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TRIP REPORT - INDONESIA  
PREPARE MASS MEDIA CAMPAIGN STRATEGY  
PLAN FOR ORT

A Report Prepared By PRITECH Consultant:  
ELIZABETH M. BOOTH

During The Period:  
OCTOBER 17 - NOVEMBER 13, 1984

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT  
Supported By The:  
U.S. Agency For International Development  
AID/DPE-5927-C-00-2083-00

AUTHORIZATION:  
AID/S&T/HEA: 2/25/85  
ASSGN. NO: DC 73

TRIP REPORT

ELIZABETH MILLS BOOTH

October 17 - November 13, 1984

I. TRIP OBJECTIVE:

The Scope of Work outlined by USAID/Indonesia requested that the consultant prepare a three-to-five-year mass media campaign strategy plan to support the Ministry of Health Control of Diarrheal Disease program. This plan would be written in collaboration with the Ministry of Health and UNICEF and would be designed to begin immediately.

II. PERSONS CONTACTED

MINISTRY OF HEALTH:

Dr. M. Adhyatma	Director General - Control of Communicable Diseases
Dr. Nyoman Kumara Rai	Director Transmissible Diseases

Directorate of Control of Diarrheal Disease (CDD):

Dr. Bambang Winardi	Chief, CDD Sub-Directorate
Gardi Kosim	Surveillance, CDD
Dr. Widodo	Staff Assistant
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Dr. S. Gunawan	Director
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Directorate of Nutrition:

Dr. Suaspendi Notodihardjo	Chief, Sub-directorate Family Nutrition Improvement
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Directorate for Community Participation:

Dr. Anwar Siregar	
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Center for Health Education:

Dr. Ida Bagus Mantra	Director
Dr. Tri Komala Wati	
Mr. Djep Marku	

Training Directorate:

Dr. Dachroni Health Educator

East Java:

Department Control of Diarrhea Disease:

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Dr. Marsetio Sariowan	Surveillance Section
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Health Service Research Unit, Surabaya:

Dr. Ajik P. Suwondo  
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Community Health Division:

Dr. Kusuma Hali Chief

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Dr. Dadi	Chief of Epidemiology
Mr. Ali Basah	Chief, Office of CDD

USIS:

Lynn Sever Assistant Information Officer

USAID/INDONESIA:

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Rebecca Cohn	Family Planning Advisor
Julie Klements	Nutrition Advisor
David Korten	Regional Advisor on Development Management
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Management, CDC/EPI  
Surveillance Training  
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Epidemiologist, CDD

PIACT:

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Director, PATH/PIACT Indonesia

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Arief Sadihan	Evaluation
Sudirman	Planning Division
Radikun	Evaluation
Lazarus Harianja	Out-of-School Education

Manoff International:

Marcia Griffiths

World Bank Team

III. PRINCIPAL ACTIVITIES

The first stage of the consultancy was to become as familiar as possible with experience in marketing, communications, diarrheal disease control, health and family planning systems/infrastructure, and research activities in Indonesia. This included:

Meetings with the USAID, MOH, UNICEF, WHO and other institutions' personnel (listed in Section II).

A field trip to Surabaya, Central Java with Dr. Bambang which included discussions with the Surabaya Health Service Research Unit and observation/interviews at a Regency Hospital, a Puskesmas (health center), a village Weighing Post, village kader, a pharmacy, and a village kiosk.

A search for existing materials/research on diarrheal disease control, health and family planning activities and systems, communications, and marketing in Indonesia.

A review of existing print materials about ORT and diarrheal disease control.

The second stage of the consultancy was the development of the draft proposal plan through workgroup discussions with Dr. Bambang Winardi, other CDD Staff, UNICEF, WHO, USAID, and staff of the Health Service Research Unit. At the end of each day the consultant would write a summary of the discussion and list discussion points for the succeeding day's work. This would then be reviewed by the group and the work would proceed on the discussion points.

Once the outline of the draft proposal was formulated, it was presented to the Director General of CDC and, at his suggestion, to the Integrated Activities Workgroup to gain commitment from these decision-makers and incorporate their suggestions. Their comments are reflected in the proposal.

The final days of the consultancy were then spent "filling in the details" of the proposal through meetings with the directorates and national and provincial level staff who would be most involved in the Component implementation. The decisions and comments of these final meetings are also included in the proposal.

Debriefings on the consultancy and the draft proposal were held with USAID/Indonesia Health and Population Division staff and UNICEF.

Other activities of the consultancy included a presentation to the Radio Republik Indonesia/Televisi Republik Indonesia "Planning for Rural Broadcasting Seminar" on the Mass Media and Health Practices project and the public communications model. It also included a workshop on "Marketing ORT" with Survey Research Indonesia, the probable implementor of the proposed Audience Research (in coordination with UNICEF, CDD staff, and the Center for Health Education Communications Component Coordinator).

It should be noted that this proposal is really a product of several years of discussions and work. The amount of commitment to the proposal the consultant was able to accomplish in the short time span was because people were already interested in and committed to doing public education on ORT. The consultant was then able to provide a systematic structure and plan to deliver this public education.

I would also like to thank Warren Jones, CDC Management and USAID consultant to the EPI and CDD programs. His established credibility, his insights into Indonesia and the MOH, his support and time were really critical to the consultancy performance.

#### IV. CONSULTANCY RESULTS

Draft proposal: "Public Communications for Health-A Health Communications Component Five Year Plan: 1985-1990.

This draft proposal was left with Dr: Bambang Winardi, the director of the Diarrheal Disease Program, and the USAID/Indonesia Health and Population Office.

#### V. RECOMMENDATIONS

##### A. TO USAID/INDONESIA

1. USAID/Indonesia, through daily work with the Ministry, should encourage and support the immediate steps listed in the

proposal to put the Communications Component into action. Once the Component really begins, it will take on a life of its own. However, these first months, while national and provincial level people are brought on board and become involved in the implementation, will be critical.

2. USAID should begin the documentation necessary to insure that the long-term and short-term consultants can be brought into country for the Strategy Planning activity in February. The long-term consultant's effectiveness and the strategy will be seriously effected if the consultant is not involved in this initial planning.

3. USAID should work in close coordination with UNICEF and WHO to insure that all of materials/activities defined in the strategy are funded in a timely fashion. Initial funding planning can be made based on the draft budget (building in a some additional contingency funds). The donor agencies should participate as soon as possible in a joint planning session to identify areas of funding for each. This will give time for the bureaucratic processes to be performed in time to provide funds in February when they are needed. The final budget will be defined as a part of the Annual Plan and future funding needs can be projected based on this first year experience.

4. Discussions with USAID Health and Population staff indicate that they support the concept of institutionalization of systematic communications in Indonesia. USAID should take a lead role in supporting this institutionalization through:

Identification of the decision-makers who need to be involved in the Communications Component in order for it to be accepted and supported. Implementation of activities to insure that these people are actively involved.

Identification of the best positioning of the Communications Component within the Indonesian bureaucracy to achieve the highest quality outputs and on-going support.

On-going funding support for the Communications Component.

Continued emphasis that the Communications Component consultant should have a full-time counterpart. This should be listed in the PIOT as one of the requirements for USAID support.

Funding of training for national and provincial level staff in Communications Component planning and delivery.

## B. RECOMMENDATIONS TO PRITECH

Indonesia should be included as one of the PRITECH priority countries.

Indonesia has the fifth largest population in the world—160 million people.

It has a relatively high infant mortality rate, especially in specific provinces. Reported infant mortality varies from 90 to 150/1000 in the different provinces.

Dehydration from diarrhea is the principal cause of deaths of children under five-years old. At least 24% of all under five deaths are caused by dehydration. This represents almost a half million children every year.

Immunizable diseases are another principal cause of infant mortality. Neonatal tetanus is the reported cause of 20% of deaths of children under one-year-old.

The Government of Indonesia is committed to lowering infant mortality through integrated planning and service delivery of their five priority programs—infant diarrhea, immunizations, family planning, nutrition, and maternal/child health. The GOI 1984-1989 five-year plan, Repelita IV, calls for immunization coverage of 65% of all children under 14 months, a reduction in mortality from neonatal tetanus by 85%, and a reduction in case fatality from diarrheal disease to less than 1% by 1990.

USAID/Indonesia is committed to supporting the GOI in these efforts and possibly will be requesting PRITECH assistance in various ways throughout 1986. PRITECH should view Indonesia as a priority country and support these requests .

## VI. CONSULTANCY BIBLIOGRAPHY

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#5485A

PUBLIC COMMUNICATIONS FOR HEALTH  
A HEALTH COMMUNICATIONS COMPONENT FIVE YEAR PLAN

1985-1990

A draft proposal written through a  
PRITECH-USAID/Indonesia consultancy by  
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Academy for Educational Development,  
in collaboration with:

Dr. Bambang Winardi, Ministry of Health, Chief - CDD  
Sub-directorate and other CDD Staff

Representatives of the directorates/institutions  
of the Integrated Activities Workgroup

Mr. John McEnany-USAID/Indonesia Public Health Advisor

Mr. Warren Jones: CDC Management-USAID/Indonesia  
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Mr. Rodney Hatfield: UNICEF Program Officer/CDD Program

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#5521A

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## I. EXECUTIVE SUMMARY

Systematic, coordinated public communications has proven to be an effective method to change health behaviors. This proposal outlines a plan to implement a Communications Component based on the public communications model. The plan calls for implementation in one province, West Java, in 1985 and staged implementation in other provinces to reach 100% coverage by 1990. The initial work of the Communications Component would focus on ORT and diarrheal disease control. The institutional capacity, personnel, and process can then be applied to the other Ministry of Health (MOH) priority programs--family planning, nutrition, immunizations, and maternal/child health. This systematic approach to health education permits the MOH and donor agencies to provide coordinated planning, delivery, and funding focused on specific behavioral changes.

## II. RATIONALE

This proposal is based on several basic premises:

- A. Dehydration caused by diarrhea is the leading cause of infant mortality in Indonesia. Almost a half million children under five die from dehydration every year. The GOI in their 1984-1989 five-year plan, Pelita IV, committed the government to lowering the case fatality rate of diarrheal disease to less than 1% by 1990 through extension of the Control of Diarrheal Diseases (CDD) Program and improved ORT promotion/education. The WHO/UNICEF/USAID/MOH 1983 CDD Program Review and consultancies by Dr. John Snyder, Drs. Huq and Mulla from ICCDR-B, and Dr. Stephen Lerman all report extensive coverage of ORS packets throughout the MOH health system and various kader (primary health care workers) programs. However the reports agree that there is very little demand for ORS and even less correct use. MOH program planners feel that there is a need for a concentrated, intensive public education component to increase ORS demand and teach and support correct ORT behaviors.
- B. USAID/Indonesia, WHO, and UNICEF are interested in supporting and funding a public education component about ORT if they are convinced that there is a plan which is systematic, practical, and comprehensive.

- C. The public communications model, which emphasizes systematic, coordinated communications planning, formative research as a basis for decision-making, integrated channels (interpersonal, mass media, and print materials), and the reinforcement of focused measurable behaviors over a period of time, has proven to be an effective model for changing health behaviors in both developed and developing countries. This proposal seeks to implement and institutionalize this model, specifically applying it to ORT. The MOH already has successful experience with this model applied to infant nutrition. A recent two-year nutrition education project funded by the World Bank demonstrated 40% increase in weight in a study sample of children in the target area. This proposal seeks to further build on and strengthen that MOH experience.
- D. Indonesia has been described as an "interrelated conglomerate of distinct regional cultures". An effective Communications Component will need to take into consideration the cultural, socioeconomic, and infrastructure differences of each province. At the same time, one of the keys to previous successful communications activities has been placing responsibility for implementation at the provincial level. This has proven to give greater interministerial/intersectoral coordination and support and has made the materials and messages more responsive to the unique differences of each province. This proposal therefore calls for Communications Component implementation by province, and attempts to strengthen provincial level institutional skills and capacity for on-going, systematic public communications planning and delivery.
- E. The GOI, as a part of Pelita IV, is committed to integrated planning and service delivery of five priority health programs -- infant diarrhea, immunizations, family planning, nutrition, and maternal/child health. This proposal supports that integration by developing and institutionalizing a systematic, coordinated provincial level communications planning process which can be applied to all five priority programs. However, it calls for an initial concentrated effort focusing on ORT, followed by immunizations. This is due to the fact these programs have had little systematic public communications effort in Indonesia. Family planning,

nutrition, and, to a lesser degree, maternal/child health have had major public education funding and activities in recent years. Diarrhea and immunizations need to "catch up", and through this process institutionalize provincial level capacity for systematic communications planning which can then be applied to all priority programs.

### III. COMMUNICATIONS COMPONENT OBJECTIVES

- A. To change public behaviors and ultimately lower infant mortality by applying systematic, coordinated health communications to the five integrated priority programs--diarrheal disease, immunizations, family planning, nutrition, and maternal/child health.
- B. To strengthen national and provincial-to-village-level institutional capacity to apply an on-going, systematic, coordinated Communications Component to these activities.
- C. The immediate objective will be to support the Sub-directorate for Control of Diarrheal Disease in the design and implementation of a Communications Component to change behaviors related to oral rehydration therapy (ORT).

### IV. COMMUNICATIONS COMPONENT DESCRIPTION

An effective Communications Component includes:

A coordinated, comprehensive plan which takes into consideration policies and norms, existing health personnel and infrastructure capacity, and target audience beliefs, practices, and needs.

Informed decision-making about Component strategies, messages, and materials based on systematic, yet practical, formative research.

Integration of mass media, print materials, and training of health workers, village kaders, and other opinion leaders so that mothers receive standard information from all sources.

Phrasing of messages so that a limited number of salient, actionable behaviors are taught and reinforced over a period of time.

The steps of this process are:

1. PREPROGRAM RESEARCH: Practical studies on audience beliefs and practices, the health personnel and infrastructure capacity to support the Component impact, and an inventory of other programs, systems, and personnel who can be incorporated into the communications strategy.
2. ANNUAL STRATEGY PLAN which, based on the Preprogram Research, defines the Communications Component strategy, the target audiences, the behaviors to be changed, the messages to be promoted, and the materials to be developed.
3. DEVELOPMENT/PRETESTING of messages and materials with the target audience to insure that they are understandable, attractive, and relevant.
4. PROGRAM LAUNCH AND ONGOING ACTIVITIES in which the print materials, mass media, and interpersonal support are all in place and interacting with the target audience.
5. SYSTEMATIC MONITORING—a practical feedback system to periodically assess the output and impact of the Communications Component and make midcourse corrections. New messages and materials are developed based on this monitoring. This insures that the program responds to changes in the target audience affected by the campaign. It also permits planners to begin introducing messages about the other priority programs as sufficient levels of correct ORT knowledge and behaviors are reached.
6. EVALUATION: 1) Service Provider/Distribution Monitoring: Monitoring of distribution of ORS packets (immunizations and other health products) give initial indicators of increase in product and service delivery demand and usage. 2) Quantitative KAP Studies to evaluate the changes in knowledge and behaviors of the target audiences should be performed to give MOH and donor agency decision-makers data to assess the effectiveness of the Communications Component for future funding. 3) Mortality Studies: The objective of the Communications Component is not only to change health behaviors, but ultimately to lower infant mortality. Mortality reduction, especially from diarrheal disease, is frequently difficult to demonstrate, but should be attempted as a part of the Component.

Chart A attempts to visually demonstrate the Communication Component as an on-going process. Through systematic monitoring which feeds back into the planning of the second and succeeding years annual communications strategies the Communications Component becomes a normal activity of national and provincial MOH planning and service delivery.

#### V. COMMUNICATIONS COMPONENT IMPLEMENTATION SCHEDULE

The Communications Component will begin in West Java in 1984-1985. The lessons learned from applying this type of systematic communications process to a large provincial population will then be used to expand the Component into other provinces. The Component will continue in West Java, however, fine-tuning and institutionalizing systematic communications planning and delivery applied to priority health programs.

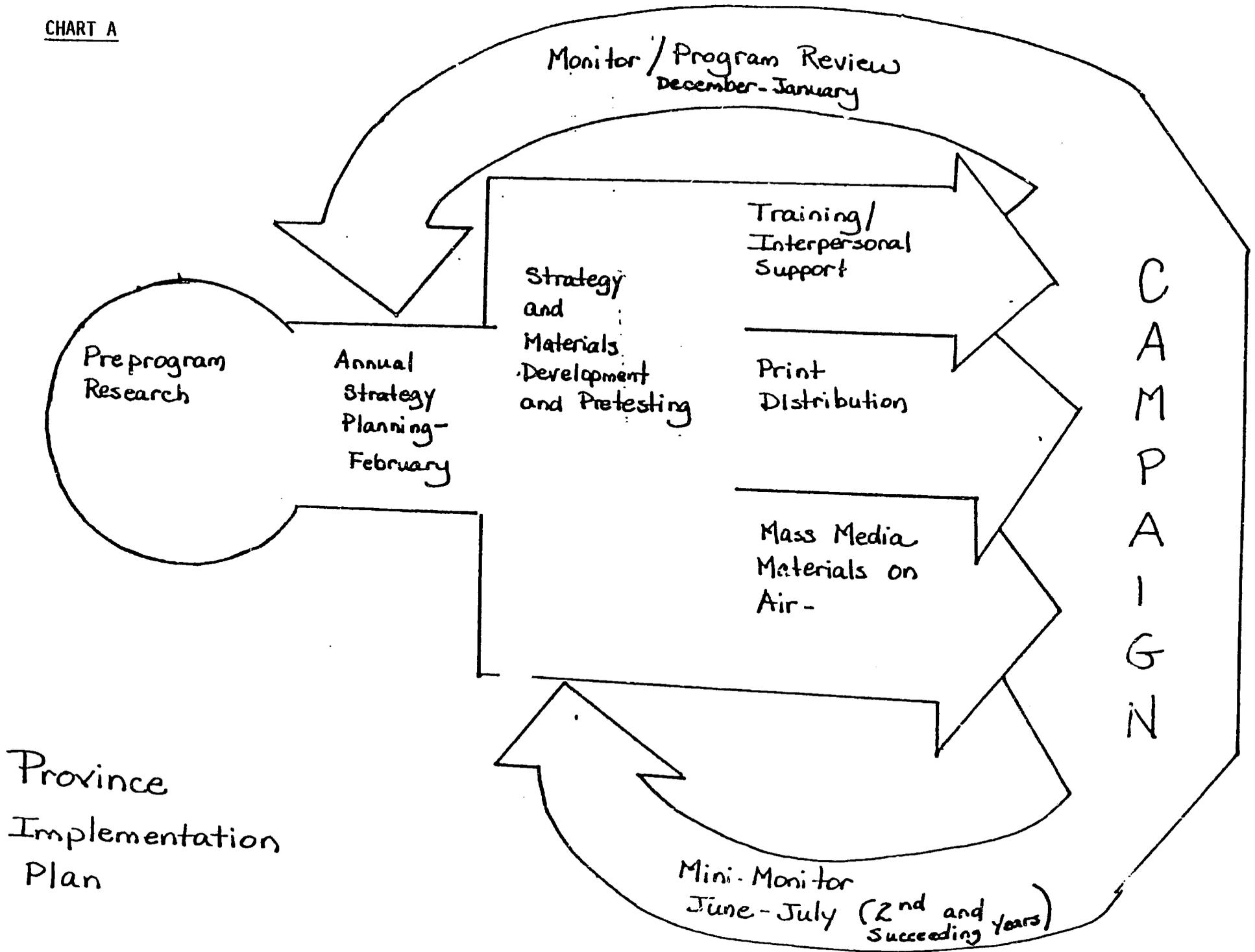
The selection of the provinces for expansion in 1986 through 1990 will depend to a large extent on the experience of 1985. However it is expected that the expansion will cover 100% of the population by 1990. Each year the new provinces should implement all of the steps of the process of the Communications Component. Provincial differences require the development of strategies, materials, and messages which are relevant to each provincial culture and infrastructure. Materials developed for West Java should not just be reproduced for distribution to the rest of the provinces. However, the experience gained during the initial years will teach program planners and implementors short-cuts to easier, but still systematic, provincial level Communications Component implementation.

Chart B demonstrates the expansion of the Communications Component over the next five years, reaching 100% coverage by 1990. It is a static representation, however, and doesn't show the adaptation and changes in the Component in the second and succeeding years of implementation in each province.

#### VI. YEAR ONE: WEST JAVA

##### A. DESCRIPTION OF THE PROVINCE

West Java was selected as the first province for the Component for several reasons. It has a high infant mortality rate--130/1000 and high infant mortality from diarrheal disease. It is a UNICEF priority province and has sufficient population and "provincial status" that other provinces will be likely to want to implement a similar Component. It has fairly good MOH infrastructure, regional radio and television stations, and fewer major health project activities which could confuse evaluation of the impact of the Communications Component.





West Java is one of the three most highly populated provinces in Indonesia with a total population of 28 million. The 1984 Indonesian Consumer reports that the strip between Jakarta and Bogor, known as the Jakarta/Bogor corridor, has a population density of over 1,300 people per square mile and represents one of the major markets in the country. West Java is also representative of Indonesia with about 78% of the population living in rural areas and 12% living in urban areas.

The following gives a brief summary of some of the important statistics of the Province:

Total population: 28 million

Number of mothers with children less than five-years-old: 2 million

Number of children under five-years-old: 5.4 million

Number of children under one-year-old: 850,000

Infant mortality rate: 130/1000

Principal causes of infant mortality: diarrheal disease, pneumonia, and immunizable diseases, particularly tetanus.

Number of households: 5.6 million

Number of Regencies (counties): 24

Number of villages: 7,000

Number of Hospitals: Government operated-35/  
Privately operated-31

Number of Puskesmas (MOH Clinics): 612

Number of "CDD Puskesmas" where staff have received training by the CDD Program: 70

Approximate numbers of village kader (primary health care workers): Nutrition-73,580, BKKBN-55,785, CDD-31,500. Total 160,865.

Peak diarrhea season-October through January

B. PROVINCIAL START-UP ACTIVITIES AND PREPROGRAM RESEARCH: November, 1984-February, 1985

The goals of these activities are two-fold. The first goal is to operationalize the Communications Component on the national and provincial levels and, through the Preprogram Research activities, gain involvement in, support for, and commitment to the Communications Component by the personnel at all levels who will actually implement the activities. The second goal is to systematically, yet quickly, gather basic information about the target audiences, the service provider system, and existing provincial programs which can then be incorporated into the design of the Annual Strategy Plan in February.

The Provincial Start-Up Activities will require a series of meetings through the Integrated Activities Workgroups at the national and provincial levels to explain the Component, seek ideas to improve and operationalize the first steps, and identify personnel to implement the activities.

The Preprogram Research will involve three activities--A Provincial Inventory, a Health Provider Study, and an Audience Research Study. The Provincial Inventory and Health Services Provider Study should be implemented by the national and provincial Communications Component Coordinators and other participating program (nutrition, BKKBN, CDD, etc.) national and provincial level staff as a first step in involving them in the Component. The Audience Research Study should be performed by a professional marketing research firm with experience in marketing research at the village level. The reports from these three studies should be completed by January 31, 1985 so that program planners can use them as a basis for the strategy planning in February. The following is a more detailed description of the three research activities:

PROVINCIAL INVENTORY: The objective of this activity is to identify existing institutions, programs, and personnel to work with and support initial and future communications activities. This gives provincial level MOH staff the opportunity to renew old contacts and make new ones, to explain the proposed Component, and seek ideas and support for implementation. Some of the institutions which should be contacted include the Ministry of Information, the Ministry of Interior, Ministry of Religion and other religious

leaders, the Scouts, PKK, the Village Newspaper Program, and other development programs which work at the village level. It will be particularly important to obtain commitment from the Ministry of Information and the provincial radio and television stations to provide studio and staff time for materials production, sufficient prime time air time, and access to existing programs such as the Radio and Television Listening Groups.

Methodology: Meetings/individual interviews. Each meeting should cover the following points: 1) Explain the Communications Component and proposed activities. 2) Request support for the Communications Component by the institution. 3) Request an explanation of the on-going activities of the institution which could be coordinated with the Communications Component. 4) Identify personnel who would be responsible for coordinating with the Communications Component. 5) Identify steps which need to be taken to formally achieve this coordination (including, when necessary, funding requirements). 6) Request existing research about health beliefs and practices, media usage patterns, and other research which would be useful for the strategy design. 7) Request ideas/suggestions for effective implementation and names of other institutions/persons who should be contacted.

A draft "checklist" for the Provincial Inventory is included in Appendix D.

SERVICE PROVIDER RESEARCH: The objective of this activity is to assess the service provider/infrastructure capacity to support the ORT campaign and to identify immediate activities to overcome constraints and strengthen existing personnel/health care delivery before the campaign is launched in September.

Methodology: Observation/in-depth interviews with staff in a limited number of Puskesmas, weighing posts, and village kader (including Nutrition, BKKBN, and CDD kader). This need not be a long academic research activity, but rather a participatory approach to identify service provider problems and needs and practical solutions to be incorporated into the ORT communications strategy in February. The Draft Service Provider Research Protocol in Appendix D further outlines this research.

AUDIENCE RESEARCH: The objective of this activity is to collect information at the village level which will serve as the basis for the design of the health communications strategy, messages, and materials. The research protocol included in Appendix D has been provided as a guide to the contracted agency which will then design the research methodologies.

C. STRATEGY PLANNING: February, 1985

The Preprogram Research reports should be completed by January 31 in order to serve as a basis for the design of the communications strategy and writing of the 1985 Annual Communications Plan in February. This plan should be designed and written as a coordinated effort between the Director of the CDD Program, the national and provincial level Communication Component Coordinators, the requested technical consultants and representatives of the Integrated Activities Workgroup, the institution responsible for performing the Audience Research, and the donor agencies. The strategy and plan will include:

1. Standardized norms and messages in each province concerning ORT including the product (ORS packet, water/sugar/salt), mixing, administration, patient referral, and feeding during diarrhea episodes.
2. A promotion strategy which will take into account audience segmentation, product positioning, product packaging, campaign tone, and message phasing.
3. A media plan which defines which messages will be communicated through each channel (interpersonal, mass media, and print) and how those channels will reinforce each other.
4. An implementation plan which will include a schedule for design, pretesting, production, and distribution of mass media and print materials, training, and systematic monitoring.
5. A budget for review and funding by the MOH and donor agencies. This budget will also serve as a base for requesting funding for 1986-90.

D. STRATEGY/MATERIALS DEVELOPMENT AND PRETESTING:  
March - September, 1984

Once the Annual Plan is written, implementors will begin developing and pretesting promotion strategies and

materials. Usually the newest or most innovative messages and materials are pretested with the target audience. Since this is a new activity, various alternative strategies, promotion plans, and materials may need to be pretested. Pretesting will permit program planners to make informed decisions about which promotion approach and educational materials are most attractive, understandable, and appropriate to the target audience. It's also possible that some product testing will need to take place during this phase. Since print materials take longer to produce and distribute than mass media materials, these will probably be pretested first. The implementation plan schedule will take into account the time needed to produce and distribute materials so that all of the elements will be in place for campaign launch in September.

E. CAMPAIGN LAUNCH/IMPLEMENTATION: September, 1985-February, 1986

All the major pieces of the campaign--training, print materials, and promotion activities -- should be in place by September, 1985 when the mass media materials go on the air. These mass media materials will be broadcast through February, 1986. This will permit interaction of all of the channels with the target audience for several months before and after the peak diarrhea season. The promotion plan, messages, and materials will ultimately be defined from the Preprogram Research. However, previous successful communications activities present some general guidelines and ideas:

1. TRAINING/INTERPERSONAL

An important aspect of the Communications Component will be to standardize the ORT norms to be followed in each level of the MOH system. There is presently some confusion about packet size, the correct water/sugar/salt formula, and ORS administration. The research will give program planners and donor agencies information on which to base decisions to standardize these norms. Discussion with program planners and donor agency representatives suggest the following policy as a basis for the Preprogram Research:

Home Treatment: Prevention of dehydration in the home through the most appropriate home treatment--extra liquids, teas, coconut water, water/sugar/salt,

or purchased packet. The Preprogram Research will help to identify the most appropriate treatment(s) which will be taught and reinforced through the Communications Component activities. The government would not, however, provide packets in the home to prevent dehydration. With a population of over 150 million people, this would not be a strategy which the Ministry could sustain, and would ultimately result in public sector supply problems. The private sector could and should, however, be encouraged to promote purchased packet use in the home to prevent dehydration.

Treatment of Mild Dehydration by a limited number (two to three) specially trained kader in each village. Mothers will be taught that when a child presents certain signs, she should take her child to the kader for treatment. Preprogram Research will identify which early signs of dehydration a mother observes which can be tied into ORS product positioning. Earlier research indicates that mothers believe that "loose stools" are a normal part of growing up. They do become concerned, however, when a child who has loose stools becomes weak or doesn't want to eat. Although ORS does not stop diarrhea, it does improve activity and appetite of a child during diarrhea episodes. ORS must be tied into signs mothers can observe that 1) her child needs special treatment and that 2) ORS is being effective even though it doesn't stop the child's diarrhea. This has been important to continued and correct ORS use in other CDD programs.

Training of kader will then focus on knowledge and skills of treating mild dehydration and signs which indicate that the child must be referred to the Puskesmas. It will also focus on teaching the kader to be a better trainer and reinforcer of mothers' correct ORT behaviors.

Treatment of Moderate and Severe Dehydration at the Health Center/Referral to the Hospital level, if necessary. Training of Puskesmas level staff would focus on knowledge and skills for treatment of mild, moderate, and severe dehydration at the Puskesmas level, training and reinforcement of village kader to treat mild dehydration, and training and reinforcement of the mother to prevent dehydration through appropriate home treatment.

Previous research and discussion with MOH staff indicate that there is still a good deal of resistance and misunderstanding about ORT at the Puskesmas level. Some of the reported problems include:

Widespread treatment of diarrhea with antibiotics.

Staff only use ORS for cases of mild dehydration, but moderate cases are most frequently treated with I.V.

If a child vomits while being given ORS, staff frequently change to I.V. treatment.

Mothers are given only one packet of ORS to continue treatment in the home when a child is mildly dehydration.

Health professionals feel that they must prescribe various treatments for infant diarrhea, including pills and antibiotics, or the mother will not be satisfied and won't return for other treatment.

ORS is not appropriate treatment for infants under four-months-old.

The CDD Program presently is beginning a concentrated health professional training program at hospitals throughout the country. This, and an effort to change health professional training institution curriculums, are important long-term strategies for gaining support for ORT. However, the Communications Component will need to implement some type of practical, concentrated effort to gain the support of the Puskesmas level staff in the Province before the mass media materials go on the air. Mothers must receive the same information from all channels of the Communications Component and other experience has demonstrated that without the support of physicians and other health professionals the Communications Component will have much less, if any, impact. The preprogram Service Provider Research will attempt to identify the most important misconceptions/constraints to effective ORT at the Puskesmas level. Some type of concentrated activity/training should then be focused on changing these misconceptions and removing these constraints. It will be important to identify ways to positively reinforce the

Puskesmas-level staff in correct ORT and diarrheal disease control activities. One way might be a "Health Professional Kit" which focuses on and reinforces specific ORT activities for the Puskesmas staff. The research will also explore the possibility of tying CDD Program implementation into the Puskesmas competition. The idea of grading Puskesmas and rewarding the most effective ones has been implemented in some areas with a good deal of success. The CDD Program could offer some type of reward to the Puskesmas in each Regency that best implements the CDD Program. Criteria for evaluation would be identified by the CDD Program staff, but might include a prize for the clinic which most successfully rehydrates the highest percentage of mild and moderately dehydrated children using ORS instead of I.V., for example. This type of competition could also be implemented at the village level. Appropriate rewards will be identified by the preprogram research, however they might include interviews on national television, trips to visit other provinces, ceremonies with the President (presently done by BKKBN), or other culturally appropriate, but inexpensive activities.

## 2. MASS MEDIA

Mass media has proven to be critical to effective Communications Components. Radio and television spot messages, frequently repeated during times of highest audience, are timely reminders of key program messages. Longer programs can be effectively used to standardize training of health center staff and primary health care workers. The selection of radio stations, the types of materials, and the scheduling of materials during times of highest listening of the Component target audiences will be planned based on the Preprogram Research. However, the draft budget includes radio programs, tentatively a "Kader Radio Program" to give ORT training and support the kader activities, and radio spots for the general public. The Kader Radio Program is further discussed later in the proposal.

Other experience in Indonesia has demonstrated that it will be critical to get commitment from the Ministry of Information to 1) Produce the mass media materials and 2) air the materials at the times requested by the MOH. This should be accomplished as

soon as possible at a policy level through the Ministry of Information and through negotiations with the government radio and television stations in the province. Earlier experience indicates that it is important that the government stations produce the materials or they are less likely to air them. Private stations have tended to collaborate irrespective of where the materials are produced. The MOH may have to pay for some air time on private stations in order to insure that materials are aired at the scheduled times, however.

Although the production of television materials is expensive, the Program Research may demonstrate that it is the most effective way to give ORS status and credibility to both medical decision-makers and the target audience. The 1984 Indonesian Consumer reports that the change in policy of the GOI to not permit spot advertising on television has had a major impact on private sector marketing. Private sector marketing specialists reported that companies would put 50% of their budget in television, if they were allowed access. Because ORT and lowering infant mortality from diarrhea are Pelita IV priorities, the MOH should be able to obtain government television stations' commitment for support and air time. This is a tremendous potential that private sector can not utilize, and could be one of the keys to real impact of the program in a very competitive market.

The draft budget tentatively includes three television spots to be broadcast daily at prime audience time for 2-3 months during the diarrhea season. Longer video materials could be broadcast on television and used to support/standardize training. The Component should also attempt to introduce ORT in locally produced popular programs such as the puppet shows and soap operas.

### 3. PRINT MATERIALS

Due to the large population and the costs of producing print materials, it is critical that the materials designed be 1) Durable, with a projected use of several years. 2) Interactive - materials that are useful to and likely to be repeatedly used by the service providers and target audience. 3) Ones which the private pharmaceutical companies could reproduce to distribute through the commercial and public sector distribution systems.

The draft budget tentatively bases print materials planning and distribution by desa (village), rather than by household. Some materials which might be considered in the strategy include:

An "ORT Promotion Kit": "Point-of-purchase materials" for Health Centers and Weighing Posts: This would be a kit of print materials for teaching and reinforcing ORT behaviors and activities at each Health Center and two weighing posts per village. These could also be reproduced and distributed by the pharmaceutical companies to village stores.

A "Village Kader Kit" for the kader selected and trained to treat mild dehydration in each village. It could include a flag or sign with the program logo to identify the house. Mass media materials could then teach mothers to seek help at the houses with the program logo. Other materials might include a graphic or games to teach mothers mixing, administration, and feeding messages, as well as some type of reinforcement for the kader to support her in her new activities.

The "Health Professional Kit" discussed earlier.

ORT Radio Course Manual/diploma/badge: Training of large numbers of village kader and other village-level opinion leaders would be difficult and expensive in the short amount of time allowed before campaign launch in September. The Preprogram Research will explore the possibility/appropriateness of training this personnel through radio courses. This would build on the existing Listening Group training already being carried out by the Ministry of Information. Health workers/kaders/opinion leaders could be motivated to listen to a series of radio programs while following a specially designed training manual. A simple exam attached to the manual could be returned to the Health Center by the kader/opinion leader who could then receive a diploma, certificate, badge, or other appropriate reward. If this approach proved successful, it could be used to standardize and upgrade training in other areas as well. One of the reported reasons for high kader drop-out rate is that kader don't feel supported or rewarded in their work. A Kader Radio Program would be a way of rewarding and reinforcing kader in their work, making them feel special and part of a larger system.

The strategy will also attempt to incorporate messages into existing print materials such as the "Village Newspaper Program".

#### 4. TRADITIONAL MEDIA:

Indonesia is unusually rich in traditional media such as puppets, folk songs, and dances. The Health Communications strategy should take advantage of this richness and incorporate the creativity provided by this media into the strategy. The Preprogram Research protocol includes exploring traditional media both as a channel for delivering ORT messages and as a resource for strategy and message design. For example, a traditional folk tale, song, or myth might exist in the culture which could be linked to the concept of dehydration or of correct ORT behaviors.

#### F. COMMUNICATION COMPONENT MONITORING:

Systematic Communications Component monitoring is necessary to enable planners to respond to changes in the target audiences affected by the communications activities. This gives a basis for mid-course changes as well as annual strategy planning. The Preprogram Research will identify the most appropriate, cost-effective mechanism for giving on-going, systematic monitoring of program impact in a timely manner so that program implementors can make decisions based on this information. The monitoring will include at least two areas:

Communications Component Outputs: Records will be kept of numbers of print materials distributed and personnel trained. Earlier experience has shown that it is also necessary to contract someone to monitor the broadcast radio/television materials to insure that they are aired at the scheduled times. Discrepancies between programmed scheduling and actual broadcast can then be discussed and renegotiated with the radio and television stations based on this monitoring.

Communications Component Impact: Changes in knowledge and practices of the target audiences (service providers and villagers) should be periodically assessed and messages and materials

changed in response to accumulated learning. This is proposed to be performed through bi-annual reviews--qualitative studies with representative members of the of the target audience(s). The final Monitoring System design will be based on the Preprogram Research. It is important that the monitoring system be practical and based as much as possible on existing review and monitoring systems. It's also important that it be viewed as a practical tool for decision-making and not become a cumbersome research exercise or one which will alienate health staff because it requires a lot of extra work.

G. AFTER 1985...THE COMMUNICATIONS COMPONENT AS AN ON-GOING ACTIVITY IN WEST JAVA

The Communications Component should ultimately become an on-going process in each province. The first program monitoring activity in December, 1985 will therefore give program planners a basis for designing the West Java 1986 Annual Strategy Plan. It's possible that some correct ORT behaviours will be sufficient that program planners will want to incorporate immunizations or other messages into the 1986 Annual Plan. An important part of public communications is message phasing emphasizing or "pulsing" certain messages at times when mothers most need and can act on that information. The first year Communications Component plans for intensive activities about ORT during the months of highest diarrhea incidence - October through January. However mass media materials, especially radio spots, should be changed every five-to-six months to avoid listener fatigue. This allows planners to focus on other priority programs and messages during the "off-diarrhea" season while still giving on-going "maintenance level" support/activities about diarrhea. Succeeding years in each province would then phase in new messages as Component monitoring indicated program needs. For example, in 1986 the West Java Component will probably want to focus on immunizable diseases from March through August and emphasize diarrhea from September through February, 1987. Each succeeding year the Annual Plan will focus on new messages and materials. The public communications model permits flexible, yet systematic planning which incorporates audience perceptions, behaviors, and needs, as well as the MUH priorities and norms.

Chart C summarizes how the Communications Component would be implemented in West Java.

VII. COMPONENT EXPANSION: 1986-1990

The Communications Component should be expanded to reach 100% coverage of the population by 1990. The selection of the new provinces will be made based on the problems and successes of the first year. However, the following demonstrates a potential plan:

1985: West Java

1986: Central Java and one other province to reach 45% coverage.

1987: East Java, Yoyakarta, and one other province to reach 70% coverage.

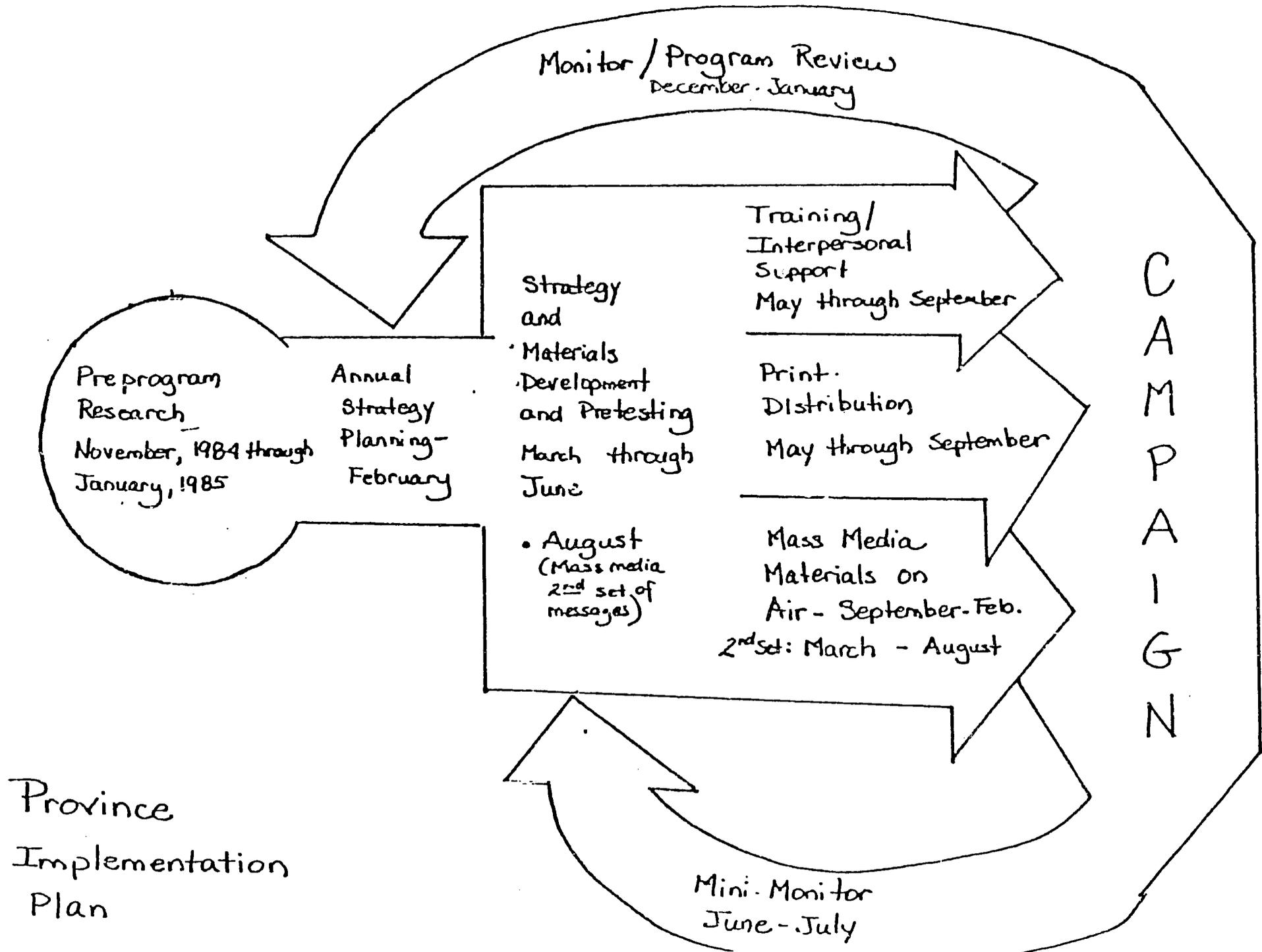
1988: Additional provinces to reach 85% coverage

1989: Additional provinces to reach 95% coverage

1990: Final provinces

This plan calls for coverage of all of Java, 70% of the total Indonesian population within three years. This is an extremely optimistic and aggressive plan which will require real commitment on the part of both the government and the funding agencies. Due to the higher level of infrastructure and communications, Java will be at the same time the easiest and the most difficult to implement. The easiest, because the MOH infrastructure is the most developed. The most difficult because there is much more competition within the marketplace. Although the other islands can build on the experience gained in Java and learn lessons from the process, the actual messages and materials will need to be developed based on formative research in each of the islands. Actual population coverage becomes less cost-effective since the same process needs to be performed to reach a much smaller target audience. Thus the proposal attempts to extend coverage to the largest numbers of people while still in the learning stages. A cost-effective way to extend Component expansion to the other islands would be through a series of training courses in 1988. The training modules would be designed by the national and provincial level Communications Component implementors based on the field experience gained in 1985-1987.

Chart C



## VIII. EVALUATION

In order to assess the Communications Component impact and provide a basis for decisions about funding and support, the following evaluation activities should be performed:

### A. PACKET DISTRIBUTION MONITORING:

The first indication of Communication Component success will be an increase in ORS demand. However, due to the unusual and varied mechanisms of packet purchase and distribution, program planners presently do not know how many packets are being distributed through the various systems. A practical system for monitoring distribution to and from the hospitals, Puskesmas, and village kader should be implemented throughout the integrated programs in order to assess the impact on ORS demand created by the Communications Component.

### B. KAP SURVEYS:

The type of formative research Communications Component implementors need to design materials and messages is usually not sufficient for MOH and donor agency funding decisions. Annual KAP Surveys with a statistically significant sample of the target audiences should be made to provide these decision-makers with quantitative data to demonstrate the impact of the Component. In 1985 the West Java baseline survey should be implemented in March/April--before the training begins, but after the design of the Annual Strategy Plan --so that the instrument can include questions about specific messages and materials included in the plan. This should be repeated in West Java in March/April of 1987 and 1988.

As the Component begins in other Provinces, KAP Studies should also be included in the overall Communications Component design. A tentative schedule would include:

Chart

	1985	1986	1987	1988	1989	1990
Baseline	West Java	New Province 1				
1st Year Impact		West Java	New Province 1	New Province 2		
2nd Year Impact			West Java	New Province 1	New Province 2	
3rd Year Impact					New Province 1	New Province 2

This type of large-scale KAP studies need not be carried on indefinitely. However it would be a useful for several key provinces to be evaluated up to three years. This would serve not only as a basis for funding decisions, but would also contribute substantially to state-of-the-art knowledge about development communications.

This evaluation activity should be sub-contracted to a third party so that the provincial and national level Communications Component implementors are not incumbered by these additional responsibilities. However, it is important that the instrument be designed in coordination with the Communications Component implementors so that it does incorporate the specific messages of the Annual Strategy Plans.

C. MORTALITY SURVEYS:

The objective of the Communications Component is not only to change health behaviors, but ultimately to lower infant mortality. Changes in mortality, especially from diarrheal disease, are difficult to demonstrate, but should be attempted. MOH and consultant epidemiologists should coordinate to design a cost-effective mechanism to measure the effect of the Communications Component on infant mortality from diarrheal disease.

## IX. MANAGEMENT STRUCTURE

The Communication Component management structure was the most difficult part of the proposal to define. This is partially due to the fact that the Ministry has recently had a major reorganization and there are still some questions about internal management systems and responsibilities. It is also due to the fact MOH staff have several job responsibilities and workgroup meetings are frequently attended by different staff who then report to their Sub-Directorate Chief. This makes planning continuity difficult. However, working meetings have led to the following proposed management structure for the Component.

### A. INTERSECTORAL INTEGRATION:

Previous communications activities have shown that the commitment of the Ministry of Interior, Ministry of Information, Ministry of Religion, and BKKBN are critical to effective implementation. At one level the commitment to coordinated integration of the five priority health programs will be achieved through a planned Letter of Agreement between the Ministry of Interior, the Ministry of Health, and BKKBN. However, the MOH should seek commitment from these Ministries and institutions to specifically support the Communications Component in West Java and succeeding provinces. Program implementors should define exactly what collaboration they need from each of these Ministries/Institutions (access to production facilities and radio and television air time at prime listening times from the Ministry of Information, access to the village level government officials to support the Component activities, inclusion of ORT messages in the Ministry of Religion "green book", for example) and present formal requests for national and provincial level commitment and support for these specific requests. In some cases Letters of Agreement may be necessary to formalize these requests.

### B. NORMATIVE:

Standardized norms, messages, and materials will be critical to Component impact. The Communications Component messages will be reviewed by the Control of Diarrheal Diseases Workgroup and recommendations will be made to the Director General of Control of Communicable Diseases. He in turn will present these

norms to the other MOH Director Generals for operationalization through their activities. Standardization of ORS packaging, labeling, etc. would be discussed and operationalized with the Director General of Food and Drugs.

It will be critical that these norms are operationalized through BKKBN, the MOH Training Unit, and the various Ministry of Health sub-directorates. This would include standardizing the type of packets distributed by each level of the service provider system, standardized training, and production/use of the same print materials so that mothers receive the same information from Nutrition, CDD, Puskesmas, and BKKBN personnel. All print materials concerning CDD produced by donor agencies and other non-governmental institutions should be required to have the "CDD Stamp of Approval" (the CDD logo) or Ministry staff should be instructed not to use or distribute them.

C. OPERATIONALIZATION OF THE COMPONENT:

The Communications Component will be operationalized at both the national and provincial levels through the Integrated Activities Workgroup. It's been proposed that a smaller sub-group of this Workgroup be more directly involved in the Communications Component activities. This Communications Component Workgroup would be composed of Dr. Bambang of CDD, the Center for Health Education, and a representative from Nutrition, Community Participation, and BKKBN. The Center for Health Education would ultimately be responsible for the Communications Component coordination and has named Mr. Djep Marku as the Communications Component Coordinator. Dr. Bambang would be responsible for the technical direction about ORT.

On the provincial level, the first step of the Component will be to identify a provincial Communication Component Coordinator, meet with the provincial Integrated Activities Workgroup, and establish the provincial Communications Component Workgroup, counterparts to the national Communications Component Workgroup. The Provincial Workgroup should also include a representative from BKKBN.

An initial meeting with West Java MOH CDD and CDC directors have scheduled the following initial activities in the province:

November 20-30: Dr. Bambang and Mr. Marku begin provincial start-up. Meetings with the Integrated Activities Workgroup, establish Communications Component Workgroup, implement the Provincial Inventory, and design the Service Provider methodologies and instruments.

December 3-7: Training of interviewers for the Service Provider Research.

December 10-21: Researchers in the field.

January: Analysis and report writing.

The Annual Communications Strategy Plan will define who will actually design, produce, pretest and distribute mass media and print materials and implement training and other Component activities. However, the Ministry may want to consider sub-contracting an advertising agency to develop the promotion strategy, and design, produce and distribute the mass media, print, and promotion materials. ORS as a product is competing in a complex, sophisticated market, especially in Java. This is further complicated by the fact that ORS is not a new product, but rather one which has been tried and rejected by a significant proportion of the population. This will require "repositioning" or "relaunching" the product in order to change preconceptions about ORS. This is much more difficult than introducing a product into the market. An advertising agency with experience in product relaunch can create a potentially more effective strategy and materials. This would give the MOH the role of overall coordination and management, training of health workers and other opinion leaders, obtaining government radio and television station time, and systematic monitoring. The experience gained through working with the advertising agency could then be applied in the province in succeeding years.

D. TECHNICAL ASSISTANCE:

Dr. Bambang Winardi, chief of the CDD Sub-Directorate has requested a long-term technical consultant to assist in the initial implementation of the Communications Component. This consultant should

arrive in country in January in order to have time at the provincial and village level before assisting in writing the Annual Plan in February. Dr. Bambang has also requested the return of Bette Booth in February to assist in the design of the strategy and writing of the Annual Plan. The following is the draft Scope of Work for the long-term consultant:

MINIMUM REQUIREMENTS: Masters degree in Development Communications, Marketing, Education, or Public Health. At least five years overseas experience in developing countries, preferably in Asia. Experience in the design and management of communications programs, including intercultural/ intersectoral management, formative research, materials pretesting, materials design and production, and training.

The Communications Consultant will give technical guidance in the:

1. Analysis of Preprogram Research/ writing of the Annual Plans which outline a coordinated, systematic communications strategy, management structure, budget, and timeline for implementation.
2. Development of print and mass media materials including pretesting with the target audience.
3. Design and implementation of training of health workers, village kader, and other opinion leaders.
4. Design and operationalization of an on-going Communications Component monitoring system at the provincial level to make mid-course corrections and design new annual strategies.
5. Design and supervision of evaluation of the Communications Component through KAP Surveys, Mortality Studies, and ORS Packet Distribution Monitoring.
6. Coordination and management of the Communications Component between participating Ministries and institutions.
7. Expansion of the Communications Component to other provinces.

8. Institutionalization of the Communications Component as an on-going activity of the Integrated Program. This would include training of national, provincial, and village-level staff in appropriate communications skills such as communications strategy planning and management, formative research, pretesting of materials, design and production of mass media and print materials, and competency-based training methodologies.
9. Coordination with donor agencies to assist in writing of necessary documents and budgets for ongoing Communications Component funding.

The consultant will work with the MOH Center for Health Education and Sub-Directorate for Diarrheal Disease Control for the coordinated implementation of the ORT communications activities.

#### X. BUDGET/FUNDING

This proposal was designed to be a joint funding venture between the MOH and three donor agencies--USAID, UNICEF, and WHO. Donor agencies frequently talk about coordination and collaboration, but generally programming and funding are implemented individually. This component presents a challenging opportunity for the donor agencies to jointly support a coordinated, systematic activity which could be built on over the next five years. The draft budget in Appendix E is an outline of possible line items for the first year Communications Component implementation. The actual materials, training needs, and promotion activities will ultimately be defined as a part of the Annual Plan. The costs would be higher if an advertising agency was contracted, but the additional cost would probably pay off in program impact. The MOH and donor agencies should review the budget as soon as possible and identify areas of funding for each donor. This would give the agencies time to process the bureaucratic steps necessary to have access to the funds when they are needed in February. The proposed first year plan requires very tight scheduling which will be impossible if program implementors have to wait for funding.

The Annual Plan budget should then serve as a base for MOH and donor agency funding requests for 1986 and future Communications Component activities.

## XI. OTHER RECOMMENDATIONS/SUGGESTIONS

### A. PHARMACEUTICAL COMPANY COLLABORATION:

Several pharmaceutical companies have already demonstrated interest in collaborating with the CDD program. They represent an extraordinary potential for extending coverage and support for the program. The CDD Program Coordinator and Communications Component Coordinator should make a presentation to the Pharmaceutical Associations about the CDD program and Communications Component plans. Meetings could then be held with interested pharmaceutical company managers and marketing specialists to define ways they could collaborate with and support the Component. Some of the potential ways include:

1. Pharmaceutical companies could use the MOH Audience Research to design similar promotions and product positioning.
2. Companies could assist in the actual design and production of the Communication Component print and mass media materials.
3. The component will only be able to afford limited production of print materials to targeted village kader. Companies could reproduce the Communications Component-designed materials and distribute them to additional kader and opinion leaders and/or through their own distribution system (village kiosks and other stores).
4. Companies could be given access to use village kaders for house-to-house visits to teach and promote correct use of commercial ORS products. The pharmaceutical company would then be responsible for funding MOH designed/approved training to this personnel, the production and distribution of MOH designed/approved print materials, and any type of kader reward system. A system similar to the Bangladesh BRACs program might be appropriate. Kader are rewarded based on how well the mothers they visit learn ORT messages and behaviors. Evaluators visit a few homes several weeks after the kader visit, observe ORS mixing, and assess mothers' knowledge and skills about ORT use.

Although allowing the private sector access to village kader is an unprecedented approach, it has the potential of improving kader training and support, and increasing ORT coverage and correct usage at no expense to the government. This might be attempted as a carefully controlled pilot project in one regency in 1985.

- B. It will be important for the Communications Component strategy to build on existing systems and programs, to use those systems to expand coverage without having to provide funding. Standardizing training norms, curriculum, methods, and materials of all three kader programs will provide an on-going method of eventually strengthening the kader ORT knowledge and skills. Identifying and working with other institutions to include CDD Communications Component messages, reproduce and use CDD materials, and use the CDD training curriculum and methods will also be important. PKK, the Ministry of Religion and religious groups, the Scouts, the Village Newspaper, and other programs should be involved in implementing the Communications Component as a part of their on-going activities at little or not additional cost to CDD.
- C. The Communications Component implementation should support the Center for Health Education in their search for existing KAP studies, ethnographies, and other research about child care and health behaviours. A national level research search should be implemented in December. Contacts should include Yayasan Kusuma Buana, Dr. Kuncoro Ningrat, anthropologist at the Faculty of Letters and Culture, and Dr. Nico Kalangi, head of Medical Anthropology. Implementors should also consider asking Dr. Ningrat to assist in the Audience Research analysis and strategy planning. The Provincial Inventory will also seek to identify research being done in West Java.

PATH is assisting KONIMEX to launch a new ORS product in tablet form and is planning on funding ORT research. UNICEF and AID are also planning ORT research in other provinces. These, and other researchers identified in the national research search, should meet to organize and coordinate research plans to avoid duplication and unnecessary expenditures of time and resources.

- D. Various researchers and people with field experience have emphasized that the quality of research is greatly affected if the interviewer does not speak the local language. Interviewers for both the Audience Research and Health Providers Research should speak the local language of the area in order to obtain quality information for the strategy planning.
- E. The MOH should make the Preprogram Research available to other institutions/companies and urge them to use it as basis for educational strategies and materials. In some cases, the data could be exchanged for coordinated services or materials production funding. However, the MOH should emphasize that this data was collected in and is relevant to West Java, and should not be the only basis for the design and production of nationally distributed materials.
- F. The use of water/sugar/salt solution as an appropriate home treatment has the potential risk of dangerous sodium levels. Mixing trials in other countries even under close supervision have produced very dangerous solutions. If after the Preprogram Research the MOH is still committed to promoting W/S/S in the home, they must identify a really standard measuring utensil and an integrated communications strategy to teach this behavior. Studies of sodium levels of W/S/S mixing trials should be made in several locations to assess if mothers make a safe/standard W/S/S solution.
- G. Another important consideration for future program planning would be epidemiological studies on the causes of diarrhea. The program strategy in the Gambia was radically changed when the epidemiological research showed that dehydration from acute diarrhea was not the principal mortality problem, but rather an on-going 'wasting' caused by chronic diarrhea and malnutrition. The communications strategy therefore emphasized a "Diet for Dryness" which focused equally on improved feeding during diarrhea episodes as on ORS. In Honduras, where the problem was identified as dehydration from rapid onset, acute diarrhea, the strategy also included feeding messages, but focused on the concept of dehydration and continued use of ORS throughout the diarrhea episode. Epidemiological studies in Indonesia would give planners a basis for appropriate diarrhea treatment and strategy emphasis.

- H. Throughout the consultancy, people have emphasized that one of the keys to any program success in Indonesia is involvement of groups at all levels. The Preprogram Research will attempt to identify the most important/culturally relevant groups and the strategy should attempt to build on the cultural pattern of group concensus building and reinforcement.
- I. This plans calls for every tight, coordinated scheduling. The timeline is really determined, however, by the diarrhea season. It will be critical to program impact to have all of the elements in place and interacting from mid-September till February.
- J. START UP STEPS-NOVEMBER-JANUARY: Final meetings with Dr. Bambang, Mr. Marku, provincial level staff and the donor agencies identified the following necessary steps for November to January implementation.

#### November Activities

1. Review steps to be taken November-January. Identify other important steps, identify person responsible for each step, and date of implementation.
2. Formally request consultant from USAID.
3. Contract Audience Research.
4. Inform about Component/obtain commitment from the Ministry of Information and Ministry Interior.
5. Provincial Start Up: November 20-30

Meetings with: MOH, Integrated Activities Workgroup, BKKBN, Ministry of Information, RRI, and TVRI.

Establish Provincial Communications Component Workgroup: Nutrition, CDD, BKKBN, Health Education, Community Participation to:

- a. Identify who will do Provincial Study. Obtain commitment for sufficient time and staff.
  - b. Identify who will do Service Provider Study. Obtain commitment for sufficient staff and time. Design methodology, select sample and sites, write/pretest instruments.
6. Donor agencies meet to review draft budget and define funding areas.

### December Activities

1. Sign Letter of Agreement between the D.G. and the province.
2. Sign Letter of Agreement between MOH and radio/television stations for air time at requested MOH times. (To be decided in February based on the Preprogram Research.)
3. Presentation to the Pharmaceutical Associations to discuss coordination with the Communications Component/explore funding possibilities.
4. Meetings with advertising agencies to explain Component and get bids on a marketing package to at least have a ball park figure on what it would cost to include an advertising agency in the strategy planning in February.
5. National level research search: Contact YKB, anthropologists, and others at the national level to find studies on child care and health practices. Meeting with PATH, UNICEF, AID, and other researchers to coordinate research on ORT.
6. Provincial Inventory: Write report. Take steps to formalize collaboration with necessary institutions. Sign Letters of Agreement, etc.
7. Service Provider Research:  
December 3-7: Training of Interviews.  
December 10-20: Researchers in the field.
8. Audience Research: Marketing research agency contracted and in the field doing research.

### January Activities

1. Design Mortality Studies.
2. Contract KAP studies - baseline in West Java to be performed in March/April.
3. Review research activities to insure that all of the reports will be completed by the end of January.
4. Service Provider Research: Analysis and report writing.

5. Audience Research: Marketing Research Agency should be finished with the field work and be in the process of writing reports.
6. Provincial Inventory: Continue steps to formalize commitment

APPENDIX A  
PERSONS WHO CONTRIBUTED TO THIS PROPOSAL

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PERSONS CONTACTED

MINISTRY OF HEALTH:

Dr. M. Adhyatma	Director General - Control of Communicable Diseases
Dr. Nyoman Kumara Rai	Director Transmissible Diseases

Directorate of Control of Diarrheal Disease (CDD):

Dr. Bambang Winardi	Chief, CDD Sub-Directorate
Gandi Kosim	Surveillance, CDD
Dr. Widodo	Staff Assistant
Dr. Akib	Staff Assistant
Mr. Reijito	Chief, Surveillance Section

Directorate of Epidemiology and Immunization:

Dr. S. Gunawan	Director
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Directorate of Nutrition:

Dr. Suaspendi Notodihardjo	Chief, Sub-directorate Family Nutrition Improvement
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Directorate for Community Participation:

Dr. Anwar Siregar

Center for Health Education:

Dr. Ida Bagus Mantra	Director
Dr. Tri Komala Wati	
Mr. Djep Marku	

Training Directorate:

Dr. Dachroni	Health Educator
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East Java:

Department Control of Diarrhea Disease:

Dr. Soediono	Chief
Dr. Marsetio Sariowan	Surveillance Section
Dr. Samsuri	CDD Manager

Health Service Research Unit, Surabaya:

Dr. Ajik P. Suwondo  
Ariyanto  
Dr. Haraiadi  
Dr. Subagyo Martodipuro

Community Health Division:

Dr. Kusuma Hali	Chief
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West Java:

Dr. Dadi	Chief of Epidemiology
Mr. Ali Basah	Chief, Office of CDD

USIS:

Lynn Sever	Assistant Information Officer
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USAID/INDONESIA:

Dr. Manny Voulgaropoulos	Chief of Population/Health
David Piet	Deputy Chief, Pop. Health
Dr. John McEnaney	Public Health Advisor
Rebecca Cohn	Family Planning Advisor
Julie Klements	Nutrition Advisor
David Korten	Regional Advisor on Development Management
James Gingerich	Chief, Agriculture
Mike Morfit	Training Office

USAID CONSULTANTS:

Mr. Warren Jones, CDC	Management, CDC/EPI
Dr. Doug Klauke, CDC	Surveillance Training
Dr. Ed Brink, CDC/WHO	Surveillance, CDC
Dr. Richard Arnold	Epidemiologist
Peter Shipp, MSH/WHO	Management

BKKBN:

Ibu Suyatni Head, Division of Coordination

WHO:

Dr. Mohamad El Naggar Epidemiologist, CDD

PIACT:

Ms. Leona D'Agnes Director, PATH/PIACT Indonesia

FORD FOUNDATION:

Dr. Henry Moseley Program Officer/Child Survival  
Ms. Fran Korten Program Officer

UNICEF:

Mr. Daniel Brooks	UNICEF Representative
Mr. Louis Leefers	Senior Program Coordinator
Mr. Terrel Hill	Coord. Health and Nutrition
Mr. Rodney Hatfield	Program Officer, CDD/EPI
Ms. Jaqueline Peters	Nutrition Education
Ms. Jane Bunnag	Regional Comm. Consultant, Bangkok, Thailand
Mr. Malicca Ratne	PSC Officer
Mr. Deradjat Natanegara	Information Officer

YAYASAN INDONESIA SEJAHTERA - MEDIA PRODUCTION UNIT

Dr. Sofijandi W.	Director
Dra. Toety Syafiee	Manager

RADIO REPUBLIK INDONESIA TRAINING CENTER:

Dr. H.T. Suwardi Hasan

PUSTEKKOM: Center for Communications Technology for Education and Culture:

Jusuf Hadi	Special Advisor
Sanbjay	Television Producer
Wayan Inten	Studio IV
Arief Sadiman	Evaluation
Sudirman	Planning Division
Radikun	Evaluation
Lazarus Harianja	Out-of-School Education

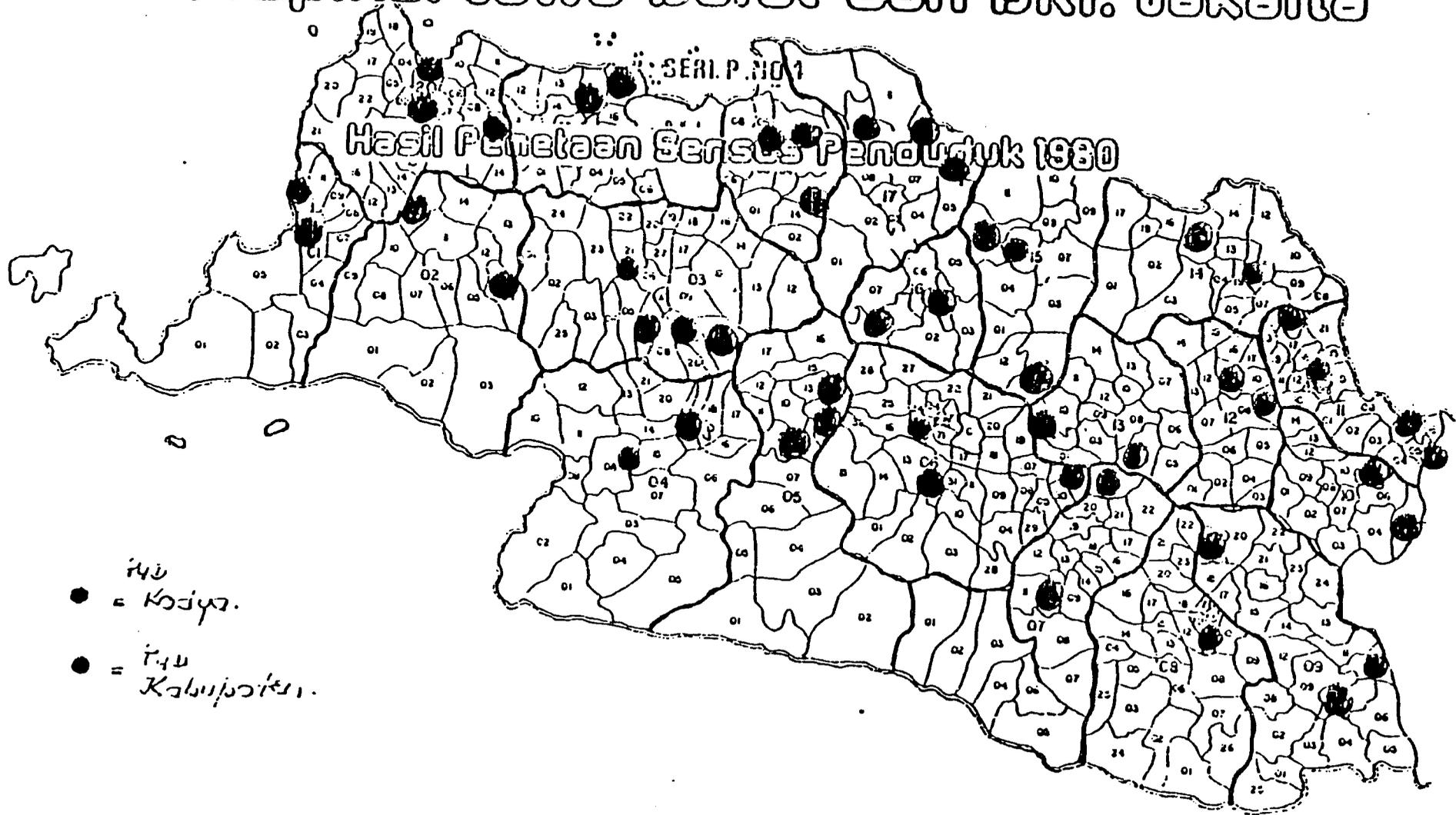
Manoff International:

Marcia Griffiths	World Bank Team
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APPENDIX B  
BACKGROUND INFORMATION ON  
INDONESIA AND WEST JAVA



# Kecamatan dan Desa/Kelurahan di Propinsi Jawa Barat dan DKI. Jakarta



### Background information on the country

Indonesia is a tropical archipelago in South-East Asia consisting of over 13 000 islands in six island groups spread over an area of nearly 2 million square kilometres. It is a developing country possessing many natural resources, including large oil resources.

The climate is tropical, with high rainfall. Many of the islands are of volcanic origin.

The main religion is Islam, although Christianity, Hinduism and Buddhism represent important minorities.

Indonesia is divided for administrative purposes into 27 provinces, 300 regencies (kabupaten) and municipalities (kotamadya), and 3408 sub-districts (kecamatan). Each province is composed of from 4 to 35 regencies, and the regencies are divided into 1 to 20 sub-districts. Villages (desa) number 62 000 and are the smallest administrative unit. They usually have between 500 and 10 000 inhabitants and are headed by a village chief.

### 6.2 Population and vital statistics

#### Population of Indonesia by age group (based on 1980 census)

AGE GROUP YEARS	POPULATION	% OF TOTAL POPULATION
0 - 4	20.719.538	14,0
5 - 9	21.228.179	14,4
14 - 14	18.168.623	12,3
15 - 24	28.461.435	19,3
25 - 49	42.381.431	28,8
50	16.372.617	11,1
unclassified	158.475	0,1
All Ages Total	147.490.298	100

For population by province and by island group see Table 1

#### Average Annual Growth Rate of Population

1930-1961 = 1.5%

1961-1971 = 2.1%

1971-1980 = 2.3%

Life expectancy at birth (years)

	<u>Male</u>	<u>Female</u>
1971-1975	45	48.0
1976-1980	46.5	49.4
1981-1985	48.9	51.9

Infant Mortality Rate per 1000 births, 1961-1980

1961-1971 (per year)	137.0
1976	110.0
1980	98.0

Crude Birth Rate per 1000 total population

1961-1971	39.1
1971-1980	35.9

Crude Death Rate per 1000 total population

1961-1970	18.7
1971-1980	12.5
Household survey (1980)	12.1

Age Specific Mortality Rate

Age Group (years)	Age Specific Mortality Rate per 1000
0 - 1	104.9
1 - 4	19.6
5 - 14	2.4
15 - 24	2.5
25 - 34	2.7
35 - 44	6.8
45 - 54	15.0
55+	44.3

Source: National Household Survey, 1980

Approximately 46% of the total mortality is in the 0-4 year age group.

6.3 Health system

6.3.1 Health Administration

The Ministry of Health is responsible for public health and most primary health care in the country. The Ministry is divided into four Directorates, Generals of which Communicable Diseases Control (CDC) is one.

TABLE 1: POPULATION OF INDONESIA BY PROVINCE AND BY ISLAND GROUPS - 1980

Provinces and Island Groups	Population		
	All ages	0-4 years	(% of total)
1. D.I. Aceh	2 610 528	383 748	14.7
2. Sumatra Utara	8 350 950	1 286 046	15.4
3. Sumatera Barat	3 406 132	483 671	14.2
4. Riau	2 163 896	348 387	16.1
5. Jambi	1 444 476	234 005	16.2
6. Sumatera Selatan	4 627 719	735 807	15.9
7. Bengkulu	767 988	132 094	17.2
8. Lampung	4 624 238	772 248	16.7
Sumatera TOTAL	27 995 927	4 367 365	15.6
9. DKI Jakarta	6 480 654	907 292	14.0
10. Jawa Barat	27 449 840	4 035 126	14.7
11. Jawa Tengah	25 367 344	3 247 020	12.8
12. Yogyakarta	2 750 128	275 012	10.0
13. Jawa Timur	29 169 004	3 266 928	11.2
Jawa TOTAL	912 169 970	11 675 772	12.8
14. Bali	2 469 724	293 897	11.9
15. Nusa Tenggara Barat	2 723 678	438 512	16.1
16. Nusa Tenggara Timur	2 736 988	407 811	14.9
17. Timor Timur	555 350	62 199	11.2
Nusa Tenggara TOTAL	8 485 740	1 204 975	14.2
18. Kalimantan Barat	2 484 891	327 643	15.6
19. Kalimantan Tengah	954 176	156 485	16.4
20. Kalimantan Selatan	2 064 649	282 662	13.7
21. Kalimantan Timur	1 214 602	197 980	16.3
Kalimantan TOTAL	6 716 896	1 020 968	15.2
22. Sulawesi Utara	2 114 822	285 501	15.5
23. Sulawesi Tengah	1 284 528	210 663	16.4
24. Sulawesi Selatan	6 059 564	848 339	14.0
25. Sulawesi Tenggara	941 634	157 253	16.7
Sulawesi TOTAL	10 400 548	1 508 079	14.5
26. Maluku	1 408 451	232 394	16.5
27. Irian Jaya	1 107 291	181 596	16.4
Maluku + Irian Jaya TOTAL	2 515 742	415 097	16.5
Indonesia TOTAL	147 331 823	20 184 259	13.7

Source: Series L. No. 3, 1980 Population Census, CBS.

MAIN CAUSES OF DEATH AMONG UNDER 5 CHILDREN AT SUKABUMI, WEST JAVA DURING  
ONE YEAR PROSPECTIVE STUDY BY DR. RATNA ( R & D )  
( BASED ON 1 - 4 = 7815 AND 2309 BIRTHS ) 1982/83

CAUSE OF DEATH	New born 0 - 1 month		1 month - 11 months		1 - 4 years		Total Under 5	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Diarrhoea	2	2,2	12	15,0	23	19,2	37	12,5
Typhoid fever	0	-	2	2,3	19	15,8	21	7,1
Tuberculosis	0	-	0	-	3	2,5	3	1,0
Diphtheria	0	-	0	-	3	2,5	3	1,0
Whooping cough	0	-	7	8,1	3	2,5	10	3,4
Measles	37	41,1	5	5,8	2	1,6	44	14,9
Pneumonia	0	-	8	9,3	7	5,8	15	5,1
Chronic bronchitis - emphysema asthma	4	4,4	26	30,2	35	29,2	65	22,0
Influenza	0	-	0	-	5	4,2	5	1,7
Otitis media	0	-	1	1,2	0	-	1	0,3
Fever of unknown origin	0	-	8	9,3	1	0,8	9	3,0
Other infections & parasitic	7	7,8	6	6,8	3	2,5	16	5,4
Nutritional deficiency	1	1,1	0	-	5	4,2	6	2,0
Injuries	3	3,3	3	3,5	1	0,8	-	2,4
Immunodeficiency	0	-	0	-	3	2,5	3	1,0
Prematurity	0	-	1	1,2	0	-	21	7,1
Congenital anomalies	20	22,2	1	1,2	0	-	21	7,1
Birth accidents	2	2,2	4	4,7	0	-	6	2,0
All defined conditions & others	14	15,5	0	-	0	-	14	4,7
	0	-	3	3,5	7	5,8	10	3,4
<b>TOTAL</b>	90	100,0	86	100,0	120	100,0	296	100,0

APPENDIX C  
SUMMARY OF SOME PREVIOUS RESEARCH

SUMMARY OF SOME OF THE EXISTING AUDIENCE RESEARCH

1. COST EFFECTIVENESS STUDY - 1983

Sample - 1,050 Children less than 5 years old - WHO cluster sample

- . ORT use did not reduce hospitalization
- . JRT did not reduce substantial use of antibiotics and other medications. Tetracycline treatment at health centers - 27%. Highest area of use seems related to use of ORS by private provider, VHWs, or self-care, not by expanding health center treatment. Also distributed through traditional healers.
- . Amount of ORS given is very low, but appears to increase w/severity 0.3 liter average.
- . Diarrhea episodes per year 2 - 3
- . Reported treatment for infant diarrhea

Health Center - 40%	Traditional Healer	- 10%
Private Nurse - 17%	Private Doctor	- 4%
(Didn't ask about VHWs)		
ORS - 60%	Sulfagualadine	- 23%
Tetracycline - 34%	Traditional medicines	- 23%
Enterobioform - 27%	Other medicines	- 39%

Health center statistics were markedly less however for both visits and ORS use. Tend to go to Health Center when diarrhea more severe.

- . Community pays 50% of diarrhea treatment costs - mostly in medications.

2. NUTRITION COMMUNICATIONS RESEARCH PROJECT: Area - five kecamatan, 60 villages in Central Java and South Sumatra, 1982

Sample - Ten villages (17% of participating villages). Two villages in each kecamatan. Approximately 35 households in each village. Biased towards malnourished children/poorer families - 328 households in total.

Individual interview - very open ended. "Key informants". Interviewer and mother worked together to try new behaviour. Mother agreed to continue new behaviour three days. Interviewer returned to probe about adaptations/success.

## RADIO

Radio : Ownership lower than audience. "Group" listening patterns. Amount of ownership listening varied by area. Highest Yogyakarta. Lowest Sapuran, Central Java. Average listenership - 60%. In urban areas ownership related to income, but not in rural areas.

Listening home-based (large radios) generally in evening or afternoon. (Exception Sumatera where women listen in the morning.

Program popularity varies by region, but "music" generally most popular. Ketoprak - Javanese drama mentioned. Also-listening group program "Siaran Pedesaan" and PKK (women's group) program.

Literacy: Varies by area but 38% have at least one literate family member. However, only 18% of homes have any printed material. Generally newspaper (Minggu Pagi and Kedaulatan) and old text books.

Community Meeting Attendance: 51% occasionally. 22% frequently.

Sources of Info. for Child Care - family members, especially parents or grand parents (sole source for 33%). Husbands sole source - 19%.

29% outside the home - 14% kader. 16% own judgement.

However, when child is ill, there's a greater tendency to seek advice outside the home (48%). Of this 48% 61% -kader/Health center; 32% - local healer; 7% -both.

46% still only w/in the family. Half of these parents or grandparents.

Highest "inside home" South Sumatera.

Child Ill Enough for Treatment Outside Home: 40% Health Center, 40% local healers (then to Health Center).

Kader contact: 80% knew a kader, 71% visited in their home by kader, but knowledge of specific messages very low.

STUDY OBSERVED IN 43 HOMES WHERE CHILD ~~IS~~ PRESENTLY OR RECENTLY HAD DIARRHEA:

Of sample - 44% mildly malnourished  
15% moderately malnourished  
10% severely malnourished

- . Diarrhea is a normal occurrence, part of a child's development
- . Most episodes last only 1 - 3 days
  
- . Disturbing changes -
  - Weakness - 60%
  - Cried frequently
  - or difficult to manage - 50%
  - Pale - 27%
  - Loss of Appetite - 20%
  - Sunken eyes - 10%
  
- . Treatment process: First days evenly divided between no treatment, jamu, medication, Health Center, and w/s/s.

Diarrhea

More than three days all "take action"

- 25% continue first treatment
- 25% local healer
- 25% ORS (18% of the ORS didn't work, they would go to the traditional healer.

- 18% - store for medication
- 11% - if prolonged - Health Center

### Feeding during Diarrhea

Continue Breast feeding 86%

Stop all food - 14%

Decrease quantity and change food - 86%

(Usually starchy foods cooked into a porridge. Change from rice to rice porridge. 31% give only rice, 11% give banana).

Many commented they wanted to continue feeding, but the child wouldn't eat.

- . Foods to be avoided - chili, salted fish, ripe papaya, fried foods, and green vegetables.
- . Good foods-fried chicken blood and banana.

### Fluid Intake Concepts:

- . half said fluid intake remains the same when a child has diarrhea.
- . half report that child: drank more -- usually breastmilk, some tea, some other milk.
- . half thought 6 glasses of liquid a day excessive, 4 glasses upper limit.
- . Half didn't know if a child could drink 6 glasses.

### ORS

#### Liter Packet

20% knew packet, mostly from kader. Less than half <sup>of this 20%</sup> had used it. Only 6% could mix correctly. Asked to prepare, only 1 in 20 could mix from packet instructions. Explained orally only 1 in 19. After

demonstration 17 out of 18. However - they asked mother to divide the liter packet into 5 equal parts and mix one part in a 200 cc glass. Confusion about what to do with remainder. In follow-up, all could mix correctly.

Sugar/salt ORS - 34% knew of it, but of these only 25% had used it. Of that 25%, only 30% could mix correctly (8% of the total sample) 11% could mix correctly following the Growth Chart instructions. Confusion over teaspoon/tablespoon. Extremely high sodium levels. Orally - an additional 23% could prepare, but they changed the salt to 1-2 finger pinch. Additional 60% after demonstration. Usually pinches of salt too small.

Of mothers who agreed to give solution during entire <sup>diarrhea</sup> episode - 80% successful. 20% failure reported that the child refused, they had no sugar, too lazy, or gave only tea. None gave one glass for each stool. Usually 2 - 3 glasses per day. On follow-up, 80% could prepare correctly.

Behaviour Trials Success

- |  |        |   |
|--|--------|---|
| - Give more liquids                              | - 83%  |   |
| - Give porridge w/protein, rice and vegetable    | - 64%  | failure generally sickest children. Mother thought child could not digest protein. "Green leaves make diarrhea worse" |
| - Offer food in small portions 5 - 6 times a day | - 31%  | Mothers say they want to feed but children won't eat.   |
| - Give mashed banana                             | - 100% |   |

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KADER INTERVIEWS

43% said they would recommend w/s/s but only 17% could give formula.

57% recommended oralite

Other advice: Continued breast-feeding, stop hard/fried foods, take child to Health Center (low levels of each)

(Kader half men/half women, about 30 years old, most have other community responsibilities, literate. Have more reading materials.)

TRADITIONAL MIDWIVES - Generally don't deal w/sick children

STOREKEEPERS - (30)

73% of the stores sold medicines. Aspirin most common. 45% had medicines for diarrhea. Only one had been selling Oralit, but did not have any more.

75% say they would recommend pills, 30% local jamu, 25% Health Center.

Often solicited for advice. Common gathering place for community.

78% had no signs or advertisements, but wanted them.

Other findings:

- . Mothers are busy. Since ORS is time-consuming, we must identify a strong reward/reinforcement to motivate them.
- . Messages must be focussed, specific, and explicit about the recommended "behavior".
- . Many people don't know the term "kader", but rather call them "the people who weigh babies".
- . Possible need for a flag, diploma, or other identifying rewards to support kader work. Need to feel part of a larger network. Kader radio program ? Through the listening group people ?

3. A CASE STUDY OF SEVEN VILLAGES (Evaluation of the UPGK Programme)

Sample-seven villages in five provinces • Biased towards "the best villages". Spent 4-5 days in each village living w/ chief and kader. Observation of weighing. Interviews with 20-25 mothers, as well as others involved in the program.

Results:

ORALIT

Knowledge (65%)

15% had packet in the home

77% knew where to obtain (Kader, weighing post)

57% of the 65% knew how many glasses needed to prepare the liter packet. (37% of total sample.)

S/S

46% knew about

26% could state correct formula

29% knew correct administration - to give after each defecation

- Higher reported diarrhea incidence in villages with higher ORS knowledge.

- Definition of diarrhea varies greatly - Watery stools normal. mencret more severe. <sup>Mothers believe it</sup> can be life threatening.

Reported treatment

6% Jamus

34% Oralit

9% Kiosk medicine

6% S/S

36% Health Center

- . Didn't know s/s receipe was on growth chart: spoon size in picture confusing.
- . Demonstration (w/taste test) effective teaching method.
- . Questions about palm sugar measure since this sugar is coarser.
- . Blue teaspoons seem effective when Kadres have them in their homes and lend them.
- . Kader - based distribution better than weighing post distribution.
- . Chronic shortages of packets.
- . Mother only given one 200 cc packet so they think that is enough treatment.
- . Only pot big enough for mixing the liter packet is frequently in use.
- . ORS should be presented as scientific medicine.
- . Health Centers give out various treatments, so people don't believe in only ORS.
- . Should do mass media campaign.

4. WHO/UNICEF/USAID/MOH CDD PROGRAM REVIEW

Sentinel Surveillance - 24 Health Centers. 48% knowledge of ORS and W/S/S. 14% use of ORS and W/S/S. Of packets distributed - 50% by VHW and 50% by Health Centers. 70% of mothers report continued breastfeeding during diarrhea episodes.

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APPENDIX D  
PREPROGRAM RESEARCH PROTOCOLS

## DRAFT AUDIENCE RESEARCH PROTOCOL

### CHILDCARE:

QUESTION: Who are our target audiences? Who influences and supports the primary target audience in childcare behaviors, especially those related to infant diarrhea.

Who takes care of a child when he has loose watery stools? When he has diarrhea? Does the childcare pattern change as the mother perceives the diarrhea to worsen?

Who takes care of the (sick) child when the mother has to work?

Who does the mother seek advice from first when her child has loose stools/diarrhea? Who does she seek advice from when she perceives the diarrhea to worsen?

What role do the grandparents, older siblings, and father play in childcare, especially when a child is ill with diarrhea?

What attitudes do mothers have concerning the village kader as a source of diarrhea treatment. What attitudes do they have concerning the treatment they receive at the Puskesmas? At the hospital?

### HEALTH CONCEPTS:

QUESTION: What cultural perceptions about illness, particularly infant diarrhea, need to be considered in the communication strategy and materials development.

What is a "healthy" child? What does he look and act like?

What is an "unhealthy" child? What does he look and act like?

What does a mother consider to be diarrhea? Specifically, how many stools per day does the mother consider to be normal? How many stools per day does she consider to be "loose stools"? How many for "diarrhea"?

Does the caretaker consider diarrhea to be dangerous? Other studies indicate that diarrhea is not considered to be a serious disease, but rather a normal part of growing up. When does the mother perceive that diarrhea passes from being the "normal" kind to being dangerous?

What is the process for diarrhea treatment? What does a mother do for a child with loose stools the first day? The second day? The third day? etc.

What signs does a child during a diarrhea episode have that concern a mother? What signs make her:

Take a child to a traditional healer?  
Give self treatment?  
Give a jamu  
Buy a kiosk medicine  
Go to a Health Center?  
Other

What does the mother believe causes loose stools/diarrhea?  
How does the treatment change for each cause?

What are cultural beliefs concerning immunizations. Do they believe that they can prevent diseases? Which ones? What do they like and dislike about immunizations?

#### ORAL REHYDRATION THERAPY

##### PRODUCT:

QUESTION: What product(s) are the most appropriate for home use in this province. What constraints do caretakers have in the use of ORS products presently being promoted and distributed in the marketplace? What solutions can be offered to overcome these constraints?

WATER/SUGAR/SALT: What is the best method of mixing water/sugar/salt which will insure a standard mixing method with solutions within the safety margins recommended by WHO? How many families have a teaspoon? What vocabulary do they use for this utensil? Is this term standard throughout the province? What other measuring utensils exist in the home which could be used to standardize the measures for sugar/salt? Take into consideration utensils presently not used for measuring such as bottle caps. Ask mothers to prepare the water/sugar/salt solution. What problems do they have? What solutions do mothers suggest to overcome these problems? Ask mothers to use the water/sugar/salt solution for her child when he has diarrhea and afterwards follow up. How many mothers were able to complete the request? Why or why not? What problems did they have? What adaptations did they make? Take samples of the solutions prepared in the home with the

various methods presently being taught by the village kader programs and by the new methods developed through the mixing trials. Are these solutions within the safety margins recommended by WHO?

ORS LITER MEASURE PACKET: UNICEF presently plans to continue to distribute the liter packet through various kader programs because of cost. What constraints does the caretaker have in preparing ORS with this packet? How many families have a liter measure? What other utensils exist in the home which could be used to measure a liter--bottles, 200cc glass, etc.? What other solutions such as distributing a plastic liter measuring bag with the packets could be offered?

How many families have a utensil large enough to hold a liter of water that is not in continual use? What solutions does the family suggest to this problem. Ask various mothers to prepare the solution with the liter packet? What problems does she have? Ask her to prepare it with the suggestions/improvements developed from the research? What problems does she have? Ask various mothers to give the solution to her child during the diarrrhea episode and follow up several days later. How many mothers completed the request? Why or why not? What problems did she have or adaptations did she make? If the mother has to divide the salts in the packet in order to mix it, take samples of this solution to evaluate if the sodium level is within the WHO guidelines.

ORS 200cc MEASURE PACKET: The MOH is also distributing 200cc packets. How many families have a 200 cc glass? What vocabulary do they use to call it? Is this vocabulary consistant throughout the province? Ask various mothers to prepare the solution using the 200cc packet. What problems does she have? Ask various mothers to give the solution to her child during the diarrrhea episode and follow up several days later. How many mothers completed the request? Why or why not? What problems did she have or adaptations did she make? If there appears to be a need, take samples of several of the solutions to insure that the proportions are within the WHO guidelines.

OTHER APPROPRIATE HOME TREATMENTS: What other liquids exist in the home or are being given to children during diarrrhea episodes which would be an appropriate first step for home treatment? How much of these liquids are mothers

presently giving and how do they feel about increasing the amount? What solutions do caretakers/kaders who understand the need for liquids suggest for early home treatment? Coconut water is an appropriate home treatment for dehydration prevention. Does this exist widely in the province? What do caretakers think about giving coconut water to young children during diarrhea episodes-do they feel that it will affect the diarrhea in any way? Rice water and other teas are also appropriate home treatments. Do caretakers presently give these liquids to children during diarrhea episodes? How much? How do they feel about giving more of these liquids?

Once the most appropriate and effective method of mixing the products to be promoted have been identified, product testing using verbal, written, pictorial, and demonstration methods of teaching should be tried to identify which mix of methods will be most effective in teaching this new behavior.

#### PRODUCT ADMINISTRATION:

QUESTION: Previous research indicates that one of the major existing constraints to ORS use is that mothers are not administering sufficient solution. An average of less than one third liter is reported in several studies. Why is this happening and what solutions can the communication strategy incorporate to overcome this constraint?

How much liquid does a mother perceive that an infant/child can drink during a diarrhea episode? Why? What does she feel will happen if the child drinks a lot of liquids? What suggestions do caretakers/ kader who understand the need to drink a lot of liquids give for explaining this concept to other caretakers?

Does a mother perceive that she can give more teas, more water/sugar/salt, more ORS packets, or another liquid?

Will packaging the 200cc packets in groups of three to five make mothers give more solutions. (product testing could be used here)

What stimulus/reward can the communications strategy give caretakers for correct administration? Interpersonal, radio, other?

PRODUCT POSITIONING:

QUESTION: How can this product be positioned/repositioned within the marketplace? How can it be fit into present treatment patterns or how can new treatment patterns be created?

Mothers generally want a diarrhea treatment to stop diarrhea and ORS does not. Many programs try to promote the idea that ORS does not stop the diarrhea, but does prevent the child from dieing from dehydration. Teaching the concept of dehydration, however, has proved to be very difficult. What existing belief or concept could be used as a link to the concept of dehydration and replacing liquids? Many mothers are presently using jamus. What is the rationale behind their use? Are they replacing "something lost from the body" or is what the jamu made of more important? The metaphor of "the plant without water is like a child becoming dehydrated" is presently being used in many of the educational materials. Do caretakers really understand this concept? Do they believe it? Do they believe it enough to make them change their behavior and give ORS correctly? Is there any existing folktale, story, or myth which could be tied into the concept of dehydration and use of ORS?

People want to observe a result of a treatment for illness or they generally discontinue use. It's important to tie the use of ORS into something that mothers can observe when the medicine is being effective. What signs concern a mother when her child is ill? Which of the signs (explored under the category of health concepts) indicate the need for treatment? How can we tie the use of ORS into improving these signs?

For example, research in West Java indicates that mothers perceive a child to need treatment when he becomes weak. Mothers also complain that they want to feed their child when he has diarrhea, but that the child won't eat. ORS doesn't stop diarrhea, but it does improve activity and appetite. Would these (or other signs uncovered during the research) be appropriate signs to include in the strategy and materials as the signs that mothers can observe which indicate that ORS is effective.

The last time a mother tried a new treatment for any illness, why did she try it? Who did she hear about it from-radio, TV, neighbor, other?

PRODUCT PACKAGING:

QUESTION: What is the most appropriate packaging for the ORS packets?

Is the resistance to Oralit high enough that we should consider changing the name?

What packaging do mothers prefer for an infant diarrhea treatment? Show mothers various types of packaging for diarrhea treatment including the 200cc ORS packet, the liter ORS packet (different colors of each), water/sugar/salt, pills, jamus, etc. What packaging does she prefer? Why? Is color, size, symbol, other important in treatment selection?.pill, packet, water/sugar/salt, other?

The MOH is presently trying to standardize the colors of the packets so that the 200cc packet is red and the liter packet is blue in order to help mothers differentiate between the two. What are mothers' perceptions of these colors for an infant diarrhea treatment? What colors might be more appropriate? Does having the packets in two colors make any difference in mothers' perceptions of size, correct mixing, and quality of the treatment?

What is an appropriate logo for the package and other print materials? Product symbols have proven to be important in other product promotions in Indonesia. Marketing companies report that consumers frequently ask for the product by symbol name rather than the name of the actual product. This indicates that it will be especially important to identify an appropriate symbol for ORS which ties into the the desired results of the product for diarrhea treatment, as well as an appropriate image for the overall campaign.

#### PRODUCT PRICE:

QUESTION: What are consumers perceptions about the price of a product in relation to its quality? In particular, what is the target audience perception of the "price/quality" of water/sugar/salt? Of the packets when they are distributed free through the health system? Of the packets and other diarrhea treatments sold in the kiosks?

#### FEEDING DURING DIARRHEA EPISODES:

QUESTION: What are existing feeding patterns of children during diarrhea episodes? How do these compare with MOH guidelines? What specific behaviors/solutions can be offered to overcome feeding constraints?

How many mothers breastfeed during diarrhea episodes? Why? Why not?

What foods do mothers give during diarrhea episodes? Why?

What foods do mothers believe are good for diarrhea? What foods are considered to be bad for diarrhea?

What specific foods should the CDD materials reinforce which mothers are already giving? What foods could be suggested that are close to what mothers are already giving and fit into beliefs about foods that are good for diarrhea?

Some formative research about feeding during diarrhea episodes indicates that mothers want to feed their children, but that the children refuse to eat. What specific suggestions could be offered to assist mothers in this task? In some countries they have suggested adding sugar or milk to porridges to make them more palatable, or offering small snacks several times during the day so that the child eats more, but over a longer period of time. If child's appetite is a constraint to correct feeding behaviors, ask various mothers to try these or other alternatives suggested by mothers during the research. Follow up and find out how many mothers were able to complete the request. What problems did they have or what adaptations did they make?

### IMMUNIZATIONS

The MOH believes that one of the primary constraints to effective widespread immunizations is that mothers don't know or have difficulty understanding the time when they should bring their child for the first and succeeding vaccinations. The MOH wants to identify existing ways of telling time which the service providers can then reinforce, rather than trying to force mothers to learn a new way way of telling time:

How is the period of a year measured in the province? What events or numbering system are used to indicate the passing of time. Some research indicates that the 35 day marketing system is well known and understood. Would this be an appropriate way of indicating to mothers when they should bring their child for a second vaccination?

What signs does a mother see in the development of her child that correspond to one month old, two months, three months, and nine months. Are there ceremonies or other significant events around this period of time that could be tied into the concept of the time to take the child for a vaccination?

Another constraint the MOH has identified is that the Mobile Vaccination Teams don't go to the village on the day

they are scheduled. At the same time the MOH is encouraging the village to take more responsibility for funding and performing their own health care. What suggestions do mothers and village leaders have to solve this problem. How can the Vaccination Teams be made to feel more responsible to the village. What other mechanism could the village suggest so that the immunizations reach the village when the village needs them.

### MEDIA PATTERNS

QUESTION: What media usage patterns exist in the various target audiences and how can these be effectively and appropriately used to reach and influence them?

RADIO: How many families own radios? How many families listen to radio even if they don't own one? Who controls the access to the radio? Do mothers have access to the radio? At what times of day? Can mothers listen if the father or other person who has the control is not present? Where do mothers listen--at home, at a friends, alone, in a group? What are the favorite channels, at what time of day--week days and week-end listening patterns should be explored. What are the names of their favorite programs? Can they recall a spot that they like? Why do they like it? What is a credible source(s) of information to give childcare advice on the radio--doctor, nurse, traditional healer, radio or political personality, older woman, male/female, other?

TELEVISION: Basically the same as radio with adaptations to the medium (for example, no spot advertising)

GRAPHICS: How many mothers are literate? How many households have at least one person who can read? Generally, who is that person-father, child, other? What languages do they read-should materials be printed in Arabic? What printed materials exist in the home? In the community? What print material would a mother like to have? Would it be more effective to develop print materials for the school children to bring home and read to their mothers? Are children an acceptable source of information about childcare information? Would their mothers listen and be affected by information from this source? Can mothers remember any poster or print materials that they liked? What was it, what did it say, where was it, and why did they like it? Show some samples of printed materials and ask which they like. Use a selection of black/white, urban/rural models, and other cultural differences which might affect attractiveness and appropriateness.

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TRADITIONAL MEDIA: What traditional media exist in the community? How can it be integrated into the communications strategy. Specifically, how can the traditional puppets be integrated into the strategy? Are there traditional characters and/or stories which might explain ORS, dehydration, be an appropriate symbol for the campaign, etc?

CULTURAL CHANGE:

QUESTION: What are the patterns of change within the culture? How can the communications strategy build on existing patterns of cultural change? What changes have taken place in the village in the last five years? What and who have been the principle causes of that change?

SOURCES OF INFORMATION/REINFORCEMENT:

QUESTION: What are the most appropriate, affective sources of information and reinforcement for correct use of ORS?

What is the cultural goal of a woman? What does she most want to be which can be tied into the communications strategy? Other programs have promoted the use of ORT into the cultural goals of the mother. For example, in Egypt mothers preferred to be "wise mothers", in Honduras-" loving mothers", in The Gambia mothers wanted "happy babies". The campaign strategies and materials then focused on this objective, tying it into the correct use of ORT.

What other reinforcements can be identified to support the mother in correct use of ORT--interpersonal praise through opinion leaders, radio or television messages praising mothers or with testimonials, other? The use of competition between villages, regencies, and provinces should be explored as a means of promoting and rewarding correct ORS use. This is presently being used for other development programs, including the MOH, and might be an appropriate creative way of product relaunch.

DRAFT RESEARCH PROTOCOL FOR SERVICE PROVIDERS

QUESTIONS: What is the current level of knowledge and practices of correct ORT in the service providers? What specific inappropriate knowledge and practices need to be changed in the most immediately? What are the most cost-effective and appropriate ways of teaching these service providers new knowledge and behaviors within a short period of time? What knowledge and practices need to be changed over the long term? What are the most cost-effective and appropriate ways of teaching these service providers new knowledge and behaviors over the long term? (Changing curriculum in the teaching centers, continued coordination with the Pediatrics and other health professional Associations, for example.) How effective are these service providers as educators? What skills and support materials do they need to become better educators? How can the service providers be most effectively used to support and reinforce the primary audience in the correct use of ORT? Do service providers have enough packets to supply the additional demand this campaign is going to create? Is the logistical system really able to meet this demand? If not, what needs to be done to insure timely distribution of sufficient packets?

The protocol on the KAP of ORT and other diarrheal disease management knowledge and skills should include the norms of the program and WHO guidelines.

ADDITIONAL KADER:

QUESTIONS: Other research indicates that kader feel that they need more support. Is a radio or television course an appropriate way to standardize training of the various types of kader and to reinforce them in their work? What is the most appropriate and cost-effective mechanism for developing an on-going kader radio or television program, one which will build on existing programming such as the Radio/TV Listening Group Program or PKK Womens Program.

What other support or stimulus would kader like? What print materials such as diplomas, identification cards, etc., would be most appropriate?

In order to insure timely distribution of packets when the mothers need them (when her child has diarrhea), it's going to be important that one or two kader in each village have packets in their homes as well as distributing them from the weighing posts. Can the health system support a kader distribution system of this nature? What needs to be done to improve this system if it cannot? What would be appropriate to help identify the houses where packets can be received--a flag, a poster, a metal plate, other?

Many marketing programs are using house-to-house visits to launch or relaunch a product. The kader system represents a virtual army of personnel for this purpose. Is this an effective strategy for the CRT campaign? How can it best be implemented? What types of cost effective incentives, both in the short and long term, can be used to support the kader in this work? .

What are the most appropriate, cost-effective "point-of-purchase" materials for the health centers, weighing posts, and kader distributors? How can these also be placed in other important places in the village such as stores. Is it possible that the materials developed for the CDD Program be produced and distributed by the pharmaceutical companies to other "point-of-purchase" sites?

DRAFT SERVICE PROVIDER RESEARCH METHODOLOGY

The following is an outline of a possible methodology for implementing the Service Provider Research. It is offered as an alternative which should be reviewed by national and provincial level researchers to adapt it to the needs and realities of the province. Additional questions will also need to be identified and included. This is a rough draft of some of the questions which might be included.

SAMPLE:

Ten Puskesmas: Various staff who treat or give advice to mothers when their child has diarrhea.

Ten village weighing posts (equally divided between the sponsoring programs)

Thirty village kader--ten kader from each program (nutrition, CDD, and BKKBN.

The sites should be selected taking into account provincial differences such as culture, local languages, infrastructure, support, etc.

METHODOLOGY: Participant observation followed by in-depth interviews. The interviewer would first observe the service provider interacting with several mothers giving treatment/ advice about infant diarrhea. After observing the service provider with several mothers, the interviewer would find a quiet time and place to discuss with the provider their problems, suggestions, and ideas about the program. The providers should be made to feel that they are not being judged or assessed by the interviewer, but rather that the interviewer is seeking their participation in how to improve ORT program delivery.

INTERVIEWER TRAINING: The interviewers should be trained in correct ORT and diarrheal disease control. Known resistance points to ORT, some of which are listed in Section VI-E-"Training and Interpersonal Support", should be specifically addressed. They should also be trained in observation and in-depth interview techniques. Specifically they should be taught how to ask open-ended questions and probe for more information without "leading" the interview or affecting the provider's answers. The interviewer should also be trained in how to approach the service provider personnel in

a way that is not threatening, how to explain the reason for his/her presence, so that the provider feels comfortable and will talk openly about his/her problems and ideas. Names of the interviewer should not be included on the questionnaire form and providers should be assured that what they say will not be "reported" to their supervisors. Interviewers should not use this time in the field to "retrain or correct" the service provider (unless a child's life is in danger). Gaining the confidence of the provider to speak openly will be critical to identifying real constraints and solutions to the ORT program performance.

The following are some of the questions which might be included in the observation and in-depth interviews. (Service providers are obviously both male and female. The use of "she" in these questions is to avoid having to write "he/she" in each case.):

OBSERVATION:

How does the provider treat the child:

- With diarrhea, but not dehydration
- With mild dehydration
- With moderate dehydration
- With severe dehydration

What problems does the provider have in carrying out that treatment. What can the Component do to eliminate that problem.

What advice does the provider give to the mother concerning:

- Mixing ORS
- Administering ORS
- Seeking help-signs that indicate the child is getting better or worse
- The reason the mother should give ORS/the concept of dehydration
- Feeding during diarrhea episodes
- Breastfeeding during diarrhea episodes.

What questions does the mother ask? Is the provider able to answer all of her questions correctly?

What skills does the provider have as an educator? How much time does the provider spend with the mother? Does the provider use a vocabulary that is understandable to the mother (local language)? Is the provider's attitude and/or tone-of-voice "positive" to the mother. Does the provider tell the mother she is doing anything right? What is it?

What educational materials does the provider have to help teach the mother? Does the provider use them as she talks to the mother? Does she use them well? Does the mother seem to understand them?

### IN-DEPTH INTERVIEWS

After observing the service provider with several mothers, the interviewer should find a quiet place away from other people and at a time that is convenient to the provider to interview her. The following are some of the questions which could be asked:

What are their primary problems with ORT treatment?

Do they feel that ORS is accepted by physicians? By nurses? By kader? By mothers? In each case, ask why or why not.

What are mothers most frequent questions about ORT? Probe about mixing/administration of ORS and feeding during diarrhea episodes.

What problems do they observe or believe that mothers have in mixing or administering ORS? Ask specifically about the water/sugar/salt formula, the 200cc packet, and the one liter packet. What suggestions do they give to mothers to help them overcome these problems?

What does the provider believe that ORS is for? What does she tell the mother that the ORS is for/what the ORS will do for her child? Does the provider really understand the concept of dehydration and need for the use of ORS. If she does, how does she explain this concept to mothers? Does she believe that mothers understand? Does she believe that mothers understand the concept of the comparing the plant without water to a child with diarrhea? Does she know of any folk tales/myths/songs or stories that might be used to explain dehydration or be tied into ORS use.

Specifically ask the provider:

How should diarrhea without dehydration be treated?

How should mild dehydration be treated?

How should moderate dehydration be treated?

How should severe dehydration be treated?

What should a child be fed during diarrhea episodes?

Should a mother continue breastfeeding during diarrhea episodes?

When should antibiotics be given to a child with diarrhea?

(Some of these questions will only be appropriate for certain level service providers)

How many packets does the provider (Health Center or weighing post) actually have right now? How many of these packets are melted or hard? Does the provider always have enough ORS packets? The Communications Component might even double the demand. Does she think that she will have enough packets then? How does the provider request packets. How long does it take to get the packets after she makes the request? How many of the packets gets are melted? How many are discolored or hard?

What educational materials would the provider like to help her teach the mother about ORT? To teach the community about ORT?

Does the provider watch television. What time does she watch? What is her favorite program?

Does the provider listen to radio? What are her favorite stations at what time of day. We're thinking about giving beginning a special radio program for village kader. We want to start by giving a radio course where village kader and other village opinion leaders could learn about ORT and receive a diploma. Does the provider think this is a good idea? Does she think the kader could really learn from this type of course? Why or why not? What stations should the program be broadcast on/ at what time? How could we motivate the kader to listen and follow the program?

Does the provider regularly read any print materials? Which ones?

We're thinking about promoting ORT through Puskesmas/ village, and/or Kader competitions. Does she like or dislike that idea? Why? For which level does she think it would be appropriate? Inappropriate? Why? If she thinks it's appropriate, what would be good prizes--for the Puskesmas? For the village? For the Kader?

What are the most important groups in the village? What groups do mothers belong to?

PACKET LOGISTICS ASSESSMENT: The Service Provider Research will also want to assess the provincial capacity to meet ORS demand, assuming an increase in demand of 50%.

How many packets are in storage at the provincial storage center? Take a sample of these packets and see what percentage are melted? Are hard or discolored?

How are the packets distributed in the province? How long does it take from the time the province requests the packets until they are delivered to the provincial storage center? How long does it take from the time that the provincial storage center gets the request from the Puskesmas until the packets are delivered?

How are packets distributed through the kader system in the province? Are the packets distributed only at the weighing post or do some kader have packets in their homes. How are these kader instructed to distribute these packets--to any mother whose child has diarrhea or to treat dehydration?

PROVINCIAL INVENTORY PROTOCOL

The Provincial Inventory protocol is outlined in Section V-B "Provincial Start-up Activities/Preprogram Research. The following is offered as a draft checklist form for recording the information gathered:

DRAFT PROVINCIAL INVENTORY CHECKLIST

NAME OF INSTITUTION: \_\_\_\_\_

NAMES OF CHIEFS/DIRECTORS OF DIVISION OR INSTITUTION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERSON RESPONSIBLE FOR COORDINATING WITH THE COMMUNICATIONS COMPONENT: \_\_\_\_\_

ADDRESS OF INSTITUTION:

\_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

ACTIVITIES WHICH THE INSTITUTION DOES WHICH CAN BE COORDINATED WITH THE COMMUNICAT. JNS COMPONENT:

STEPS NEEDED TO FORMALLY GET COMMITMENT FOR THIS COORDINATION

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RESEARCH ON CHILDCARE, HEALTH, COMMUNICATIONS, ETC.

NAME OF RESEARCH

DATE COPY RECEIVED

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IDEAS/SUGGESTIONS FOR COMMUNICATIONS COMPONENT ACTIVITIES:

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SUGGESTIONS OF NAMES OF OTHER PEOPLE TO CONTACT:

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PROVINCIAL HEALTH SYSTEM PROGRAMMED ACTIVITIES: The provincial inventory will also want to assess programmed MOH and other service provider plans to incorporate the Communications Component into these activities. Two questions are:

What Puskesmas staff and village kader (all programs) training is programmed for 1985?

What is the system for provincial level review, evaluation, or assessment? When is it done and by whom?

The province will need to identify other questions to assess how the Communications Component can be coordinated with on-going activities.

APPENDIX E  
INFORMATION AND COMMUNICATIONS CHANNELS AND RESOURCES

INFORMATION AND COMMUNICATION CHANNELS  
AND RESOURCES IN INDONESIA.

1. INDONESIAN TELEVISION - TELEVISI REPUBLIK INDONESIA (TVRI).

The State-owned Televisi Republik Indonesia has production and broadcasting studios in Jakarta and eight major provincial capitals (Yogyakarta, Special Area of Yogyakarta; Surabaya, East Java; Denpasar, Bali; Ujung Pandang, South Sulawesi; Manado, North Sulawesi; Balikpapan, East Kalimantan; Palembang, South Sumatra; and Medan, North Sumatra) and mobile production units in 10 provinces (Aceh, W. Sumatra, W. Kalimantan, S. Kalimantan, Irian Jaya, Maluku, W. Java, Central Java, East Java and Bali).

Television programmes are shown from 4.00 p.m. to near midnight, an average of seven and a half hours of broadcast time a day, 1 from 08.00 a.m. to about 1.30 p.m. Television programmes cater to all levels of society and presents a tremendous variety of shows from serious vocal or instrumental renditions and cultural dances to comedies and American film series. Some programmes are specifically targeted towards children and mothers, either as entertainment or education. Provincial stations produce their own programmes, which are usually educational cultural, and information in nature, but the majority of the programmes come from the Jakarta central station.

No. of TV sets in the country :	5,000,000 (registered, 1983).
Area coverage :	70% of total area; all of Java, most of Sumatra and areas surrounding major cities in the other islands.
Population coverage :	80% - 63% on Java - of total population or about 125 million.
Viewership :	Average 10 persons per set to total 50,000,000 (Viewer-set ratio used by Government). One community set is provided by the Government for every village which can receive TV programmes.

2. INDONESIAN RADIO - RADIO REPUBLIK INDONESIA (RRI).

The state-owned Radio Republik Indonesia operates an extensive network of 300 stations throughout 27 provinces, broadcasting both from their central station in Jakarta, 5 coordinating stations in Medan, Yogyakarta, Banjarmasin, Ujung Pandang and Jaya Pura, and transmission stations in 27 provinces and 17 regencies.

The central station transmit a total of 12 hours and thirty minutes of programmes per day, broken up into morning (from 05.00 to 08.00), afternoon (15.00-16.30) and evening (17.00-03.00), broadcasts. Like television, RRI offers a host of programmes to please virtually every segment of the society; they have, however, a comparatively large number of attractive talk shows aimed at mothers (Obrolan untuk Ibu Rumah Tangga, Kesehatan Keluarga, Tukang Sado dan Gado-Gado, etc.). RRI also has one programme which is very well suited and effective for development support purposes, namely Rural Broadcasting. Rural Broadcasting has become virtually a programming entity by itself. Supervised by the National Programming Division, it transmits programmes in the national language from the central station in Jakarta and in local languages from the provincial and regency stations. Reinforcing and following up on the messages delivered are 40,000 listeners' groups now established in 20,000 villages. Constant monitoring of listener groups is carried out by village volunteers and RRI officials, and a yearly competition of the best listener groups have contributed to its growing success. Programmes aired through Rural Broadcasting mostly deal with agriculture, particularly grain production as it was established to promote the Government's BIMAS (Mass intensification to increase rice production) programme. But in recent years, Rural Broadcasting has also devoted more time to health and nutrition issues and have made health improvement as one of the criteria used in the competition.

No. of radio sets in the country	:	30,000,000 (ets. 1983).
Area coverage	:	100% except for isolated mountainous areas
Population coverage	:	100%
Listenership	:	Average 5 persons per set to total 150,000,000 or almost 94% of the total population.

### 3. COMMERCIAL/PRIVATE RADIO STATIONS

Private radio stations owned and cooperate by commercial entities proliferated only after 1967, when the Government allowed certain wavelengths to be used by private radio stations. The stations are all local, with only the larger ones capable of reaching across an entire city. But because they are numerous and cater to the needs

of local communities, as a whole they have a more massive outreach than RRI.

There are 374 private radio stations in the country, concentrated in provincial and regency level cities, with the great majority operating in Java.

#### 4. PRINTED MEDIA

The printed media consist of newspapers and magazines published daily weekly or monthly with some being published quarterly. There are a total of 203 newspapers and 82 magazines published in Indonesia with a total circulation of about 4.8 million. Only two newspapers can really be considered national, namely KOMPAS and Sinar Harapan, which are available in most provincial capitals. Some like Pikiran Rakyat (Bandung) and Java Pos (Surabaya) are circulated beyond their provincial boundaries.

Tempo newsweekly is the only one of its kind available outside of Jakarta and is sold in all the provincial capitals and other major cities. Of the monthly or quarterly magazines FEMINA and KARTINI - both women magazines - are available in almost all provincial capitals and most major cities in Java.

Among development journals, only TRUBUS, an agricultural monthly published by Bina Swadaya Masyarakat, an NGO, and PRISMA, an intellectual - oriented quarterly development journal published by LPJES, a social and economic research institute, are available outside of Jakarta. Information on the circulation of major printed media is attached.

#### 5. KORAN MASUK DESA ("Newspapers Enter the Village" scheme).

Koran Masuk Desa (KMD) is a project initiated by the Government in order to provide reading material to villagers which are relevant to their interest, and at the same time a means to channel information to rural communities. The government provides a subsidy of Rp. 35 to offset production costs for up to 5,000 copies, which the paper sells at Rp. 50 or Rp. 60 per copy. Published weekly as a four-page village edition by provincial privately-owned newspapers, the project now covers 22 provinces (those not covered include Jakarta, Riau, South Sumatra, Jambi, and East Timor).

Total circulation of KMD in 1982/83 was 15,652,000.-

As the papers are sold, there are varying degrees of success among the publishers. Some have proven successful like Banjarmasin Post in South Kalimantan (circulation approx 17,000), Bali Post in Bali (12,000) and Pikiran Rakyat Cirebon in West Java (12,000), while most range between 5-10,000 copies of KMD.

6. PRIVATE/INDEPENDENT PRODUCTION HOUSES,

Virtually all communication materials can be produced within the country. For printing purposes, large production houses, like Gramedia and Inter-Masa, offer the latest techniques in photo-typesetting and colour separation and produce high quality materials. For audio-visual production, there is a large number of large and medium size production houses that have full recording and programming facilities.

7. ADVERTISING AGENCIES.

Advertising has been a fast-rising industry which has bloomed from only a handful 15 years ago to the present 3,000 companies which deal with all or individual aspects of advertising throughout the country. The larger companies like Matari, Intervista, Fortune UMM-Thomson and Indo-Ad offers full range of services from strategy planning, to implementation to evaluation. Only a few - Matari and Fortune - have their own complete set of production facilities.

8. NON-GOVERNMENT ORGANIZATIONS

As communication channels, non-government organizations - inclusive also of organizations operating under government auspices - are effective in delivering messages on an inter-personal basis a catalogue of 181 active NGOs is available. Below the major national level NGOs:

- Pramuka, Indonesian Scouts Movement.

With a registered membership of 10,000,000 members - boys and girls aged 10-24 - Pramuka is present from the central to at least sub-district levels. Larger villages, especially those where primary schools are located, also have scout troops. UNICEF has a cooperation agreement with Pramuka for the dissemination and application of appropriate technology, specifically in the field of environmental sanitation.

- Indonesian National Council for Social Welfare/  
Coordinating Board for Social Welfare (DNIKS/BKKS).

This is an umbrella organization of non-government organizations dealing with social welfare.

The main function of DNIKS/BKKS has been to coordinate the member NGO's activities and as a conduit for funds provided by government and private donors.

- National Council of Women (KOWANI)

This is a federation of about 50 women organizations - inclusive pseudo-government associations like Associations of the Wives of Civil Servants and of Wives of Armed Forces - in the country which provides policy guidance and coordination to all its member NGOs.

- Family Welfare Movement (PKK).

Existing at every administrative level, from central to village PKK is a national movement of women operating under the auspices of the Department of Home Affairs. The head of the PKK at the village level is usually the wife of the village head, and all the women in the village are members of the organization. PKK has been active in supporting government programmes, particularly in providing volunteers for village health and nutrition programmes.

- Village volunteers

Volunteerism is a basic tenet of Indonesian life and is embodied in the "gotong royong" or mutual self-help system rooted in Indonesian culture. There are now approximately one-quarter million volunteers in around 40,000 villages involved in health, nutrition and family planning activities.

CIRCULATION OF MAJOR NEWSPAPERS AND MAGAZINES

A. Newspapers

National/Jakarta-based :

1. KOMPAS	: 335,000
2. SINAR HARAPAN	: 300,000
3. JAKARTA POST	: 13,000
4. JAKARTA TIMES	: 45,000
5. INDONESIAN OBSERVER	: 60,000
6. ANTARA NEWS BULLETIN	: 4,000
7. KNI News Bulletin	: 1,500
8. BERITA YUDHA	: 80,000
9. ANGKATAN BERSENJATA	: 51,250
10. SUARA KARYA	: 128,500
11. PELITA	: 65,000
12. BERITA BUANA	: 30,000

Regional/Local

1. ANALISA	: 40,000
2. SURABAYA POST, Surabaya	: 75,000
3. BERITA NASIONAL, Yogyakarta	: 10,000
4. BANJARMASIN POST, Banjarmasin	: 8,000
5. WASPADA, Medan	: 28,000
6. BUKIT BARISAN	: 10,000
7. BALI POST, Denpasar	: 13,325
8. KEDAULATAN RAKYAT, Yogyakarta	: 35,525
9. SUARA MERDEKA, Semarang	: 95,000
10. MIMBAR UMUM	: 8,750
11. PEDOMAN RAKYAT, Ujung Pandang	: 25,000
12. PELITA PEMBANGUNAN	: 3,000
13. BANDUNG POST, Bandung	: 13,000

B. Magazines (Weeklies, monthlies).

1. TEMPO Newsweekly	: 112,000
2. BALITA	: 30,000
3. FEMINA	: 60,000
4. KARTINI	: 60,000
5. SARINAH	: 40,000
6. TRUBUS	: 30,000
7. PRISMA	: 15,000

APPENDIX F  
MINISTRY OF HEALTH-CENTER FOR HEALTH EDUCATION

Ministry of Health  
CENTRE FOR HEALTH EDUCATION

I. BACKGROUND.

Presidential Decree No.15/1984 has supported the decision for setting up a new structure in the organization of the Ministry of Health. The Directorate of Health Education, which was under the Directorate General of Community Health, has become Centre for Health Education. This unit is technically under the direct line of the Minister of Health.

Centre for Health Education is responsible for planning, implementing, monitoring, and evaluating all of the educational components of the various programmes of Community Health, Medical Services, Communicable Disease Control and Environmental Health, Food and Drug Control. The responsibility covers health education programmes for health service providers and other agents from non health sectors as well as the community.

The goal of Indonesian Health Development is to gain ability to live a healthy life for each individual in order to reach optimal health status of the public as an aspect of social welfare in the overall national development.

To achieve the goal, health education in Indonesia is using Educative Approach. The underlying philosophy is that community has right to make their own choices and potency to solve their own problems. This is manifested in some basic concepts of health service, that it should be developed on social norms and life values of community, on active participation of community in planning, implementing, and evaluating the programmes, and on social acceptability of health workers. As an integral part of the National Health System, the pattern of services should be interrelated and harmoniously give support to each other. Therefore, the service should be intersectorally coordinated and integrated with other development programmes. It should be able to stimulate social potencies and make use of available resources.

The strategy is basically aimed at developing providers and developing community. The development of providers is for reaching common understanding that community is not merely a passive object, but also active object of development programmes. The success requires intersectoral coordinative efforts. To be able to play an appropriate role, each sector has to know the community. And, the objective of the development of community is to strengthen their motivation and ability for helping themselves within their own rights and capabilities.

## II. PROGRAMMES.

The focus of health programmes in Pelita IV is on decreasing IMR from 90/1000 to 70/100 by 1989. To achieve the objective the programme priority is on Integrated Programme (Program Terpadu) of Immunization, Diarrheal Disease Control, Nutrition, and Family Planning.

The priority of health education programme in Pelita IV is also in line with this policy. Centre for Health Education will support the educational components of each one of the programmes which forms the Integrated Programme (Program Terpadu) and will promote the idea of integration through special communications to providers and community. This is done without neglecting the other health programmes.

To carry out the mandate, centre for Health Education has enumerated five basic areas :

- 1) Development, production, and dissemination of health education messages and materials for all health service programmes.
- 2) Transfer of educational technology, such as development of curricula for training health and non health workers, orientation for special groups, village volunteers, etc. in health education and communication skills.
- 3) Monitoring and evaluation.
- 4) Conduct special studies on innovations, such as experimenting in pilot areas, effectiveness of rural newspapers, etc.
- 5) Development of interministerial and intersectoral coordination for educational activities through women, youth, religious, and other form of social organizations.

The following steps correspond to the basic tasks which must be completed in the implementation of a communication programme :

- 1) Define the problems.
  - 2) Conduct qualitative research.
  - 3) Develop educational objectives, contents, and basic messages.
  - 4) Select media and formulate communication strategy.
  - 5) Design educational materials.
  - 6) Test the educational materials.
  - 7) Modify and produce the educational materials.
  - 8) Train the users of the educational materials.
  - 9) Disseminate the educational materials.
  - 10) Monitor and evaluate.
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### III. ORGANIZATION.

Centre for Health Education has chosen an operational pattern which reflects the work to be done to provide service programmes with proper support. It has one Secretariat and four Divisions. They are :

- 1) Secretariat, which is responsible for all secretarial work, such as data compilation, financial, domestic, and personnel affairs. It has four Sections of Data and Reporting, Financial Affairs, Domestic Affairs, and Personnel.
- 2) Division of Educational Methodology, which is responsible for training, developing and demonstrating newer methods of health education, conducting surveys on knowledge, attitude, and practices, defining behavioural problems and formulating basic messages, and evaluating the effectiveness of the applied health education methodology. It has three Sections of Methodology Development, Socio-cultural Investigation, and Message Development.
- 3) Division of Educational Media, which is responsible for developing, producing, disseminating, and evaluating health education materials on electronic as well as graphic. It has four Sections of Electronic Media, Graphic Materials, Exhibitions and Fairs, and Folk/Traditional Media.
- 4) Division of Interprogramme Service, which is responsible for providing consultation, and technical assistance to the other health programmes as users of health education service. It has four Sections of Community Health, Medical Services, Communicable Disease Control and Environmental Health, and Food and Drug Control.
- 5) Division of Intersectoral Service, which is responsible for providing health education service to various social organizations. It has three Sections of Women Organization, Youth Organization, Religious and Social Organizations. ( See : APPENDIX 1 )

At present Centre for Health Education is sharing office space with the Directorate of Community Participation. The available space is not enough to house the personnel required by both agencies. In addition, media production facilities are not available, so that all health education materials are still contracted out for production. As a consequence, the production is very limited in number and costly. Thus sufficient materials are not produced to meet the dissemination requirements for the expected effects. The unavailability of operational vehicles has also hampered outreach.

d/c

The available manpower in Centre for Health Education now are 51 people. They are 13 Health Educators, 1 Public Health Administrator, 1 Nutritionist, 1 Nurse, and 5 Health Inspectors. In addition, there are 24 clerical workers, 2 drivers, 3 night-watchers, and 2 janitors.

The total manpower of all provinces are 263 people of various kinds of category. While the total number of manpower in kabupaten (district) level are 291 people. Mostly still need some additional trainings and further education on health education or communication skills.

At central level the dilemma is, at present, the unavailability of working space. There should be a priority either to get office space first or immediately start to draw some experience people from provinces to fill out open posts. Centre for Health Education still needs at least 3 people with some experience and managerial skills.

#### IV. MANAGEMENT.

In the Integrated Programme (Program Terpadu) the Division of Interprogramme Service is the contact link to the programmes. Take as an example, Immunisation. Their contact link for obtaining educational support is the programme manager in the Section of Communicable Disease Control and Environmental Health from the Division of Interprogramme Service. The person will identify the needs for educational support with the programme representatives.

Then, the Division of Interprogramme Service coordinates the other divisions within Centre for Health Education to produce the appropriate communications according to the process outlined on page 2. First the Division of Educational Methodology will be involved for defining the problems and conducting qualitative research or contracting for its completion. Based on the results of the research the Division of Educational Methodology will work together with the Division of Educational Media and the programme representatives for developing educational objectives and educational contents and for formulating basic messages.

The formulation of communication strategy, the selection of media, and the development of material designs are fully under the responsibility of the Division of Educational Media with the approval of the programme representatives.

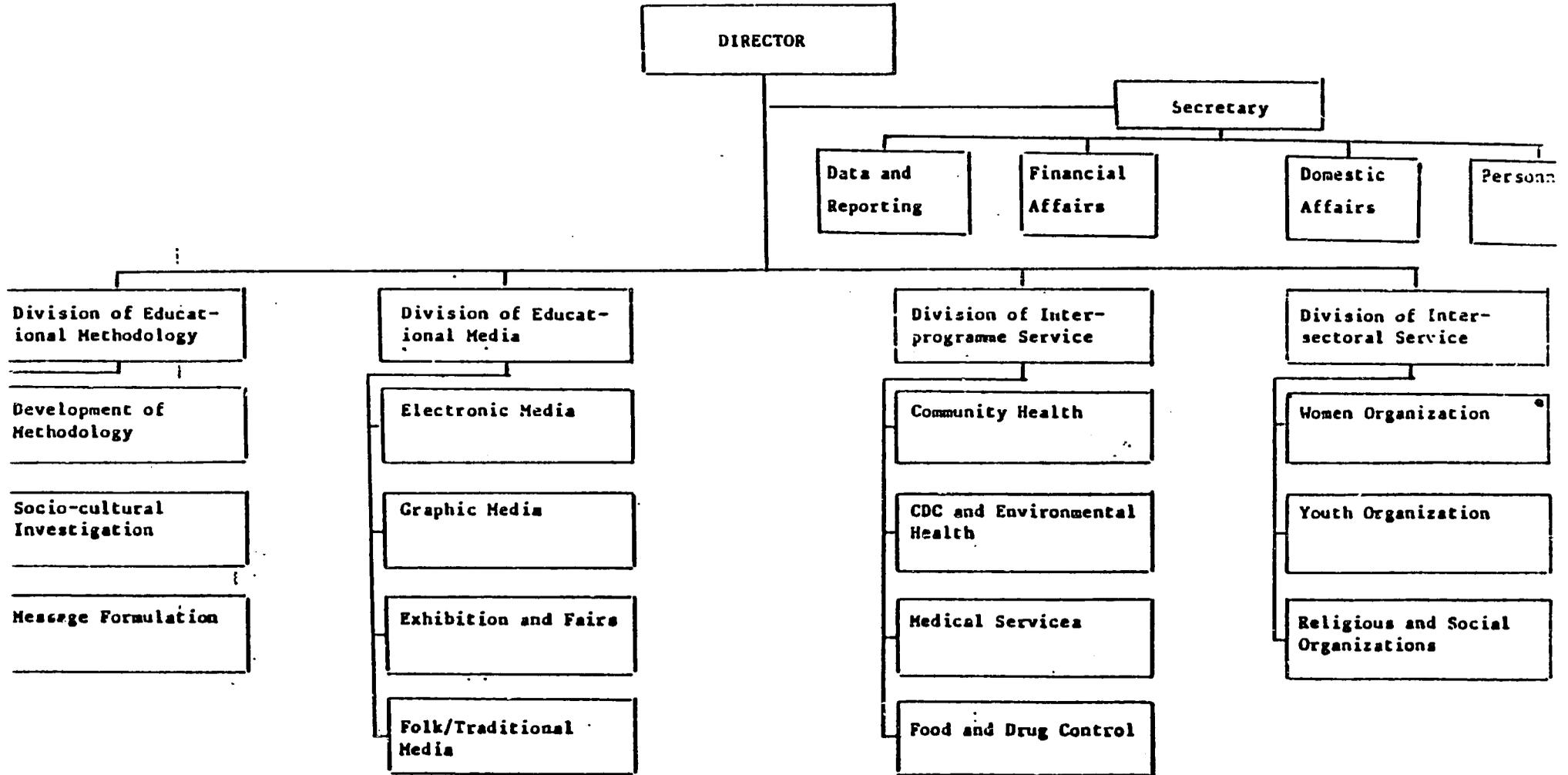
Testing of the educational materials is done by the Division of Educational Methodology and the Division of Educational Media. The actual production of the educational materials is the responsibility of the Division of Educational Media.

Training of providers, both health and non health, and the development of curricula for the training of village volunteers (kaders) is done by the Division of Educational Methodology, the Division of Interprogramme Service, and the Division of Intersectoral Service with collaboration from service programme, such as Immunization. While training sessions for village volunteers (kaders) is the responsibility of the Directorate of Community Participation.

Dissemination of educational materials for mass communication, providers, and village volunteers (kaders) is again fully the responsibility of the Division of Educational Media. And, the monitoring and evaluation is done by the Division of Educational Media.

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Organizational Chart:  
CENTRE FOR HEALTH EDUCATION



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APPENDIX G  
FIRST YEAR COMMUNICATIONS COMPONENT  
DRAFT BUDGET

ORT CAMPAIGN BUDGET ESTIMATENOVEMBER 1984 - FEBRUARY 1985

I.	<u>Pre-programme Research</u>	Rp.
A.	Provincial Inventory Service Provider Research	10,000,000
B.	Audience Research (Contracted to professional agency)	20,000,000
II.	<u>Provincial Level Administrative Start-up</u>	
A.	Travel 10 x JKT/BDG/JKT	200,000
B.	Per diem 45 days x Rp. 21,000	945,000
C.	Materials	250,000
	Sub total 1	<u>31,395,000</u>

ORT CAMPAIGN BUDGET    FEBRUARY 1985 - FEBRUARY 1986I. Formative ResearchA. Pretesting materials

Rp.

## National Staff

- Per diem, two supervisors x 30 days x Rp. 21,000	1,260,000
- Per diem, driver x 30 days x Rp. 13,000	390,000
- Fuel, 30 litres x Rp. 350 x 30 days	315,000

## Provincial Staff

- Per diem, two supervisors x 45 days x Rp. 17,000	1,530,000
- Per diem, driver x 45 days x Rp. 8,000	360,000
- Fuel, 30 litres x Rp. 350 x 45 days	472,500
- Per diem, four interviewers x 45 days x Rp. 17,000	3,060,000
- Per diem, two local staff x 45 days x Rp. 5,000	450,000
- Per diem, drivers x 45 days x Rp. 8,000	360,000
- Fuel, 30 litres x Rp. 350 x 45 days	472,500

Sub total Pretesting                      8,670,000

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B. Systematic monitoring

## National Staff

- Per diem, one supervisor x 30 days x Rp. 21,000	630,000
- Per diem, one driver x 30 days x Rp. 13,000	390,000
- Fuel, 30 litres x Rp. 350 x 30 days	315,000

## Provincial Staff

- Per diem, two supervisors x 21 days x Rp. 17,000	714,000
- Per diem, driver x 21 days x Rp. 8,000	168,000
- Fuel, 30 litres x Rp. 350 x 21 days	220,500
- Per diem, five interviewers x 21 days x Rp. 17,000	1,785,000
- Per diem, two local staff x 21 days x Rp. 5,000	210,000
- Per diem, driver x 21 days x Rp. 8,000	168,000
- Fuel, 30 litres x Rp. 350 x 21 days	220,500

Sub total Monitoring                      4,821,000

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II. Mass Media

Rp.

A. Radio

## 1. Production

Fifteen x 30-60 second spot x Rp. 500,000	7,500,000
Forty x 15 minute weekly programme x Rp. 750,000	30,000,000

## 2. Air-time

Ten spots per day on 10 provincial stations )	5,000,000
One weekly programme on 4 provincial stations )	

3. Reproduction and distribution to stations	1,000,000
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4. Reproduction and distribution of radio materials as cassettes for training - 500 cassettes x Rp. 2,000	1,000,000
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Sub total Radio	44,500,000
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B. Television

## 1. Production

- 20 minute training video	
Materials and studio time	800,000
Per diem, 4 crew x Rp. 21,000 x 5 days	420,000
Transport 4 x 5 days x Rp. 20,000	400,000

- 5 minute TV programme	
Materials and studio time	200,000
Per diem, 2 crew x Rp. 21,000 x 5 days	210,000

- 3 x 60 second TV programmes	200,000
Per diem 2 crew x Rp. 21,000 x 2 days	84,000

## 2. Air-time

- One five-minute programme 2 x per week )	5,000,000
in prime time for 2 months )	
- Three 60 second spots in prime time )	
for five months )	
- Inserts into existing programmes )	

Sub total Television	7,314,000
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C. Monitoring

- Salary, one person for one year	6,000,000
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**III. Print Materials**

Rp.

1. "Point of Purchase Kits" - one/Puskesmas and one per weighing post or two per village (iff no UPGK) 660 Puskesmas + 1650 villages x 8 posts + 2379 villages x 5 posts + 3016 x 2 = 32,000 x Rp. 2,000	64,000,000
2. 20,000 "village cadre kits" x Rp. 1,000	20,000,000
3. 1,000 "Physician's kits" at Rp. 1,500 each	1,500,000
4. 1 million litre bags at Rp. 30 each	30,000,000
5. 100,000 ORT Radio course kits (booklet, diploma, badge) x Rp. 500 each	50,000,000
<b>Sub total Print Materials</b>	<b>165,500,000</b>

**IV. Training**

Regency "training/motivation courses" 20 participants x 24 regencies x 3 days x Rp. 20,000	28,800,000
Trainers and materials	5,000,000
<b>Sub total Training</b>	<b>33,800,000</b>

**V. Promotion Activities**

Including press, prizes for competing villages,  
travelling puppet shows or other culturally  
appropriate reinforcement

<b>Sub total Promotion</b>	<b>20,000,000</b>
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**VI. Administration**

	Rp.
<b><u>National level</u></b>	
Strategy planning meeting February 1985	5,000,000
<b><u>Provincial level</u></b>	
Local Government orientation meeting	10,000,000
Contingency	20,000,000
<b>Sub total Administration</b>	<b>35,000,000</b>

**VII. Evaluation**

1. KAP, Quantitative study sample of 1,500	20,000,000
2. Mortality study	20,000,000
<b>Sub total Evaluation</b>	<b>40,000,000</b>

<b>Grand total</b>	<b>365,605,000</b>
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APPENDIX H  
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## CONSULTANCY BIBLIOGRAPHY

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