop community materials related to the capsule at the workshops for materials development
- 4) Work with capsule distribution coordinator to design material for village worker about the capsule distribution and the administration of the program.

- 5) Pretest materials with all levels of workers responsible for knowledge of concepts and actions.
- 6) Obtain approval for printing of materials.
- 7) Distribution of materials through all channels involved in capsule distribution. Distribution of radio messages to provincial and kabupaten radio stations.
- 8) Establish a newsletter to distributors which will inform them about their progress and any new developments related to capsule distribution.
- 9) Look very closely at the possibility of a "campaign strategy" for vitamin A month in a given area, especially during the seasons when the capsule is most needed. If an entire province were to give the capsule in the same month then a coordinated effort could be made and more emphasis given to community education. This strategy would need testing in an urban and rural area before initiation on a large scale.

e. Outputs:

- Newsletter article on capsule distribution
- Small booklet for distributors
- Instructions about administration of program
- Newsletter about capsule distribution
- Radio messages
- Leaflets
- Banners/posters

-- Messages for mobile units

- f. A priority in terms of education materials is in this area. Most people consulted expressed a need for the booklet for distributors and education material for the community about the capsule and its relation with eye health and green leafy vegetables.

### III. WORKPLAN

The following workplan is an attempt to put the strategies discussed above into a flow of activities which will allow for implementation as quickly as possible. Priority is given to the development of the community education messages and materials, so that other activities will elaborate or reinforce what is contained in the community materials.

#### A. Administration

The vitamin A education intervention activities will be coordinated by a Government of Indonesia nutrition or health education consultant to the Nutrition Directorate. This person will be supervised by Dr. Tarwotjo; Dr. Mantra will work closely with Imam Satibi and Dr. Tilden. The guidance on content and programming will come from the Vitamin A Deficiency Control Project within the Nutrition Directorate, while guidance on communications and community education will come from Nutrition Education, Directorate of Health Education, MOH. This person will also be responsible to the intersectoral group that will approve all matters dealing with policy and those activities which will involve the cooperation of the different sectors.

Distribution of materials will be handled through a Nutrition Management Team coordinated by Dr. Tarwotjo which will call on each sector to distribute materials to its own program personnel. Supervision and feedback about the progress of the activities will be the responsibility of the vitamin A education consultant. These reports will be made to the Project Supervisors, and in turn to the intersectoral group.

Although some money has been budgeted for production of materials and for staff there is little money for materials reproduction. A major administrative task will be to find money for materials reproduction. It is anticipated that the intersectoral group will make a commitment to the program and to materials produced if they feel that the materials meet their program's needs and if they are clear about the process used to draft the materials and the rationale for format and content decisions.

B. Time chart

(see following page)

C. Description of Initial Activities

1. Recruitment of Personnel

Given the amount of work which needs to be accomplished during the first two years of operations, and the current overload schedules of existing personnel, a vitamin A education staff consultant will be hired to coordinate and manage the component. The relationship of the consultant/coordinator to others involved in the project is described in the administration section (IIIA).



TIME CHART - VITAMIN A EDUCATION ACTIVITIES

1981

1982

1983

ACTIVITIES

MAR APL MAY JN JL AG SPT OCT NOV DEC JAN FEB MAR APL MAY JN JL AG SPT OCT NOV DEC JAN FEB

9. Decision of which materials to produce immediately

2 weeks

10. Contract and production and printing

8

11. Distribution to sectors and then to field w/instructions

4

12. Monitoring, follow-up with workshop participants and others

22

13. Organize follow-up workshop to assess materials-organize workshop

4

1

14. During monitoring look closely at capsule distribution sites for utilization of material and possibility of campaign approach

14

15. If campaign/coordinated approach possible work with capsule distribution coordinators to plan package and select area for trial

3

16. Trial and assessment of campaign approach

8

17. If appropriate expand campaign approach to a few new areas--trial

8



TIME CHART - VITAMIN A EDUCATION ACTIVITIES

1981

1982

1983

ACTIVITIES

MAR APL MAY JN JL AG SPT OCT NOV DEC JAN FEB MAR APL MAY JN JL AG SPT OCT NOV DEC JAN FEB

18. Prepare HKI Health Center Manual for pretesting w/protocol and questionnaire

8 weeks

19. Arrange for pretesting in training course/pretest

6

20. Review outcome of pretest and make recommendations for manual and support materials

6

21. Decision about Pus-KesMas training and production of materials

2

22. Production and distribution

6

23. Work with UPGK team to integrate vitamin A activities in Kader training (develop a module)

8

24. Pretest module during Kader training

4

25. Review outcome of pretest

4

26. Decision about Kader training and production of module

8

27. Distribution of module with instructions and arrangements to place it in existing manuals

8

TIME CHART - VITAMIN A EDUCATION ACTIVITIES

1981

1982

1983

ACTIVITIES

MAR APL MAY JN JL AG SPT OCT NOV DEC JAN FEB MAR APL MAY JN JL AG SPT OCT NOV DEC JAN FEB

28. Monitor periodically Kader training in different areas and work of Kader in capsule dist. and education

29. Consider revision in training materials

30. Decision about motivational package considering decision about film

31. If film then produce story board

32. Contract out film production

33. Decision on film and reproduction

34. Reproduction

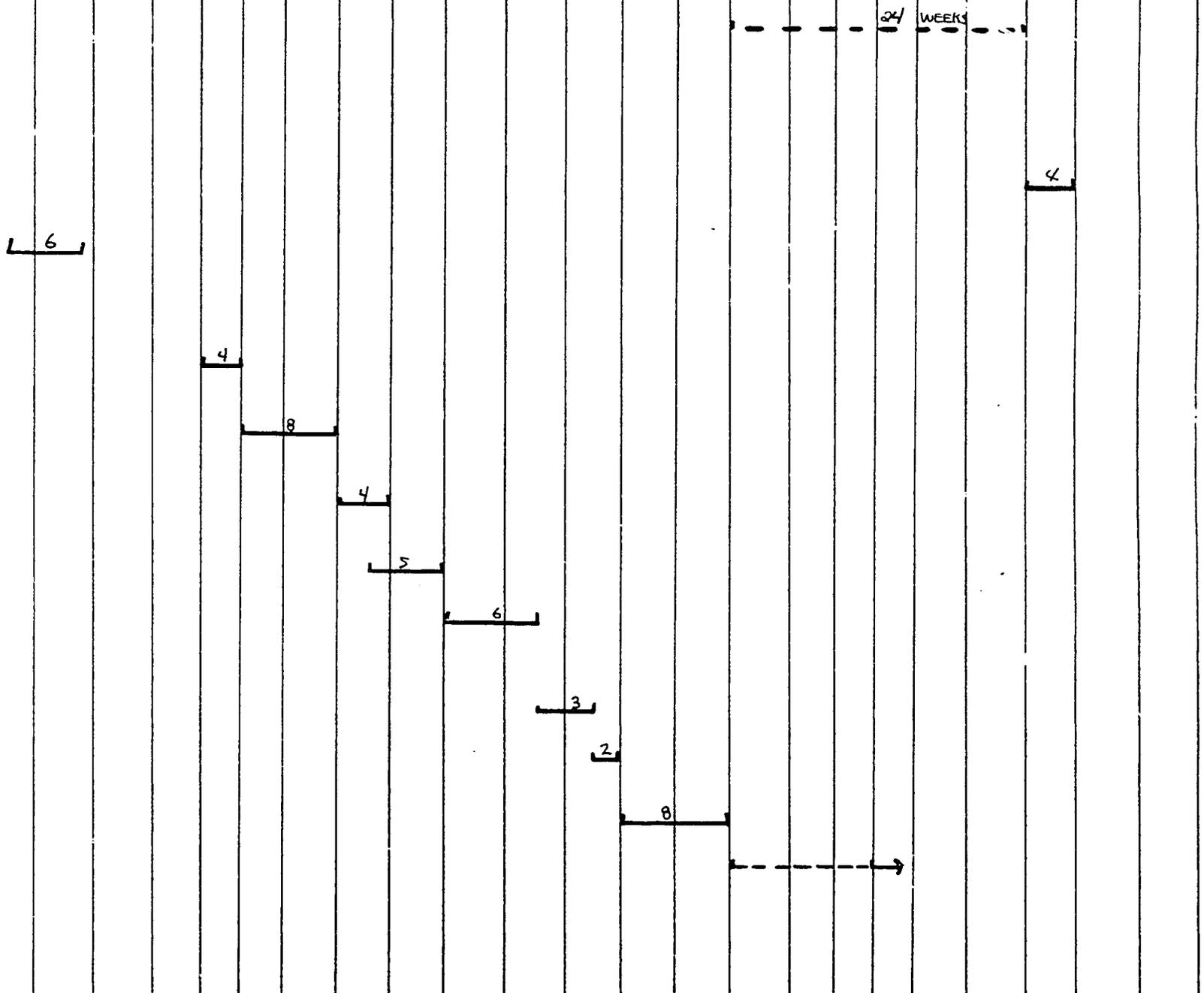
35. Production of support materials for film

36. Pretest of package

37. Decision about distribution of package

38. Distribution

39. Monitor usefulness of motivations/materials and advertise availability



The qualifications and job description for this person follow:

- Qualifications:
- communication/education experience and training
  - project management capabilities and experience
  - creativeness, initiative and willingness to work on a project which requires intersectoral coordination and cooperation.
  - Indonesian citizenship

Job description: The two year position involves working as a nutrition education consultant to the Vitamin A Intervention Project within the Nutrition Directorate, MOH/GOI. The person would be responsible to dr. Mantra and Tarwotjo and would work in close coordination with Imam Satibi and Robert Tilden. The job would involve:

- initiating education activities in all vitamin A education strategy areas during the first operating year. The activities would include:
  - review of existing materials
  - designing materials
  - field testing materials
  - organizing workshops
  - organizing and testing a campaign strategy
  - contracting production
  - distributing materials through all available channels
  - developing a curriculum for training components in communications
- supervising and monitoring the production of all materials and the activities once in operation. This will involve taking the initiative to contact groups and following through on all arrangements.
- budget formulation and frequent review.

Suggestions for where to recruit such a person include:

The Public Health school, Universities, from among retired government employees, through private companies or the BUTSI program. Initial conversations about recruitment indicate that a person maybe difficult to find. If this is the case the education component can move ahead with decisions on priority strategy areas and community messages. However, before beginning any major

activities, the coordinator should be on the job.

## 2. Behavior Change Objectives

The specific behavioral objectives were written using information obtained from actual behavior trails with village families (see Final Report of Concept Testing done by the Nutrition Education Project and Manoff International, Inc.)\* and from information obtained from the vitamin A prevalence study (see final report by GOI and HKI).\*\* Additionally, the objectives were checked for consistency with the newest capsule distribution schedule and with the UPGK messages.

These behavior knowledge and attitude change objectives for mothers and instructional objectives for village health workers are listed below. These clarify what the village educators need to know to assure that the mother receives the necessary information. This table could be continued to include all levels of health "providers." Based on the Kader's instructional objectives for teaching families, knowledge and attitude objectives for the Kader would be formulated, then the instructional objectives will be selected for the staff of the Puskesmas who train the Kader. Later knowledge and attitude objectives for regional health staff are made, until there is a system for information transfer based on the program's goal; the change in behavior of the village family to effect better vitamin A status in the young child.

— — — — —  
 \* Griffiths, Manoff, Cooke, and Zeitlin, Mothers Speak and Nutrition Educators Listen: Formative Evaluation for a Nutrition Communications Project, vol. I, submitted to Indonesian Nutrition Development Project, Nutrition Communication and Behavior Change Component, 1980.

\*\* Government of Indonesia and Helen Keller International, Indonesia Nutritional Blindness Prevention Project, Final Report, 1980.

### 3. Messages for Village Mothers

The following messages were written using the behavior and attitude change objectives, attempting to combine information with a motivational statement. The messages are not for use as slogans on posters, etc., but rather are statements which can form the core idea of a material like a short socio-drama for radio or a short story of a sequence in a flipchart.

#### General:

Everyday include green leafy vegetables and yellow-orange fruit in your meals what is locally available and inexpensive, depending on the season; for example: (daun cassava, bayam, kangkung, papaya, mango...) because these foods contain vitamin A and will help prevent nightblindness which can lead to permanent blindness in children.

#### Umum:

Sertakan sayuran daun hijau dan buah-buahan berwarna kuning atau oranye dalam makanan anda setiap hari, buah dan sayuran ini sebaiknya yang tersedia disekitar anda dan tidak mahal misalkan: (daun singkong, bayam, kangkung, papaya, mangga;) makanan-makanan ini mengandung vitamin A dan akan-mencegah buta senja yang dapat menjadi kebutaan permanen pada anak-anak.

- \*\*1. Light colored vegetables contain little vitamin A, therefore dark green leafy vegetables should be included everyday to prevent nightblindness.

Sayuran berwarna putih mengandung sedikit vitamin A, karena itu sayuran berdaun hijau harus disertakan setiap hari untuk mencegah buta senja.

— — — — —

- \*\* Indicates priority message for first operational year.

- \*\*2. Pregnant women: eating one more bowl of dark green leafy vegetables each meal and fruits each day will help you feel fresh and will ease constipation and will provide your child with vitamin A from the foods you eat.

Ibu hamil: dengan menambah makanan dengan 1 mangkuk sayuran daun hijau dan buah setiap kali makan akan membantu untuk merasa segar dan akan meringankan konstipasi dan juga melengkapi anak akan vitamin A.

- \*\*3. Lactating women: eating one more bowl of dark green leafy vegetables each meal and fruits each day will freshen your milk and will provide your child with vitamin A which is one of the "essences" transferred in your milk to your child to help prevent nightblindness.

Ibu menyusui: menambah makanan dengan 1 mangkuk sayuran daun hijau setiap kali makan dan buah setiap hari akan lebih menyegarkan air susu anda dan akan melengkapi vitamin A yang terdapat dalam sari makanan yang disalurkan pada anak anda melalui air susu ibu untuk mencegah buta senja.

- \*\*4. In addition to eating foods rich in vitamin A, a vitamin A capsule should be obtained from the (dukun bayi, kader, Puskesmas) and taken immediately after delivery and taken every six months during lactation to assure an adequate quantity of vitamin A in your breast milk.

Di samping makan makanan yang kaya vitamin A capsule vitamin A dapat diperoleh dan segera diminum sesudah melahirkan dari (dukun bayi kader, Puskesmas) dan diminum setiap 6 bulan sekali selama masa menyusui untuk menjamin cukupnya jumlah vitamin A dalam ASI.

- \*\*5. Giving colostrum, the first breastmilk, which is thick and yellowish will not cause the baby to be sick because it is not sour or dirty, but rather rich in vitamin A to help prevent nightblindness in young babies.

Pemberian colostrum (air susu ibu yang keluar pertama kali, kental dan kekuning-kuningan) tidak akan menyebabkan bayi menjadi sakit karena ASI tidak kotor maupun asam tetapi cukup kaya akan vitamin A untuk mencegah buta senja pada bayi anda.

- \*\*6. Don't wean your child too early, breastfeed for two years to be sure your child gets enough vitamin A to prevent nightblindness.

Jagan menyapih terlalu cepat, susuilah sampai anak berumur 2 tahun untuk meyakinkan bahwa anak anda mendapat cukup vitamin A untuk mencegah buta senja.

- \*\*7. Beginning at 5 months add green leaves to your child's porridge. If the leaves are finely chopped and well cooked, they will be soft and easily digested.

Beginning at 5 months try this food, bubur campur, for your child:

Recipe: depends on area but contains staple, protein food, green leaves and a source of fat.

Remember: the green leaves and the (coconut milk or oil) are important additions to prevent nightblindness in your child.

Mulai umur 5 bulan tambahkan sayuran daun hijau kedalam bubur anak anda. Bila sayuran dipotong halus dan dimasak dengan baik akan membuat sayur tsb. lunak dan mudah dicerna.

Coba makanan ini, bubur campur untuk anak anda setelah berumur 5 bulan, resep tergantung pada daerah tetapi harus mengandung tepung-tepungan, makanan berprotein, daun-daunan hijau dan sumber lemak.

- \*\*8. Include fruits rich in vitamin A like (papaya, mangga) in the diet of your child several times a week. Always include fruit if your child refuses to eat green leafy vegetables.

Sertakan buah-buahan yang kaya vitamin A seperti (pepaya, mangga) dalam makanan anak anda beberapa kali seminggu. Selalu sertakan buah-buahan terutama jika anak anda menolak untuk makan sayuran daun hijau.

- \*\*9. Be sure your child receives a vitamin A capsule once every six months after s/he is one year old from the (kader, bidan, Puskesmas). The capsule contains vitamin A and will help prevent nightblindness.

Jangan lupa memberi anak anda kapsul vitamin A setiap 6 bulan sekali setelah anak berumur satu tahun, dapat diperoleh dari (kader, bidan, Puskesmas). Kapsul mengandung vitamin A dan akan mencegah buta senja.

- \*\*10. Watch your child for eye problems. You can watch to see if your child stumbles on small objects or can't see well at dusk. If you think your child or a neighbor child has any eye problems take them to the (kader, Puskesmas) because some eye problems and nightblindness can lead to permanent blindness if untreated.

Hati-hati terhadap penyakit mata; anda dapat berwaspada apabila anak anda tersandung benda kecil atau tidak melihat dengan baik pada waktu senja. Jika anda merasa anak anda atau anak tetangga mempunyai sakit mata bawalah mereka kepada (kader, Puskesmas) sebab beberapa jenis sakit mata dan butak senja akan dapat menjadi buta permanen jika tidak diobati.

- \*\*11. Take children with measles, respiratory infections, malaria, severe diarrhea or any other serious infection to the (kader, Puskesmas) for a vitamin A capsule because they need extra vitamin A. Additionally when they recover feed them extra green leafy vegetables and fruit rich in vitamin A everyday to prevent nightblindness.

Bawalah anak-anak yang menderita penyakit campak, infeksi saluran pernafasan, malaria, diare berat dan lain-lain infeksi yang serius kepada (kader, Puskesmas) untuk mendapat kapsul vitamin A sebab mereka membutuhkan tambahan vitamin A. Di samping itu bila mereka sembuh, berikanlah makanan tambahan berupa sayuran daun hijau dan buah-buahan yang kaya vitamin A setiap hari untuk mencegah buta senja.

- \*\*12. Ask (kader pertanian) for help with a home garden so that you can grow the foods needed by your children to prevent nightblindness.

Mintalah pertolongan (kader pertanian) mengenai tanaman pekarangan sehingga anda dapat menanam bahan makanan yang dibutuhkan oleh anak-anak anda untuk mencegah buta senja.

- \*\*13. (only for some areas)  
For children with eye problems continue the practice of giving roasted liver.

(hanya untuk daerah tertentu)  
Untuk anak-anak yang menderita penyakit mata, teruskanlah kebiasaan untuk memberikan sate hati.

Once the messages have been approved by the intersectoral team, they should be distributed to all agencies involved in community education so that the process of including the messages in manuals and materials can begin. Following is a brief list of some agencies that should be informed about the messages.

1. Health Department

Akademi Gizi

Direktorat Gizi - UPGK, NIPP and Special Vitamin A project

Penyuluhan Kesehatan Masyarakat - N.E.

Puskesmas - PKMD, MCH and Primary Eye Care

2. Agriculture Department

Extension - farmers and home economics

3. Religion Department

4. Vice Ministry of Women's Affairs

5. Family Planning Bureau

Field Worker Division

Information and Motivation Division

6. Department of Information

7. UNICEF

Health and Nutrition Programs

8. UNFPA

Nutrition Programs

9. A I D

Health and Nutrition Office

10. HKI

11. Planned Parenthood of Indonesia

12. Church World Service
13. Catholic Relief Service
14. Foster Parents Programs
15. Save the Children
16. World Education
17. PENMAS/Jaya Giri
18. CARE
19. Yayasan Indonesia Sejahtera
20. Yayasan Ibu dan Anak
21. Association of Pediatricians
22. Association of Indonesian Ophthalmologist

#### 4. Existing Materials

A survey of available materials which include Vitamin A messages or are exclusively for the control of vitamin A deficiency shows the following are in use:

##### a. Motivational materials:

- HKI film, The Miracle Workers
- UNICEF poster featuring 4 large eyes and malnourished children
- N.E. poster with healthy child and fruits and vegetables and capsules
- N.E. Berita Khusus untuk Anda

##### b. Training materials

- HKI slide sets for - physicians
- health and nutrition auxiliaries
- (script translated into Indonesian)

## - training survey teams

- HKI -- "Saving A Child from Xerophthalmia" a leaflet for general health and nutrition worker.
- HKI -- Handout with fotos of eyes - currently in Puskesmas manual
- UPGK manuals for general nutrition worker and agricultural worker
- N.E. manual of nutrition messages (includes vitamin A)
- Puskesmas manual
- BKKBN Fieldworker Manual, 1977
- YIS - Guide for Taman Gizi includes Vitamin A foods in the menu
- CRDN - Kumpulan Hidangan Mengandung Banyak Pro-vitamin A
- PROKESA Manual
- Direktorat Gizi - Guide to Capsule Distribution Program (small blue manual)
- from vitamin A prevalence study - Qualitative Diet History Form
- from N.E. field work - Diet history form for rapid dietary assessment
  - Question Guide for learning about food behaviors with suggested behavioral trials
- Rhode et.al. ---"Training Course for Village Nutrition Programs"
- from Child-to-Child Program (Anak-untuk-Anak) and Activity Sheet - games to play with children to detect nightblindness

- Manual for School and Community Health/Pedoman Kesehatan Sekolah dan Masyarakat -- activities to sensitize children to blindness
- HKI - "Questions for a sibling to ask"
- DEPKES - Usaha Kesehatan Sekolah

c. Community Materials

- N.E. Flash Card Set with Story of blind child
- HKI Prototype flipchart - Story of blind child
- N.E. Sound slide on Bubur Campur (porridge with green leafy vegetables) - in progress
- N.E. Action Posters - recommend more green leafy vegetables
- N.E. radio spots - recommend more green leafy vegetables
- N.E. Bali - small flash cards with basic messages from each action poster
- UPGK - flipchart - Keluarga Sehat
  - Kebun Gizi
- Direktorat Gizi - leaflet on vitamin A
  - poster with healthy child, fruits and vegetables
- Dinas Gizi - North Sumatra - Vitamin A Song
- World Neighbors - filmstrip "Good Food, Good Health and Good Eyes"
- Save the Children - Flipchart
- UPGK - Slide set - Home Gardens for Family Health

d. Capsule Distribution

- Direktorat Gizi - Guide to Capsule Distribution Program

The amount of materials in existence appears to be sufficient for the education intervention, however each material needs to be evaluated for its merit within the overall scheme and its compliance with the standard messages. When this is done it may be evident that materials do exist that can make a good package, only needing duplication and proper distribution (ex. the materials for teachers and school children). Other materials may need to be discarded because they are outdated and others only revised. Always new materials, with fresh communications ideas, that work to involve the community, the family and/or the mother in decision making are welcome. After a review of the existing materials for community education, the addition of materials dealing exclusively with the topic of vitamin A and dietary habits and eye health is advisable. The materials with vitamin A messages integrated into the general nutrition message are good (UPGK & N.E. materials), however those specifically for vitamin A could use more community input and be structured to involve the community or the mother to a greater extent.

##### 5. Community Materials Development Workshop/Training

Below is a proposal for a workshop to be held in an area with ready access to rural villages. While this workshop provides the opportunity to try a new approach in materials development where health workers and the community work together, if the workshop is found not to be feasible as it is proposed it is hoped that whatever process replaces this will also have provisions for including the community in materials formulation.

Proposal:

This workshop would be an initial activity in the implementation of the vitamin A education strategy to be completed within three months of the starting date of the vitamin A education coordinator. This activity should be preceded by decisions about behavior change objectives and messages with the selection of priority messages for emphasis in the first year of operations. Additionally an inventory and review of existing materials would be conducted and those materials suitable for inclusion in the vitamin A education intervention package identified to avoid duplication of efforts.

The workshop will have the following objectives:

1. To systematically develop community level materials utilizing the communications experience of field personnel and the input of community families.

2. To provide "hands on" training in materials development for those persons at different administrative levels working in community education. This training would enable the participants not only to formulate new materials according to program needs but to adapt materials to local conditions, sent from the central level.

and would have as outputs:

1. Draft materials for use in the community either by people working with the village family (Kaders, field workers) or by the mother/family themselves. These materials might include: a flipchart, discussion starters, comic books, action posters, leaflets, posters, cassettes with a story or short dialogue, songs...The materials would cover the priority messages chosen for the first year of the education intervention.

2. Documentation of a process for materials development using messages formulated at the central level. The documentation would be in a form appropriate to distribute with the materials and to share with other groups interested in decentralizing materials development.

3. Resource people in different provinces with training in materials development and with the expertise (due to their knowledge of the development process of the vitamin A materials) to facilitate the use of the vitamin A education package in their area.

The participants at the workshop would come from different provinces with a high incidence of vitamin A deficiency and/or with active nutrition programs covering a high percentage of desa. It is also recommended that the provinces chosen represent several culturally distinct areas. A suggestion of possible provinces to be represented: Aceh, Sumatera Selatan, Sumatera Utara, Sumatera Barat, Jawa Barat and Bali.

Approximately 25 participants would attend the workshop and each province would be represented by at least 3 people. Although a person from every administrative level would not need to come from each province, it would be advisable if among the participants there were representatives from the provincial health education and nutrition units as well as the provincial bureau for BKKBN-PENMOT, from the Kabupaten health office, Puskesmas staff, family planning field workers and kader from different programs.

The workshop participants should be people with a great deal

of interest and experience in community education efforts. They should also be people who will participate actively in a workshop setting.

The workshop staff would consist of 3 trainers who would work closely with small workgroups of participants. Suggestions for trainers includes: Wati (UNICEF), Samsul Alam (Save the Children, Aceh) and Sartono (Health Education, Central Java). These trainers would work closely with dr. Mantra, the Head trainer. Before the workshop all the trainers would work with dr. Mantra and <sup>INC</sup> a consultant for orientation and unification of approach.

Additional staff would include 1 or 2 graphic artists and 2 secretaries.

A location for the workshop should be chosen for easy access by participants and for proximity to villages which would reflect the norm for rural families (villages continuously used for pilot projects would not be suitable). Materials would be tailored for "the rural family" as much as generalization will allow. After the workshop, through further pretesting by workshop participants adaptations can be made for specific cultural variations.

The format for the workshop/training would be: large groups sessions for general orientations and small work groups for the actual materials development and field work.

The schedule would be:

- |              |  |
|--------------|--|
| Day 1/Minggu | - Arrival                                      |
| Day 2/Senin  | - Introduction of Participants                 |
|              | - Orientation to workshop objectives and plans |

- The vitamin A Deficiency Problem in Indonesia and what we know about solutions
- Orientation to behavior change messages formulated at central level to address vitamin A problem

Day 3/Selasa

- Choice of small workgroups and selection of messages
- Analysis of message and component parts for education
- Design of open ended questions and behaviors to try in the community
- Role play

Day 4/Rabu

- Field work in community with mothers
- Review information obtained.

Day 5/Kamis

- Guidelines for Material Development (Purposes, Target Audience, Media, Information/Motivation Components)
- Workgroups

Day 6/Jum'at

- Practice in Small Groups Using Materials
- Workgroups

Break

- Orientation to Pretesting - What do we want to know?
- Design of Pretest for Materials

Day 7/Sabtu

- Pretest in Community
- Discussion of Experience

- Day 8/Minggu - Rest
- Day 9/Senin - Tabulation of Results  
- Revision of Materials Using Pretest Results
- Day 10/Selasa - Discussion of Progress in Large Group  
- Orientation for writing instructions for Use of Materials  
- Workgroups to Write Instructions  
- Outline for Further Pretesting with Community and Kader
- Day 11/Rabu - Pretest in Community  
- Discussion of Experience
- Day 12/Kamis - Tabulate Results  
- Revise Materials and Instructions
- Day 13/Jum'at - Write Report of Work Group Process and Recommendations for Material and Use of Mateiral
- Day 14/Sabtu - Closing  
- Pulang

The estimated budget is approximately Rp 12 million (US\$ 20,000)

Per diem, Lodging and Food	Rp 7.0 million
Transportation	Rp 3,5 million
Materials and Transportation to Villages	Rp 1,5 million

## APPENDIX I

### Persons Consulted About Vitamin A Education Strategy

#### 1. Department of Health, Government of Indonesia

Dr. Tarwotjo, Nutrition Program Director, Nutrition Directorate

dr. I. B. Mantra, Nutrition Education Project Director,  
Health Education Directorate

Dr. Robert Tilden, Indonesia Vitamin A Deficiency Control  
Project, Project Officer, Nutrition Directorate and  
Helen Keller International

Dunanty Doloksaribu, Nutritionist, Nutrition Education  
Project, Health Education Directorate

Drs. Tjep Marku, Health Educator, Nutrition Education Project,  
Health Education Directorate

Bonar Doloksaribu, Provincial Nutrition Officer, North Sumatra

Tito Soegiharto, Nutrition Program Administrator, Nutrition  
Directorate

Imam Satibi, Director, Vitamin A Program, Nutrition Directorate

dr. Bambang, Coordinator, Primary Eye Health Care Program,  
PusKesMas (Health Center) Directorate

Suaspendi Notodihardjo, Coordinator, UPGK Program, Nutrition  
Directorate

Carl Fritz, Advisor, World Bank Nutrition Loan

#### 2. Family Planning Bureau (BKKBN)

Suyatni, Director of the Field Worker Division

Entarsih Tjokosuwondo, Director, Integrated Programs, Field  
Worker Division

#### 3. Center for Research and Development in Nutrition

Drs. H. Husaini

Ig. Joko Susanto

Dra. Kusdinamurtirin

#### 4. UNICEF

Dr. Terril Hill, Nutrition Program Officer

Cynthia deWindt, Nutrition Education Program Officer

Wati Adi, Vitamin A Project Coordinator

Nancy Terreri, Primary Health Care Project Officer

Alan Court, Agriculture Project Officer

5. AID

Bob Pratt, Health and Nutrition Program Officer

6. WHO

Dr. Vitoon Osathamondh, Health Research Planning Consultant

7. Yayasan Indonesia Sejahtera

dr. Lukas Hendrata

8. Helen Keller International

Dr. Susan Pettiss, Director, Blindness Prevention Program

APPENDIX II LEXICON

- BKKBN: the National Family Planning Bureau
- Bupati: political head of a kabupaten or regency
- BUTSI: a voluntary program designed to provide college graduates with practical work experience
- Camat: political head of a kecamatan or sub-district
- CRDN: Center For Research and Development in Nutrition, Bogor
- Desa: a village
- Dokabu: the head doctor in a kabupaten or regency
- GOI: Government of Indonesia
- HKI: Helen Keller International
- INCS: International Nutritional Communications Service, a centrally funded AID project with headquarters at the Education Development Center, Newton Massachusetts
- Kabupaten: a political unit within a province. Also called a regency.
- Kader: a village level worker, usually a volunteer
- Kampung: a sub-division within a city, a neighborhood
- Kecamatan: a political unit within a kabupaten, also called a sub-district
- Lurah: the political head of a desa or village
- MOH: Ministry of Health or in Indonesia, the Departemen Kesehatan
- N. E.: the Nutrition Education and Behavior Change Component of the World Bank assisted Nutrition Development Program
- PKK: The women's group organized centrally, but active at the village level.
- PKKBD: the Family Planning Bureau's field workers. These people are responsible for activities in several villages.
- PKMD: Primary Health Care Program
- PLL: the Agriculture Department's extension workers
- Prokesa: the primary health care village level worker
- PusKesMas: a health center at the kecamatan level
- UPGK: the Family Nutrition Improvement Program--the model for

the country.

YIS: a private Indonesian foundation engaged in a number of nutrition projects.

SPECIFIC BEHAVIORAL OBJECTIVES  
VILLAGE FAMILIES

SPECIFIC KNOWLEDGE/ATTITUDE  
OBJECTIVES - VILLAGE FAMILY

INSTRUCTIONAL OBJECTIVES FOR  
FIELD WORKERS OR OTHERS WORKING  
WITH THE VILLAGE FAMILY

General:

Motners will make dietary changes to increase Vitamin A intake of all family members, especially their children 5 years and under.

1. Green leafy vegetables will be substituted for lighter colored vegetables in the family diet.
2. Pregnant and breast feeding mothers will eat an additional bowl of dark green leaves with each meal. The green leafy vegetables should be those available in their area for example bayam, cassava leaves, kangkung and papaya leaves. Additionally they will try to eat a serving of vitamin A rich fruit 3 times per week for example mango,ripe papaya and pisang raja.

General:

All family members will believe that the daily consumption of dark green leaves and yellow/orange fruit is important for good health and can prevent nightblindness which often leads to permanent blindness in young children.

1. Family members responsible for food purchasing decisions will know which foods are the best sources of vitamin A in their area
2. Mothers will know that their increased consumption of green vegetables and vitamin A rich fruits during pregnancy and lactation will help their child be healthier (sick less frequently) because the the essence of these foods is transferred from the mother to the child during pregnancy and lactation. Additionally she will know that these foods are "light" and "fresh", particularly good when she feels a loss of appetite or is constipated.

General:

The kader will offer general education about the link between eating green leafy vegetables and the prevention of nightblindness which often leads to permanent blindness in young children.

1. Kader will stress with the mothers the foods which are locally available, inexpensive and the best sources of vitamin A.
2. Kader will motivate the pregnant and lactating women to increase their consumption of green leafy vegetables and fruits by explaining the relationship between what the mother eats and the health of her child. Additionally the kader will point out that these foods may help the pregnant or lactating women feel better since they are "light" and "fresh" and may help alleviate the problem of constipation during pregnancy.

3. Mothers will ask for and take a vitamin A capsule at the time of birth of their baby or shortly thereafter, and will continue to take a capsule once every six months until the child is weaned.
4. Mothers will give their newborn child the first breastmilk (colostrum)
5. Mothers will breastfeed their children until 2 years.
6. Mothers will include dark green leaves in the daily diet of the children beginning at 5 months of age.
- 3a. Mothers will know that they should receive a vitamin A capsule after giving birth and every six months while lactating to assure that their child receives the vitamin A necessary for health.
- 3b. Mothers will know for their area where and from whom they can get the vitamin A capsule following delivery, and throughout lactation.
4. Mothers will know that their first milk (colostrum) is not dirty or sour but is rich in vitamin A and important for their children's health.
5. Mothers will know that among other reasons, they should breastfeed their children until 2 years to help prevent nightblindness
- 6a. Mothers will know the importance of including dark green leaves in the daily diet of their children to prevent nightblindness.
- 6b. Mothers will know that children between 5 months and one year can digest green leaves if they are finely chopped and cooked until soft.
- 6c. Mothers will know certain preparations of the green leaves for children which are appropriate for their style or cooking (which include a source of fat)
3. Kader, bidan or dukun bayi will give the woman a vitamin A capsule after delivery and at that time inform her where she can obtain her capsules every six months while she is lactating to assure that her child receives the vitamin A necessary for health.
4. Kaders will explain to pregnant women that they should offer their first milk to their child -- that this milk is rich and has plenty of vitamin A. This milk is not dirty or sour but does have a different content than the breastmilk that follows.
5. Kader will stress as part of their education about breastfeeding, that breastmilk contains vitamin A and can help in prevention of nightblindness.
- 6a. The kader will work with mothers in developing appropriate recipes including green leafy vegetables for children over the age of 5 months.
- 6b. The kader will promote preparation of certain recipes through group demonstrations and home visits.
- 6c. The kader will reinforce that green leafy vegetables if finely chopped and cooked until soft can be digested by the young child. The kader will use positive examples from mothers in the community who follow this practice.

- |  |   |   |
|--|---|---|
| <p>7. Mothers will include vitamin A rich fruits (for example papaya, pisang raja, manggo) in the diet of young children at least several times a week or every day if possible.</p> | <p>7. Mothers will know that vitamin A rich fruits are important for the eye health of their children and maybe more acceptable to their children than green leafy vegetables.</p>  | <p>7. The kader will also encourage mothers to give different fruits to their children especially if there is a problem giving green leafy vegetables.</p>  |
| <p>8. Mothers will ask for and obtain a vitamin A capsule every 6 months for their children from 1 year - 5 years of age.</p>  | <p>8a. Family members will know that children from 1 year through 5 years need to have a vitamin A capsule every six months to help prevent nightblindness.</p> <p>8b. Family members will know for their area where or from whom they can obtain this capsule.</p>   | <p>8. The kader will distribute vitamin A capsules to children from 1 year through 5 years every six months at the monthly weighing sessions and home visits. The time of distribution will allow for a special education session on vitamin A, the purpose of the capsule, the specific food preparations for young children and what to do if eye problems are detected.</p>  |
| <p>9. Mothers or other family members will take all children who stumble in the dark to the kader or to the Puskesmas.</p>   | <p>9a. Family members will know that eye problems can be serious and should be reported to the kader or to the Puskesmas.</p>   | <p>9a. Kader will instruct the community about the link between nightblindness and permanent blindness. S(he) will request everyone's help in detecting eye problems or nightblindness and will point out any existing cases.</p>   |
| <p>10. Mothers will feed extra large portions of green leafy vegetables or give fruits rich in vitamin A to children recovering from illnesses.</p>                                  | <p>9b. Family members will be concerned with the health or the eyes of the young children and will know the symptoms of nightblindness.</p> <p>9c. Family members will know that nightblindness if untreated could lead to permanent blindness.</p> <p>10-11. Family members will know that during measles, malaria, respiratory infections or severe diarrhea children are particularly vulnerable to eye problems including</p> | <p>9b. The kader will teach the games for the detection of nightblindness (see HKI handout) to mothers and other family member.</p> <p>9c. The kader will be sure to emphasize the people who can help children with eye problems.</p> <p>10-11. At the monthly weighing or by home visit the kader will watch for children with measles, malaria respiratory infections or severe diarrhea. The kader will offer</p> |

11. Mothers will ask for and obtain a vitamin A capsule for their children with measles, malaria, respiratory infections or severe diarrhea.

12. Mothers will continue the practice of giving roasted liver to children with eye problems (Practiced only in certain areas)

13. Families will increase the amount of vitamin A rich foods they grow in home yards or in the fields for home consumption.

nightblindness and should eat extra large portions of green leafy vegetables and/or more vitamin A rich fruits and should be given a vitamin A capsule from the Puskesmas or the health worker.

12. Mothers will know that the existing custom of giving roasted liver to a child with eye problems is excellent and should be continued.

13. Family members will know that they can increase their supply of vitamin A rich foods especially those which are expensive like papaya by growing them in their yard. They will know where they can obtain help for this activity.

a vitamin A capsule to these children explaining to all family members the need for this capsule and for extra green leafy vegetable and fruits when the child is recovering to protect the child's eyes from nightblindness.

12. The kader will enquire about existing customs for treatment of eye problems. The existing positive customs like giving roasted liver to a child with eye problems should be encouraged.

13. The kader will offer help to families or to the community in home gardening or they will refer families to the person who can help them.

TUJUAN KHUSUS PERUBAHAN  
PERILAKU KELAURGA DESA

TUJUAN KHUSUS PERUBAHAN PENGETAHUAN/  
SIKAP KELUARGA DESA

OBJEK PENGAJARAN PETUGAS LAPANGAN  
ATAU LAINNYA YANG BEKERJA DENGAN  
KELUARGA DESA

Umum:

Para ibu akan merubah pola makanan keluarga dengan meningkatkan konsumsi vitamin A untuk semua anggota keluarga, terutama pada anak-anak balita.

1. Sayuran daun hijau akan menjadi pengganti untuk sayuran berwarna muda dalam makanan keluarga.
2. Ibu hamil dan menyusui akan menambah satu mangkuk sayuran daun hijau setiap kali makan. Sayuran tsb. harus terdapat di wilayah mereka seperti bayam, daun singkong, kangkung dan daun pepaya. Di samping itu mereka juga disarankan untuk memakan buah yang kaya vitamin A 3 x seminggu seperti mangga, pepaya masak dan pisang raja.

Umum:

Seluruh anggota keluarga akan percaya bahwa konsumsi sayuran hijau dan buah berwarna kuning atau oranye setiap hari adalah sangat penting untuk kesehatan dan dapat mencegah buta senja yang mana kerap kali menjadi kebutaan permanen pada anak-anak.

1. Anggota keluarga yang bertanggung-jawab dalam menentukan pembelian makanan, akan mengetahui jenis makanan mana yang terbaik sebagai sumber vitamin A di wilayah mereka.
2. Ibu-ibu akan mengetahui bahwa meningkatkan konsumsi sayuran daun hijau dan buah-buahan kaya vitamin A selama masa hamil dan menyusui akan menolong anak-anak mereka menjadi lebih sehat (tidak mudah sakit) sebab sari makanan-makanan ini akan disalurkan dari ibu kepada anak selama masa hamil dan menyusui. Di samping itu dia akan mengetahui bahwa makanan-makanan ini "ringan dan segar", baik pada saat hilang selera makan maupun konstipasi.
- 3.

Umum:

Kader akan memberi pendidikan umum tentang hubungan antara makan sayur daun hijau dan pencegahan kebutaan senja yang kerap kali menjadi buta permanen pada anak-anak.

1. Kader akan menekankan kepada ibu-ibu tentang makanan-makanan yang tersedia lokal, tidak mahal dan sangat baik sebagai sumber dari vitamin A.
2. Kader akan memotivasi ibu-ibu hamil dan menyusui untuk meningkatkan konsumsi mereka akan sayuran daun hijau dan buah-buahan dengan jalan menerangkan hubungan antara apa yang dimakan ibu dan kesehatan anaknya. Di samping itu, kader akan menekankan bahwa makanan ini akan menolong ibu hamil atau menyusui merasa lebih sehat setelah mereka makan "ringan dan segar" dan akan menolong untuk menghindari masalah konstipasi selama masa kehamilan.
- 3.

3. Ibu-ibu akan meminta dan mendapat capsule vitamin A pada saat melahirkan atau secepatnya setelah bayi lahir dan selanjutnya akan mendapatkan kapsul setiap 6 bulan sekali sampai anak disapih.

4. Ibu-ibu akan memberi colostrum kepada anak mereka yang baru lahir.

5. Ibu-ibu akan menyusui sampai anak berumur 2 tahun.

6. Ibu-ibu akan menyertakan sayuran daun hijau dalam makanan setiap hari pada semua anak-anak mulai umur 5 bulan.

3a. Ibu-ibu akan mengetahui bahwa mereka akan menerima kapsul vitamin A setelah melahirkan dan setiap 6 bulan ketika menyusui, untuk menjamin bahwa anak-anak mereka menerima vitamin A yang penting untuk kesehatan.

3b. Ibu-ibu akan mengetahui untuk daerah mereka: dimana dan dari siapa mereka dapat memperoleh kapsul vitamin A sesudah melahirkan dan selama masa menyusui.

4. Ibu-ibu akan mengetahui bahwa colostrum (air susu yang keluar pertama kali) adalah tidak kotor atau asam tetapi kaya akan vitamin A yang penting untuk kesehatan anak mereka.

5. Ibu-ibu akan mengetahui bahwa salah satu alasan mengapa mereka menyusui sampai anak berusia 2 tahun adalah untuk mencegah buta senja pada anak-anaknya.

6a. Ibu-ibu akan mengetahui pentingnya menghidangkan sayuran daun hijau dalam makanan sehari-hari anak-anaknya untuk mencegah buta senja.

3. Kader, bidan atau dukun bayi akan memberi kapsul vitamin A kepada ibu sesudah persalinan dan pada waktu itu menerangkan kepada ybs. dimana ia dapat memperoleh kapsul itu setiap 6 bulan pada saat menyusui untuk menjamin bahwa anaknya menerima vitamin A yang diperlukan untuk kesehatan.

4. Kader akan menerangkan kepada ibu-ibu bahwa selayaknya mereka memberikan air susu yang pertama kali keluar kepada anaknya --- bahwa air susu ini kaya akan vitamin A, air susu ini tidak kotor atau asam akan tetapi mempunyai susunan yang berbeda daripada air susu selanjutnya.

5. Kader akan menjelaskan sebagai bagian dari pengetahuan yang diberikan mengenai menyusui bahwa air susu mengandung vitamin A dan dapat menolong dalam pencegahan buta senja.

6a. Kader akan bekerja sama dengan ibu-ibu dalam mengembangkan resep-resep yang tepat termasuk untuk sayuran daun hijau untuk anak-anak umur 5 bulan ke atas.

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- 6b. Ibu-ibu akan mengetahui bahwa anak-anak antara umur 5 bulan sampai 1 tahun dapat mencerna sayuran daun hijau yang dipotong halus dan dimasak sampai lunak.
  - 6c. Ibu-ibu akan mengetahui cara penyiapan dan memasak sayuran daun hijau untuk anak-anak (termasuk sumber lemak) yang sesuai dengan cara memasak masing-masing keluarga.
  - 7. Ibu-ibu akan menggunakan buah-buahan yang kaya vitamin A seperti pepaya, pisang raja, mangga dalam makanan anak, sedikit-tidaknya beberapa kali seminggu atau jika mungkin setiap hari.
  - 8. Setiap 6 bulan ibu-ibu akan meminta dan memperoleh kapsul vitamin A untuk anak-anak mereka yang berumur 1 - 5 tahun.
  - 9. Ibu-ibu atau anggota keluarga lain akan membawa semua anak yang sakit mata atau yang tersandung dalam gelap kepada kader atau ke Puskesmas.
  - 6b. Kader akan menjelaskan persiapan dari resep-resep tertentu dalam demonstrasi kelompok atau kunjungan ke rumah-rumah.
  - 6c. Kader akan meyakinkan bahwa sayuran daun hijau jika dipotong halus dan dimasak sampai lunak akan dapat dicerna oleh anak kecil. Kader akan menggunakan contoh-contoh yang positif dari ibu-ibu dalam masyarakat yang mengikuti praktek ini.
  - 7. Kader juga akan mendorong ibu-ibu untuk memberi buah-buahan yang berbeda-beda kepada anak-anaknya terutama jika ada kesulitan dalam pemberian sayuran daun hijau.
  - 8. Kader akan membagi kapsul vitamin A kepada anak-anak balita setiap 6 bulan sekali pada saat pembagian bulanan atau dengan kunjungan rumah. Waktu pembagian akan memungkinkan pendidikan khusus makanan untuk anak kecil dan apa yang harus dilakukan jika ditemui sakit mata.
  - 9a. Kader akan menerangkan kepada masyarakat tentang hubungan antara buta senja dengan buta permanen. Dia akan menolong setiap orang dalam menemukan kasus sakit mata atau buta senja.
  - 7. Ibu-ibu akan mengetahui bahwa buah yang kaya vitamin A adalah penting untuk kesehatan mata anak-anak mereka dan mungkin lebih disukai anak-anak daripada sayuran daun hijau.
  - 8a. Anggota keluarga akan mengetahui bahwa anak berumur 1 - 5 tahun membutuhkan kapsul vitamin A setiap 6 bulan untuk mencegah buta senja.
  - 8b. Anggota keluarga akan mengetahui dimana dan dari siapa mereka dapat memperoleh kapsul ini di wilayah mereka.
  - 9a. Anggota-anggota keluarga akan mengetahui bahwa sakit mata dapat menjadi serius dan harus dilaporkan kepada kader atau Puskesmas.

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|  | <p>9b. Anggota keluarga akan turut serta memperhatikan kesehatan mata anak-anak kecil dan akan mengetahui tanda-tanda atau gejala dari buta senja.</p> <p>9c. Anggota-anggota keluarga akan mengetahui bahwa buta senja bila tidak diobati akan menjadi buta yang permanen.</p>   | <p>9b. Kader akan mengajarkan permainan-permainan untuk menemukan buta senja (lihat buku HKI) kepada ibu-ibu dan anggota keluarga lainnya.</p> <p>9c. Kader akan menunjuk secara khusus orang-orang yang dapat menolong anak-anak yang menderita penyakit mata.</p>  |
| <p>10. Ibu-ibu akan memberi tambahan porsi sayuran daun hijau atau buah-buahan yang kaya vitamin A kepada anak yang baru sembuh dari sakit.</p> <p>11. Ibu-ibu akan meminta dan memperoleh kapsul vitamin A untuk anak-anak mereka yang menderita campak, malaria, infeksi saluran pernafasan atau diarrhea berat.</p> | <p>10-11. Anggota-anggota keluarga akan mengetahui bahwa anak-anak selama menderita campak, malaria, infeksi saluran pernafasan atau diarrhea berat adalah rawan terhadap kesehatan mata termasuk buta senja dan sebaiknya mendapat tambahan porsi sayuran daun hijau dan/atau buah-buahan yang kaya vitamin A dan akan diberikan kapsul vitamin A dari Puskesmas atau petugas kesehatan.</p> | <p>10-11. Pada setiap penimbangan bulanan atau kunjungan rumah, kader akan mengawasi anak-anak yang menderita campak, malaria, infeksi saluran pernafasan atau diarrhea berat. Kader akan memberi kapsul vit. A kepada anak-anak ini, menerangkan kepada seluruh anggota keluarga akan kebutuhan akan kapsul ini dan perlunya makanan tambahan sayuran daun hijau dan buah-buahan pada saat anak baru sembuh untuk melindungi mata anak dari buta senja.</p> |
| <p>12. Ibu-ibu akan meneruskan pemberian sate hati kepada anak-anak yang menderita sakit mata (dilakukan hanya pada daerah tertentu)</p>   | <p>12. Ibu-ibu akan mengetahui bahwa kebiasaan memberi sate hati kepada anak-anak yang menderita sakit mata adalah sangat baik dan diharapkan diteruskan.</p>   | <p>12. Kader akan mencari keterangan tentang kebiasaan yang ada untuk mengobati sakit mata. Kebiasaan yang positif seperti memberi hati kepada anak yang menderita sakit mata perlu didorong.</p>  |

13. Dengan menanam bahan-bahan makanan yang mengandung kadar vitamin A yang tinggi di pekarangan atau kebun rumah, keluarga dapat meningkatkan konsumsi rumah tangga mereka.

13. Anggota-anggota keluarga akan mengetahui bahwa mereka dapat meningkatkan persediaan akan bahan makanan dengan kadar vitamin A yang tinggi terutama bila tidak mampu membeli seperti pepaya dengan menanamnya sendiri di pekarangan rumah. Mereka akan mengetahui dimana mereka dapat memperoleh bantuan untuk kegiatan ini.

13. Kader akan memberikan bantuan kepada keluarga-keluarga atau kepada masyarakat dalam taman pekarangan (karang sari) atau mereka akan menyalurkan keluarga-keluarga kepada seseorang yang dapat membantu mereka.