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SOMAVITA PROJECT

SOCIAL MARKETING OF VITAMIN A

1 August 1990 - 31 July 1991

FINAL REPORT TO USAID

October 1991

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1 August 1990 - 31 July 1991
FINAL REPORT

A. PROJECT FOCUS & USE OF FUNDING

The major focus of the Somavita Project has been to identify factors that increase consumption rates for high-dose vitamin A capsules and to use this knowledge in working with the Ministry of Health (MOH) to develop a program to increase capsule consumption nation-wide.

CS funding has been used primarily to refine existing activities: to refine successful social marketing interventions through the development of improved plans and materials, the development of new approaches to distributing capsules, and the beginning of detailed analysis of the logistics of moving capsules.

CS funding has allowed expansion into new areas, from two regencies (counties) in Central Java Province to the nation as a whole, with special attention given to 2 of the 13 high-risk provinces, Central Java and Aceh.

HKI and USAID have agreed that the scope of this project is too broad; it has also bee{n understood that the MOH will accept nothing less at this time. Thus, this project has looked at the management issues involved in the expansion of pilot activities to broad scale.

B. ORGANIZATIONAL DEVELOPMENT

B1. Human Resources

In-country staff In this cooperative project, expatriates and host-country nationals together managed the project and conducted training and evaluation. The expatriate Project Manager (5 years' experience managing public health projects and 10 years' experience working with the Indonesian government) was responsible for the expenditures in accordance with a budget planned when the project was designed. She was supported by an assistant who managed contacts both with national MOH counterparts and with producers of communications materials (printers, radio spots, and TV spots). In Central Java, a team was led by an Indonesian M.D./Ph.D. researcher, who coordinated all Central Java project activities, including research on alternative distribution channels, contacts with the Governor's office, and communications work.

In Aceh province, the part-time HKI "Aceh Coordinator" was a retired Indonesian civil servant with excellent high-level contacts who was able to encourage and coordinate quickly among MOH and the Aceh Governor's office a variety of interventions, including radio, television, and print; he was supported by an assistant for field work, reporting, and financial accounting.

Technical training was not a part of the plan for this one-year project, although field researchers for the Central Java monitoring and other studies were trained on-the-job by the Somavita team members. Formal refresher training in data collection procedures would have been valuable in sharpening the focus towards data collection objectives for the distribution alternatives study and routine monitoring. Interviewers from the contracted research firm were formally trained for 3 days prior to data collection by a team that included the firm's field manager and the Somavita Project Manager: this training followed well-tested procedures and was important for assuring uniformity in data collection.

Although there was no management training as part of this grant, the Project Assistant attended a workshop on management of evaluation for child survival projects.

Headquarter backstopping was extensive and adequate during the period when the epidemiologists and administrative personnel at HKI headquarters were used extensively as HKI and the MOH prepared a working plan for the social marketing of vitamin A for the following 3 years.

B2. Use of Technical Resources

Key comments in the technical review (July 1990) of the original grant proposal that are relevant to this one-year project are discussed below.

Evaluating 150,000 children by interviewing "only" 800 mothers is not only possible due to careful sampling procedures but is wiser than interviewing 5,000 or even 50,000 mothers. The sampling was done in consultation with researchers from the Annenberg School for Communication, University of Pennsylvania, who are experts in evaluating the effectiveness of communications programs.

The technical review questioned the wisdom of expanding the vitamin A communications program so quickly. HKI agrees, and had already urged the MOH to go more slowly. The MOH made their decision for good reasons; HKI, in its continuing role of providing technical assistance, continued to help make the implementation of the MOH decision as effective as possible, by continuing to explore capsule distribution issues and by limiting the majority of activities to 2 provinces, Central Java and Aceh.

One of the key issues in this expansion is not whether social marketing can work (it can) but rather how to manage the process of expansion and a national program in a country as large and as varied as Indonesia. Careful planning of a 3-year program to reduce vitamin A deficiency through capsule distribution and vitamin A rich foods continued through this project. The national broad-brush effort was important to establish that the MOH policy affects the nation as a whole and it began its campaign in February 1991 with radio, TV, and printed materials. At the same time, the team began a phased approach for province-specific work by continuing activities in Central Java and

beginning new capsule activities in Aceh, where there had already been a program for the social marketing of vitamin-A-rich foods.

Regarding the question of how to reach children living in areas without a Health Post, where coverage rates are not changed by communications efforts, MOH is working to increase the number of active Health Posts throughout the country, and this project looked at alternatives to Health Post distribution of capsules. (Results of the Distribution Alternatives study appear in Appendix III.)

There was no technical review of the Detailed Implementation Plan. Primary technical assistance funded by USAID included Thomas Reis, Resident Social Marketing Consultant, and Judith McDivitt, Senior Researcher at the Annenberg School for Communication, both funded under a USAID/S&T contract for HealthCom Project. Mr. Reis lived in Central Java and travelled frequently to Jakarta to work with HKI and MOH staff on the development, pretesting, production, dissemination, and evaluation of social marketing interventions. Ms. McDivitt analyzed the data collected in 1990, comparing results with the 1988 and 1989 data sets. Both were extremely useful: the quality of Somavita Project's interventions and evaluation would have been substantially reduced without them.

Other technical assistance, supported by matching funds, included James Bates, a drug management specialist with MSH in Boston, who assisted with the design of a study of the logistics of moving vitamin A capsules from Jakarta to the Village Health Post point-of-distribution.

B3. Health Information System

The "baseline" quantitative information for this one-year project came from a 1990 survey in 2 Central Java regencies, one of which was a control area. Because of the speed of the MOH decision to go national, there was not time to collect other pre-intervention data in this project, and information on other provinces came from the MOH's own reports.

By comparing the new 1990 Central Java data set with 1988 and 1989 sets, the team learned that mothers' awareness of vitamin A capsules continued to increase in the second year of interventions and that VAC coverage rates in Posyandu areas were maintained at the new 40% level. In the 1990 sample, the number of respondents reporting a Posyandu in their neighborhood was twice that in the 1988 and 1989 samples -- yet the same coverage rates held.

Direct-mail surveys such as the one attempted in this project offer the potential for sustainable systems for information on the effectiveness of health communications. (A more complete description of the direct-mail survey is in Section D2, VAC Objective 2.)

A weakness in this project is that a health information system was not established. Although information was collected, the analysis/compilation and results were completed much later than planned, and thus the usefulness was less than had been hoped. There was feedback to GOI counterparts on an informal basis and through sharing the writing of reports. The team also shared information and experiences with non-GOI programs and researchers from such varied places as the National Nutrition Institute in Bogor, Johns Hopkins University, the University of Michigan, and the USAID Mission in Jakarta.

Information has been used to provide feedback within the MOH and the project itself but was not directly shared by the project with village-level people or with MOH Community Health Center staff.

Information from the distribution alternatives study (Phase 1) resulted in allocating staff and resources to look further into the important problems of making capsules more accessible to mothers through alternative channels.[1]

[1]A summary of the results of Phase 2 of the Distribution Alternatives Study is in Appendix III.

C. PROJECT DESIGN AND IMPLEMENTATION

C1. Actions to Improve Health Behavior: Community and Household Levels

In this project to increase capsule consumption rates, mass media communications directed at mothers and community leaders began at the national or provincial levels to heighten community awareness of the importance of vitamin A capsules and of their availability at Posyandus in February and August.

Through radio, TV, and fliers, mothers and community leaders were urged to see that all children 1-4 years old received a capsule every February and August.

In addition, in Central Java, work continued on how to mobilize the Neighborhood Heads (Kepala RT) to increase capsule consumption: it was learned that their best role was not in dispensing capsules but rather in organizing the listing of all eligible children in their neighborhood. Once the local Health Post had a more complete list, the volunteers knew better which children did not come for a capsule and, therefore, which households to visit.

Based on this finding, provincial governors became the core of a new intervention. In Central Java, in a signed flier distributed to all village leaders in February 1991, the governor instructed these civil servants under his administration to "guarantee" that all target children received a capsule. Then the Governor of the province of Aceh sent out a signed flier in August 1991 urging village leaders to actively support the vitamin A capsule distribution in August 1991, and West Java's Governor distributed a similar flier to mobilize village administrators.

C2. Appropriateness and Targeting of Activities

Studies in Indonesia, India, and Nepal have shown that Vitamin A supplementation reduces child mortality by as much as 1/3 in vitamin-A-deficient populations. A recent survey of xerophthalmia and blood serum vitamin A levels in 4 Indonesian provinces has shown that even in the 3 provinces without significant xerophthalmia, blood serum analysis shows that the children are, by WHO standards, deficient in vitamin A. Vitamin A supplementation does not stop the incidence of diseases such as measles, diarrhea, and respiratory infections, but it does help the child get over them before they become fatal. Although there are vaccines against measles, at this time vitamin A supplementation provides low-cost protection against fatal outcomes of diarrhea and ARI.[2] Thus, vitamin A supplementation is an entirely appropriate and important child survival intervention.

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[2] See also USAID's September 1991 draft paper, "Vitamin A Nutrition Strategy."

Future projects should continue to find ways to improve the coverage rates for vitamin A supplementation.

In accordance with MOH policy, there were two target groups for capsules included in the Somavita Project: children 1-4 years and lactating mothers. Mass media communications dealt only with children; mothers after delivery were the target of face-to-face communications only.

There are other groups this project did not address -- for example, school children (for capsules and as a communications resource), newborns, children 6-11 months old, and children with measles. Adding others to the groups targeted in this one-year project, would have been inappropriate, given the limited time and resources.

Strategies to target services to mothers after delivery were limited to activities in the 2 original Rovita pilot areas, where during routine TBA training, TBAs were provided with a small number of capsules to give to mothers immediately after delivery. See Appendix IV.

Strategies to target services to children 1-4 included the use of mass media directed at their mothers, informing mothers that it is important to take their children to the Health Post for a capsule in February (August).

Strategies to reach the hard-to-reach children -- those whose mothers do not listen to radio or who do not go to the Village Health Posts -- included (1) enlisting village heads to see that children eligible for capsules are identified, (2) mobilizing village administrators to see personally that the children under their jurisdiction receive capsules, and (3) mobilizing village-level Family Welfare Movement (PKK) leaders to take an active role in seeing that Health Posts in their area gave capsules to eligible children.

C3. Specific Interventions: Vitamin A

The Somavita Project focused on a single child survival intervention, vitamin A, primarily high-dose capsules, with a vitamin-A-rich foods component.

a. Appropriateness of Objectives and Phasing

The original objectives stated in the proposal for this project were modified in scope, in accordance with the needs of the MOH. In brief, the originally funded proposal had 4 major objectives: 1) to identify factors that increased capsule coverage rates, 1988-1990 in 2 Central Java regencies; 2) to identify and evaluate constraints to increasing coverage rates (especially access to capsules and access to information); 3) to test new strategies (alternative distribution channels and improved communications), and 4) to develop plans for expansion to all of Central Java.

Before the plan (in the form of a Proposal to USAID/W) was completed, however, the MOH had already decided to "go national" with social marketing of capsules and was making plans for its campaign. (This was described in the project Interim Report, submitted with the proposal to USAID/W in December 1990.) HKI (and USAID) had a choice to withdraw from what seemed to be too rapid an expansion, or continue to work with the MOH to make the expansion as effective as possible. Since the MOH, USAID, and HKI are long-time partners in a good relationship, the Somavita Project team continued to advise careful planning and a phased approach and took the opportunity to help with and learn from the management issues of large-scale expansion.

Because the project objectives are more clearly stated in the November 1990 Interim Report, the remainder of this section will discuss the four objectives in that format, with added quantitative objectives from the April 1991 Detailed Implementation Plan. (Since these are not quantifiable objectives, they appear as "outputs" in Section C3c.10 in the DIP.)

<u>Objective A</u>

to identify factors that increased capsule coverage rates (1988-1990).

Information from the 1990 data set could be available for use before the end of the project but not before a new plan for expansion of the VAC social marketing program was drafted and submitted to USAID in December 1990. Data collection for the 1990 survey was completed at the end of October 1990, with data entry and cleaning requiring one month and the first run through the data available only in early December.

Objective B

to identify and evaluate constraints to increasing capsule coverage rates: access to capsules and access to information

Meeting this objective involved more analysis of the 1988-1989-1990 data sets -- a realistic objective for the end of the project but not for the December plan.

Objective C

to test new strategies, including alternative distribution systems for VAC and refinement of VAC communications work

Testing a new alternative distribution system involved continuation of the first phase of a small study in Central Java -- achievable.

Refinement of communications for capsules was an on-going process and achievable (though difficult to quantify) objective.

Objective D

to develop detailed plans (submitted as proposal) for the expansion of social marketing of vitamin A capsules to all Indonesia

This objective was realistic and essential for future MOH work. The December deadline for the USAID/Washington proposal submission was too early to allow adequate analysis of the 1990 data set.

In addition to the above 4 objectives, the quantifiable objectives for the social marketing of high-dose vitamin A capsules as stated in the Detailed Implementation Plan for Somavita Project (section C3c.10), were:

Quantifiable VAC Objective 1:

to increase VAC consumption in August 1990 from 40% to 60% of target children in the Demak and Jepara regencies in Central Java.

This objective seemed realistic. Because of the increase in VAC consumption from 24% to 40% between 1988 and 1989, it was anticipated that the trend would continue. Phasing was not an issue, since the August 1990 capsule campaign had been prepared in the previous Rovita project with radio spots and banners.

Specific August 1991 activities to reach this objective included:

- broadcasting 1,550 one-minute radio spots in the Javanese and

Indonesian languages in the 2 target regencies from 1-31 August, and

- displaying 480 banners in 438 villages, 38 Community Health Centers, and 4 other locations in the 2 target regencies.

Quantifiable VAC Objectives 2 and 3:

to increase knowledge of new capsule distribution months (February and August),

in Central Java:

- among MOH workers to 100%;
- among Family Welfare Movement (PKK) heads (who are often heads of Health Post Volunteers in each village) to 100%
- among Village Heads to 100%

in 12 other provinces:

- among MOH workers to 100%;
- among Family Welfare Movement (PKK) heads (who are often heads of Health Post Volunteers in each village) to 75%
- among Village Heads to 60%

These knowledge objectives seemed entirely attainable during the course of the project, given that the target audiences for communications were MOH staff, who the team expected would pay close attention to and would remember MOH communications, and village leaders, who the project team expected would remember communications about the Health Post activities in t heir villages. In addition, February and August have been VAC distribution months in Central Java villages for over 4 years.

Specific activities to attain these knowledge objectives formed the February 1991 campaign to publicize the change in distribution months to February and August nation-wide. (See the booklet on the February 1991 Campaign.) All communications emphasized February and August. The national February campaign included:

- television broadcast of a statement by the Minister of Health on the promotion of vitamin A capsules
- television broadcasts of an early film and of a 2-minute filler developed for February 1991,
- radio broadcasts on >450 stations of a national radio spot developed especially for February 1991,
- newspaper articles and national TV coverage of a "nutrition day"

on 8 February which included the Minister of Health talking about capsules and then giving a capsule to a child.

To these national interventions Central Java added:

- television broadcast of a formal statement by the Governor,
- meetings with regency administrators to emphasize the importance of capsule distribution,
- 170,000 fliers from the Governor to mobilize Village Heads in face-to-face communications,

and Aceh added:

- a speech read several times on the radio providing key information on vitamin A capsules.

In this one-year project, measurement of these knowledge objectives could reasonably take place only once - after the February 91 campaign for vitamin A capsules.

Not measured (due to timing) but directed at this same goal of increasing awareness were the materials developed for the campaign for August 1991.
They included:

- preparations for broadcasting the national radio spot,
- development, printing and dissemination of a formal frameable announcement from the national Head of the Family Welfare Movement to villages throughout Indonesia on the importance of vitamin A capsule distribution in August (and February),
- development, production, and dissemination of a Governor's flier in Aceh,
- vitamin A social marketing presentations at MOH meetings for Provincial Health Department Heads.

In addition to the above objectives regarding capsules, the DIP included an output for vitamin-A-rich foods.

Foods Output/Objective:

To develop a questionnaire for market research leading to a communication strategy for vitamin-A-rich foods.

The originally proposed time frame for the vitamin A rich foods objectives (which included questionnaire development, and data collection) was realistic until the MOH required a national capsule communications program. Those objectives were simplified in the Detailed Implementation Plan to the development of a questionnaire after completing the

bibliography of vitamin-A-rich foods research in Indonesia: "Food Habits in Indonesia: A Literature Review."

b. Technical Adequacy of Intervention Design and Implementation Strategy

Under the pressure of the national VAC work, project work on vitamin A rich foods suffered. The MOH is concerned about the long-term foods strategy to replace prophylactic capsules, but they gave priority to the VAC campaigns. Adhering to the original plan would have allowed time for foods work but not time for national capsules work. This was a MOH program, and MOH made decisions regarding priorities.

HKI and USAID agree that the transition to national scope was too quick in terms of institutionalizing the social marketing process.

c. Quality of Field Activities

The quality of fieldwork in a communications project is tied into the answer to three key and increasingly difficult questions:

1. Are the communications reaching the target audience?
2. Are the messages understood?
3. Are the messages being acted upon?

To answer the first question, this project used its own staff during field visits to observe and to ask questions about radio, TV, and printed materials. To monitor radio broadcasts in Central Java, village women were hired to listen to the radio and to fill in a form to indicate whether the stations were in fact broadcasting the spots as agreed. This system worked well in 2 regencies but after expansion to all Central Java, the Somavita team seems to have lost track of the reports on broadcast monitoring.

Focus group discussions and interviews were used to answer questions 1, 2, and 3 in Central Java. The moderator was a man trained in the previous project who was skilled in drawing out feedback from Javanese villagers, who are culturally reticent from speaking their minds to people of perceived higher rank. He himself was not supervised since his skills were better developed than those of anyone else. Interviews were conducted by himself and a team of junior MOH staff, under his supervision.

The team used a direct mail survey and a limited number of interviews to attempt to answer these questions outside of Central Java.

D. EFFECTIVENESS/IMPACT OF SERVICES

D1. Evidence of Impact

Objective A:

- To identify factors that increased capsule coverage rates (1988-1990).

  This objective was met in part, with findings described below:

  As found in the Rovita Project, the basic factors that increased capsule consumption rates were access to Health Posts and access to information about Health Post capsule distribution times. Through on-going analysis of the data set, other factors were also identified as important: distance of Health Post from mother (greater distance was associated with lower capsule consumption), the age of the child (the older the eligible child, the less likely he/she was to have received a capsule), the mother's education (more years of schooling was associated with increased capsule consumption), contact with the health system as measured by immunization for her oldest child <5 years of age increased (immunization of the oldest child was associated with increased capsule consumption for the youngest eligible child), and Health Post attendance in the last 6-7 months (more frequent attendance was associated with increased capsule consumption).

  The increase in capsule consumption rates from 1988 to 1989 in neighborhoods with Health Posts leveled off in 1990, but stayed constant even though the number of respondents in Health Post neighborhoods doubled (more discussion below). This finding emphasizes the importance of Health Post distribution points.

  The Distribution Alternatives Study pointed out the importance of identifying target children for capsule distribution: by knowing the children (by name), Health Post Volunteers (in Java at least) could better track down those who did not come to the Health Post session for a capsule.

Objective B:

- To identify and evaluate constraints to increasing capsule coverage rates: access to capsules and access to information.

  This objective was met, with the findings described below:

  Health Posts themselves, though increasing in number, are not always open or active. The nearest one may be too far away for a mother to walk comfortably

carrying a child or two.

Capsules are not always at the Health Posts at the correct time. Some Health Posts are dependent on a Health Center staff member for capsule distribution; these professional health staff cannot always reach every Health Post at the agreed-upon time.

In the 1990 Central Java sample, nearly half of the target mothers listened to radio less than one day a week; this rate is similar in other provinces. Of the 1990 Central Java mothers, 56% did not complete primary school and thus can read only somewhat.

Reasons for the leveling off of capsule consumption rates in 1990 are not clear, and it is not known whether sustainable communications have done the maximum they can to increase rates. That only about 1/3 of mothers go to the Health Post each month is a serious constraint to increasing capsule coverage rates.

While the 1990 Rovita/Somavita data show that in the 2 regencies, mothers have stopped using the term "fish oil," results from the Rural Omnibus 1991 study show that capsules are still called "fish oil" outside the 2 target regencies, in Central Java and in other provinces. This different term makes radio communications more difficult.

Objective C:

- To test new strategies, including an alternative distribution system for VAC and refinement of VAC communications work.

  This objective was met. A summary of the distribution alternatives study mobilizing Neighborhood Heads appears in Appendix III. New approaches to communications, including those based on the results of the distribution alternatives study, included involving three provincial governors to mobilize village administrators, developing a national radio spot announcing the change in distribution months to February and August, and filming and broadcasting the Minister of Health supporting vitamin A capsule distribution.

  Using TBAs to deliver capsules to mothers within 1 month of delivery was another channel to reach children <1; some of these TBAs also gave a capsule to a child 1-5 if s/he hadn't received one at the previous distribution.

Objective D:

- To develop detailed plans (submitted as proposal) for the expansion of social marketing of vitamin A capsules to all of Indonesia.

Activities associated with developing this national plan included informal planning sessions, formal planning meetings beginning in early October 1990, written drafts with comments from all parties, and finally, the first proposal to USAID/W in December 1990. In April, USAID/Jkt wanted to consider funding the proposal if the MOH would consider adding an NGO component to the plan for increasing consumption of vitamin A capsules and foods. The MOH is very interested in collaborating with NGOs for social mobilization; the plan was reconsidered and revised again, with input from all parties.

Quantifiable VAC Objective 1:

- To increase VAC consumption in August 1990 from 40% to 60% of target children in the Demak and Jepara regencies in Central Java.

This objective covered the second year (1989-1990) of the social marketing interventions in the Rovita/Somavita Project. Specific August 1991 activities to reach this objective included:

- broadcasting 1,550 one-minute radio spots in the Javanese and Indonesian languages in the 2 target regencies from 1-31 August, and

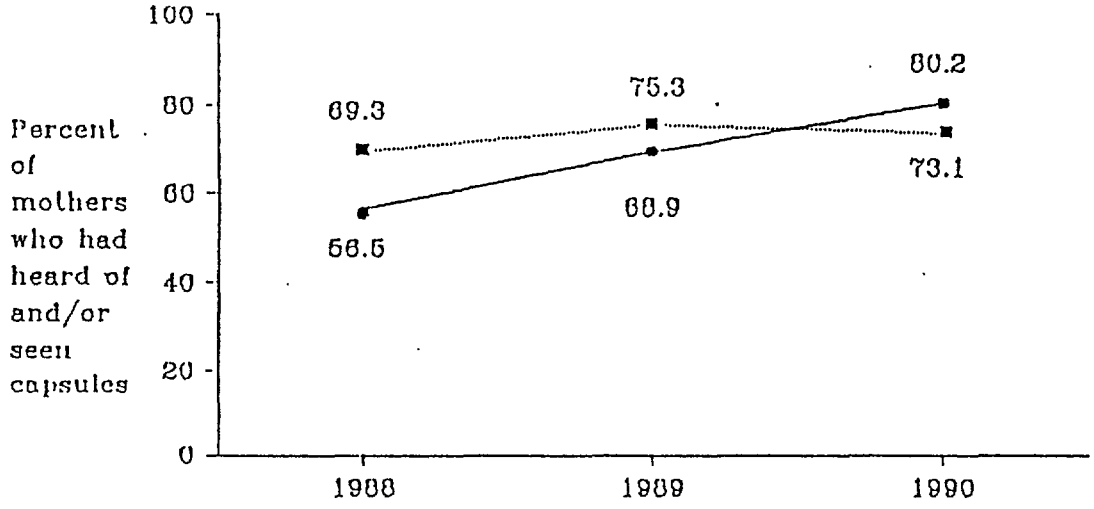
- displaying 480 banners in 438 villages, 38 Community Health Centers, and 4 other locations in the 2 target regencies.

To see if this objective was met, the Somavita Project contracted a third survey in October 1990 in the Rovita area. The survey was done on time by the same firm used in 1988 and 1989 with the same field supervisor and many of the same interviewers. The firm collected the data, edited the questionnaires, entered and cleaned the data, and provided a preliminary analysis of results. In addition, analysis on key variables was done by the Annenberg School for Communications analyst who had worked on the 1988 and 1989 surveys.[3]

Figures 1-5 below show a number of interesting results which have implications for social marketing in general as well as to the Rovita Project interventions.

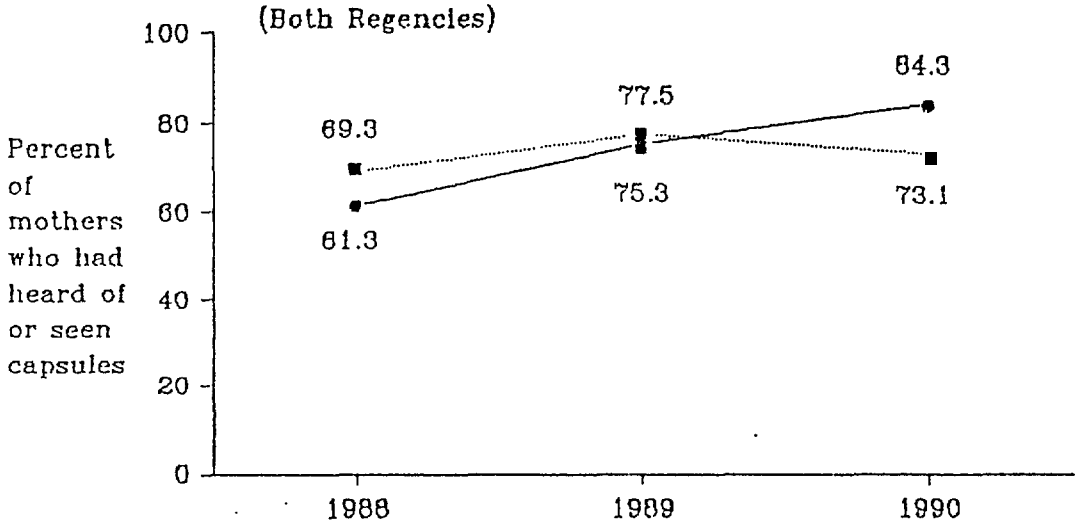
[3]These findings were presented at the Sixth International Conference of International Nutrition Planners Forum, UNESCO, Paris, 4-6 September 1991.

Figure 1. Overall Awareness of Vitamin A Capsules among Mothers (Both Regencies)



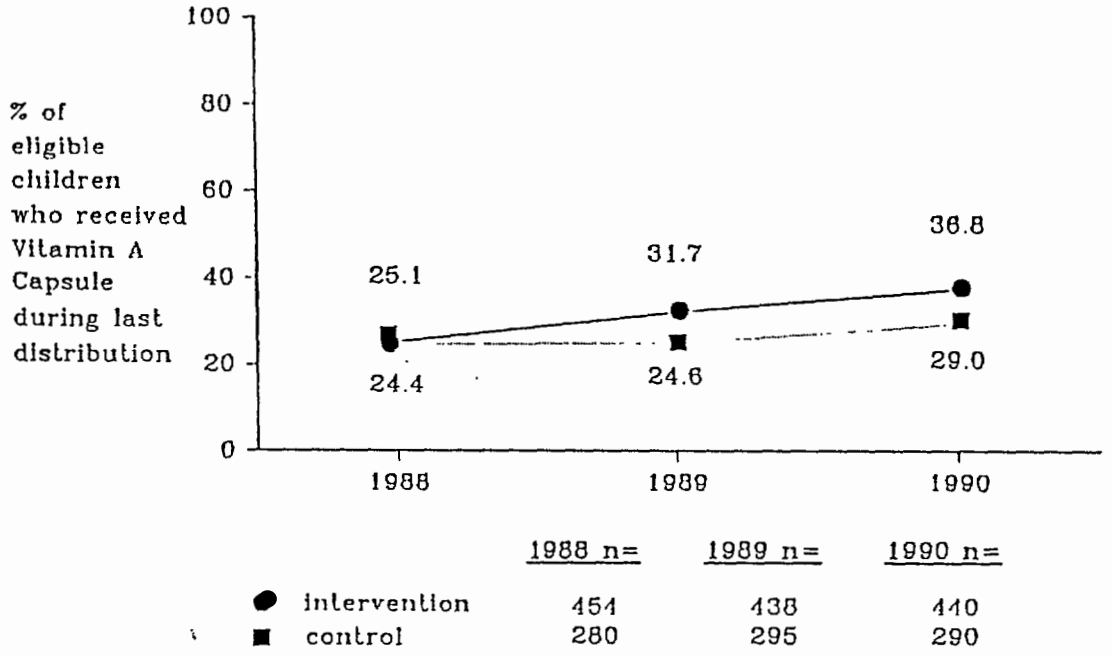
	1988 n=	1989 n=	1990 n=
• intervention	480	479	480
■ control	319	312	320

Figure 2. Awareness of Vitamin A Capsules among Mothers in Communities with a Health Post (Both Regencies)



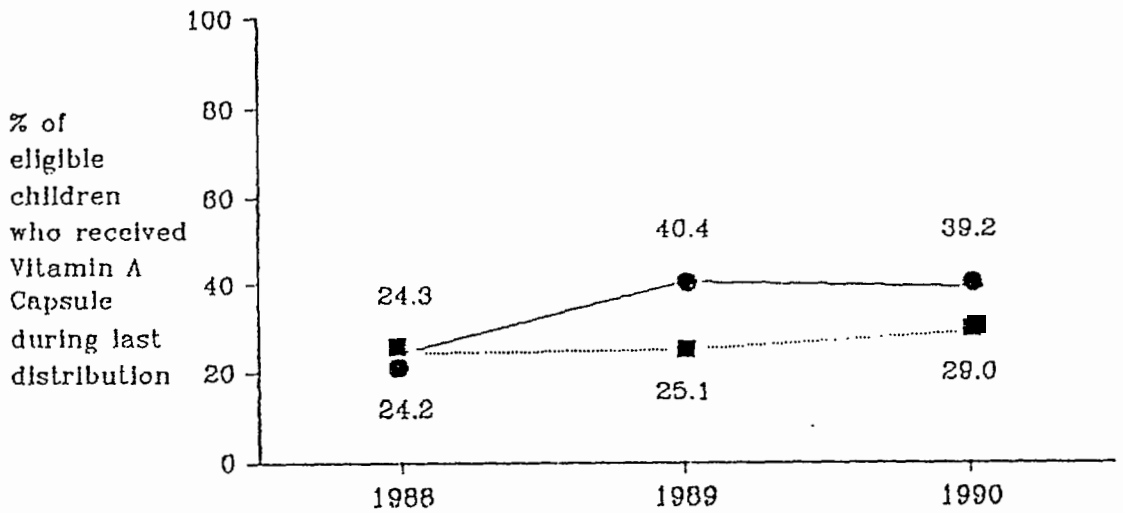
	1988 n=	1989 n=	1990 n=
• intervention	240	240	432
■ control	303	296	320

Figure 3. Overall Vitamin A Capsule Consumption (Both Regencies)



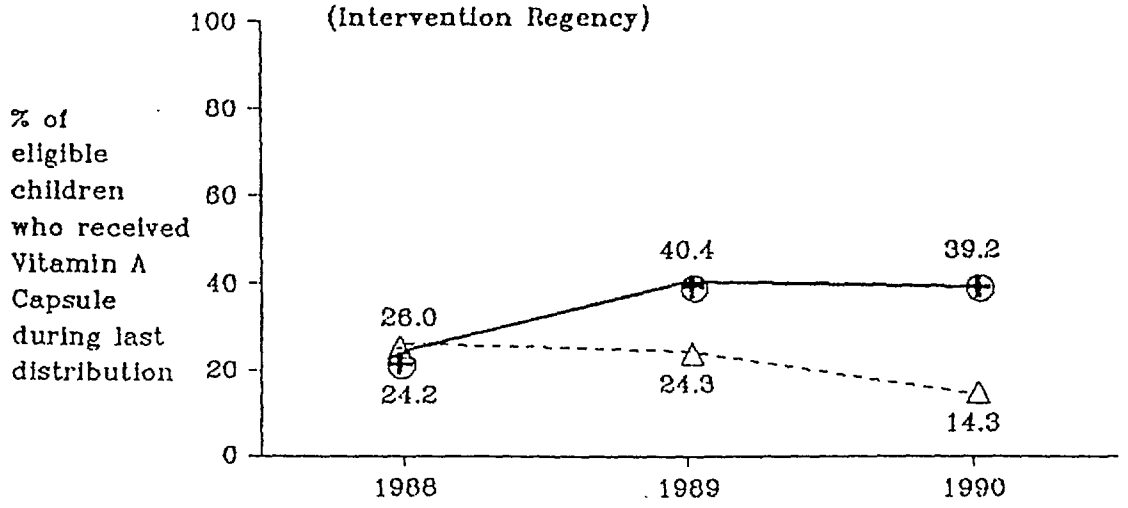
	1988 n=	1989 n=	1990 n=
● intervention	454	438	440
■ control	280	295	290

Figure 4. Capsule Consumption in Communities with a Health Post (Both Regencies)



	1988 n=	1989 n=	1990 n=
● intervention	223	203	398
■ control	267	283	290

Figure 5. Vitamin A Capsule Consumption Rates by Whether the Community had a Health Post (Intervention Regency)



	1988 n=	1989 n=	1990 n=
⊕ health post	223	203	398
△ no health post	231	235	42

In summary:

- Awareness of vitamin A capsules (mothers who had either heard of or seen capsules) in the project area rose for the 2 years from 1988 to 1990. In control areas, awareness of vitamin A capsules remained statistically unchanged.

- When there was no Village Health Post point of distribution, communications had no effect on capsule consumption rates. In the project area, capsule coverage in areas with no Health Post remained at baseline (25%) for the first year and dropped off during the second year.

- Capsule consumption rates (as reported by mothers) in project neighborhoods with Health Posts increased by 2/3 in the first year -- from 24% to 40% -- and remained at the new rate in the second year. In control area neighborhoods with Health Posts, capsule consumption rates remained statistically unchanged from baseline 25% for 2 years.

- The number of project-area mothers reporting a Posyandu in their neighborhood doubled in 1990, to the levels reported in all 3 years in the control area.

From these results, it can be concluded that the social marketing interventions made a difference. A program of multi-channel, integrated communications is associated with increasing awareness over 2 years. When there was a place to obtain a vitamin A capsule in the neighborhood, communications were associated with increased consumption rates up to a (yet unknown) limit and maintained rates at the new level even when the numbers of Health Posts increased. While reported capsule consumption rates in communities with Health Posts remained steady at about 40% from 1989 to 1990 (the second year of project interventions), the number of Health Posts doubled. This means that 40 percent of a larger number of children received capsules.

Regarding which aspects of the program were effective, statistical analyses showed that the project's communications were one factor. Awareness of capsules increased only in intervention areas, and this awareness was associated with exposure to radio messages and banners. The consumption of capsules also increased only in intervention areas. Since this capsule consumption was associated with contact with members of the health system, it is hypothesized that interpersonal communications also made a difference.

Quantifiable VAC Objectives 2 and 3:

- To increase knowledge of new capsule distribution months (February and August):

  . among MOH workers to 100%;
  . among Family Welfare Movement (PKK) heads (who are often heads of Health Post Volunteers in each village): to 100% in Central Java, and to 75% in 12 other provinces;
  . among Village Heads to 100% in Central Java, and to 60% in 12 other provinces.

A direct-mail survey was used to measure the extent to which Somavita Project interventions (television, radio, print, and interpersonal) reached this objective. In spite of an overall response rate that was too low for quantitative analysis, we can conclude that the 100% knowledge of February and August as the new capsule distribution months was not met: in no MOH category did all respondents know the correct months.

One problem was that not all respondents/MOH personnel received the communications from Jakarta. Another problem was revealed by an anecdotal report that the communications campaign months were to be February and August but the actual distribution months were up to individual provinces.

Although the response rate among village-level persons who were sent a questionnaire was too low for quantitative analysis (only 38%), the team learned that half of the respondents did not know that February and August were the capsule months. (Nothing can be assumed about the 62% who did not respond).

This direct-mail monitoring provided valuable qualitative information: it revealed a problem in the transfer of information to even the easiest of audiences -- MOH personnel and well-educated community leaders.

The direct-mail approach has potential also for valuable quantitative information at relatively low cost. To succeed quantitatively, response rates would need to be increased substantially. Since the Somavita team does not know if questionnaires did not reach potential respondents, if filled-in questionnaires did not reach Jakarta, or if the addressees simply chose not to respond, a first step in planning the next direct-mail monitoring would be to send a follow-up questionnaire to addressees to try to boost response rates.

Foods Output/Objective:

- To develop a questionnaire for market research leading to a communication strategy for vitamin-A-rich foods.

  In the end, this objective was not met due to the change in project focus, at the request of the MOH. This change reflected the shift from foods to VAC's in demands on time, but it was not clear until April/May that the food questionnaire could not be completed (ready for field work) by the end of the project in July. Work on the food questionnaire continued nevertheless, with planning and T.A. from HQ and from the AED. Part of the time taken from food work was devoted to continuing the study of alternative systems for getting capsules to children.

  The vitamin A rich food work was finally completed and included the compilation of a bibliography of research on vitamin-A-rich foods in Indonesia, and a question on egg consumption among children aged 1-5 which was analyzed in relation to other variables such as family expenditure. Mother's education was added to a private firm's large survey of rural housewives.

D2. Community Participation

Special efforts were made to involve local communities, particularly through the trials of alternatives to current capsule distribution channels. Using the Neighborhood Heads to motivate their neighborhoods was an effective way to increase capsule coverage rates.

E. HKI/HOST-COUNTRY COOPERATION

E1. MOH Involvement

HKI does not conduct projects that are independent of the Indonesian MOH. Rather, HKI provides technical assistance to the MOH's vitamin A programming. Thus, MOH involvement is intense at all levels of the project, with input into the design, financing, and staffing for project activities. The project could not exist without the MOH.

In October 1990, a steering committee meeting with key MOH officials from Jakarta and Central Java reviewed the results of the pilot project and began planning for the future. Decisions included cooperative work on the national campaign months and MOH funds to air radio and TV spots on capsules.

E2. Changes in HKI-MOH Collaboration

The change in focus from Central Java to a national program meant more face-to-face collaboration between HKI and the national policy-makers in nutrition and in the Health Education Center. Prior to the change, the national policy-makers had primarily given overall direction, responded to specific questions on policy, and had left implementation to the provincial MOH/UnDip/HKI team. This change is beneficial in that national policy-makers are becoming more aware of the field perspective, especially in terms of capsule supply.

With the direct involvement of the new Deputy of the Central Java MOH, work with the Central Java MOH increased in quantity and in variety. New activities began in Aceh Province as a result of collaboration with both the Health office and the Governor's office.

E3. Effects of Somavita on MOH activities

The plan for expanding the social marketing of vitamin A capsules and for the social marketing of vitamin A-rich foods was developed in collaboration with the MOH and included the use of MOH staff and funds. Details for the implementation of specific activities are being worked out by the MOH/HKI team at the time of this writing.

Collaboration between the MOH and UNICEF and networking between HKI and UNICEF have been in place for years, but due to a change in the project scope, the 3 agencies began working together. This relationship has been formalized by inviting UNICEF to attend formal steering committee meetings with the HKI team for the activities proposed in the expansion plan.

After seeing the Central Java Governor's flier, the Health Department and Governor's office of West Java, the province with the highest population in Indonesia adapted the idea and distributed their own governor's fliers to villages.

MOH-Nutrition is committed to social marketing efforts. The annual budgets for 1991/1992 and 1992/1993 include funds for a two-week training each year of provincial-level nutrition staff.

F.SUSTAINABILITY

F1. Community Motivation and Participation

Social marketing is a consumer-focused process. The Somavita Project involved mothers and community leaders individually and in groups in the development and monitoring of communications. "Communities" in the sense of whole neighborhoods did not work directly with the Somavita Project team: this was a communications project of national scope rather than a project to develop a health system in a community.

Village-level leaders of the Family Welfare Movement (PKK) are involved in running Health Posts and managing the volunteers. A printed message to them from the national Head of PKK was developed and printed in this project to mobilize their commitment to the capsule distribution program.

It is not known whether community leaders felt that Somavita Project activities met their current health needs. (I suspect not: since the findings on the connection between child survival and vitamin A have not yet been disseminated in Indonesia, the most common understanding of the role of vitamin A is blindness prevention).

Many NGOs represent "the community." The Somavita Project staff trained NGO personnel in vitamin A, involved NGOs in improving materials, and trained kindergarten teachers about vitamin A. Each organization works at the village level and has great potential for national impact.

F2. Commitment of the MOH

The MOH is committed to vitamin A activities because of the undisputed connection between vitamin A and xerophthalmia and because of the findings on the relationship between vitamin A and child survival.[4] This commitment is reflected in the announced

[4] The direct relationship between vitamin A deficiency and mortality has been documented since McCollum's work in 1913; the latest findings from India and Nepal support the positive effects of vitamin A supplementation on mortality in young children.

goal of the Minister of Health to eliminate xerophthalmia as a public health problem by 1993 and vitamin A deficiency as a public health problem by 1995. The MOH has brought in a short-term social marketing consultant from Cornell to help full-time for 2 months with the nutrition section's communication strategy.

The MOH is committed to vitamin A activities for the long term. Barring unlikely unsolvable problems, fortification of foods with vitamin A will be underway in the next year, required by the MOH and paid for by the consumers; vitamin-A-rich foods will be promoted in conjunction with other nutrition promotions such as iron, iodine, and breastfeeding), and capsules will continue to be used when needed. The social marketing process will continue as a communications strategy: an MOH-funded workshop in October 1991 will train a Nutrition Section delegate from each province, and a similar workshop is planned for the next year.

F3. Administrative Efforts towards Cost-effectiveness

In general, the project team sought out low-cost interventions and low-cost ways of accomplishing goals. Examples are described below.

- Using fliers to mobilize village leaders to motivate mothers and Health Post volunteers is far cheaper than the costs involved in training volunteers.

- Using a direct-mail self-administered questionnaire survey for monitoring communications effectiveness is less expensive than conducting focus groups or interviews across Indonesia and avoids interviewer bias. (Inexpensive ways of increasing response rates, however, need to be found to maximize the usefulness of this tool).

- Printing in one color is cheaper than full-color, but fliers (8-1/2x14") attractively designed and printed in full color become inexpensive mini-posters which are put up where people can see them.

- The Somavita Project used semi-private radio stations for broadcasting vitamin A spots nationally: these, with MOH guidance, provided free air time. (The constraint is that frequency of the broadcasting of project spots depends on each individual station).

F4. Cost Recovery

The only specific cost recovery mechanism discussed has been the possibility of getting mothers to pay a small amount for the capsules. This possibility had been roundly rejected in previous years; now the Head of the Nutrition Directorate is interested in trying it in a very limited area.

In some areas, mothers already pay a small fee to their Health Posts to cover the costs of supplemental food, which attracts mothers to the weighing session. Thus, this fee provides "free advertising" for Health Post services.

F5. Post-project Activities and Plans:
Continuation of Activities Begun in This Project

- The vitamin A capsule communication campaign for August 1991 distribution (radio, television, and print) will continue through 31 August.

- The August 1991 campaign activities will be monitored using direct mail.

- Results of the 1991 Rural Omnibus questions will be given to the Health Department and others.

- A paper on the Rovita Project results from 1988 - 1990 will be presented in September, at the Sixth International Conference of International Nutrition Planners Forum in Paris.

- The orientation for MOH provincial Nutrition Section Heads will include lessons learned from this project.

- A national meeting to discuss and coordinate the implementation of Indonesia's vitamin A policy will be organized and will take place in November 1991. Participants will include GOI policy makers, vitamin A researchers, nutrition/diet researchers, and program implementors.

- A special issue of Gizi Indonesia (Nutrition Bulletin) in April or May of 1992 will be devoted to articles on vitamin A, including activities in this project.

- By the end of October, UNICEF will have printed and disseminated the vitamin A Deficiency Guides which were developed in the Rovita and Somavita Projects.

- Work will continue on dietary surveys coordinated with the Nutrition Research Institute, UNICEF, the MOH, and HKI.

- Investigations into alternatives for enhancing Posyandu distribution of capsules will continue in Central Java, and a new trial will begin in NTB.

- A two-week training in the social marketing process for nutrition staff from 27 provinces will be held in October 1991.

G. PROJECT FINANCES

G1. Planned vs Actual Expenditures

USAID PVO

G2. Recurrent Costs

H. LESSONS LEARNED AND RECOMMENDATIONS

H1. LESSONS LEARNED

Awareness

- In Health Post neighborhoods over a two year period, project interventions increased mothers' awareness (having heard of or having seen) of vitamin A capsules, from 61% in 1988 to 84% in 1990.

Capsule Consumption

- In the pilot Rovita intervention area between 1989 and 1990, capsule consumption in Health Post neighborhoods remained constant at about 40%, while consumption in the control area increased somewhat to 29%.

- When the number of reported Health Post capsule distribution sites went up, the communications efforts were able to sustain capsule consumption rates at about 40% of target children.

- Within the group of children eligible for capsules, the older the child, the less likely s/he is to be taken to a Health Post for a capsule.

- Pretesting of the VAC Logistics Study questionnaire highlighted problems in the system for supplying capsules to Health Posts.

Health Communications

- A multi-channel approach is necessary to reach the variety of people important to capsule distribution -- consumers (mothers), service providers (volunteers, MOH personnel), and local leaders (village staff, PKK leaders, religious leaders).

- A multi-channel approach including interpersonal communications is necessary to reach hard-to-reach mothers.

- Village administrators can be important in identifying the target children and in reaching the hard-to-reach mothers who do not listen to radio and do not attend Village Health Posts.

- It is easy to forget the target audiences (consumers) when developing messages: pre-program assessment and pretesting of materials are too often omitted when time is short.

- Messages reached villages: Somavita Project TV spots were seen in villages; radio was heard; fliers reached villages and were posted.

- Formal, clear letters from the Head of the Nutrition Directorate and the special printed and signed Message from the Director-General for Public Health did not guarantee that all MOH Nutrition personnel knew that the new capsule distribution months are February and August.

- Using private sector firms to assist in message development and production requires intensive supervision but enhances variety and creativity.

Evaluation

- Assessment of the project impact (and the cost-effectiveness of USAID input) requires a variety of inputs.

  For example, the Somavita Project assessment includes: a 1990 survey of 800 mothers in Central Java which continues to track progress during the 2nd year of pilot Rovita interventions, information from mail surveys with questionnaires sent to 13 provinces, information from 1991 questions asked in a Rural Omnibus survey, qualitative information obtained through interviews and focus groups of mothers, health workers, and village officials, and information from a study of the logistics of getting capsules from the port of entry into the mouths of children.

- Control areas for evaluation purposes easily become contaminated.

  In spite of the careful assessment of radio stations and broadcasting reach, control area mothers also heard project radio spots. In addition, rapid institutionalization of some project interventions meant that those interventions were implemented in the control area as well as in the intervention area.

- Externally-conducted surveys cannot answer all evaluation questions but are needed to answer some of them.

  For example, the number of Health Posts increased in our intervention area to a level equal to that in the control area. The survey of mothers could not anticipate such a dramatic change and had no questions that could have explained it.

- The most accurate information on real capsule consumption/ingestion rates is far too expensive to obtain on a large scale.

  Mothers' own reports to disinterested interviewers of whether their child had a capsule are the next best option: there may be slight inflation of numbers (since people like to say yes), but careful sampling can provide an accurate denominator.

- Inaccuracies in reporting the denominator in calculated capsule consumption rates result in inflated consumption rates not based on the total number of children who actually live in an area.

- Health Department staff need to feel free to collect health information with the goal of learning and reporting on what is happening in their own system.

- Evaluation results not shared are not useful.

  For example, one province developed and produced 15 banners without knowing that the Pusat team had concluded that banners were not able to reach the hard-to-reach.

Management Issues

- Supply of capsules at Health Posts is not certain.

- MOH can and does make decisions quickly that will affect 179 million people throughout Indonesia.

- Having modern communications equipment does not mean that communications are easy, rapid, or cheap.

  Having the equipment leads to expectations that it will work as effectively as designed, but this depends on an external infrastructure. For example, when telephone lines are overloaded, telephone and fax communications are delayed at best. Indonesian telephone charges are always expensive.

- Communications within the MOH must not be taken for granted.

  e.g., a message to provincial Nutrition staff on capsule months was not necessarily communicated to the Health Education staff in charge of the health extension messages.

- Communications within the PVO (between Jakarta and provincial offices) can be difficult and must not be taken for granted.

- Involving provincial Governors in contacting the village administrators responsible to them strongly reinforces the importance of the MOH message.

- Multi-agency collaboration is important for the efficient use of manpower and funds.

  Somavita needed information on vitamin-A-rich foods and capsule consumption rates in many provinces. Draft plans (including funding) and a questionnaire were developed among MOH, the Nutrition Research Institute, Unicef, and HKI to collaborate in gathering this information for the benefit of all interested parties.

- Multi-agency collaboration is difficult.

  The planned nutrition survey in collaboration among MOH, the Nutrition Research Institute, Unicef, and HKI did not materialize due to delays that went past the deadline for availability of funds.

- One year was not time enough both to conduct nation-wide capsule activities requested by the MOH and to complete the design for marketing research (including a questionnaire) on vitamin-A-rich foods.

H2. RECOMMENDATIONS FOR FUTURE WORK

1. Continue work on capsule supply/distribution systems.

2. Continue work on distribution and communication channels to reach the "hard to reach" mothers and children.

3. Continue a multi-channel approach to communications.

4. Begin to focus communications on the importance of vitamin A to child survival.

5. Allow more time for pretesting communications with the target audience.

6. Continue to plan together and work as a team with all persons involved -- including funders.

7. Continue collaboration with other government and non-government organizations.

8. Allow more time for evaluation.

9. Focus evaluation on identifying problems as well as achievements.

10. Establish a system for sharing the results of evaluations with MOH, donors, NGOs, and others.

Collaboration with other NGOs has begun, particularly in West Nusa Tenggara (NTB) province, where a local NGO working with PATH developed a local-language version of the national radio spot and broadcast it.

SOMAVITA PROJECT

August 1990 - July 1991

FINAL REPORT

SUMMARY

The Somavita Project was funded for one year as a bridge between the Central Java pilot Rovita Project (1986-1990) and a program for the large-scale expansion of social marketing of vitamin A capsules combined with starting the social marketing of vitamin-A-rich foods in Indonesia.

This project provided technical assistance to the MOH vitamin A programs. MOH involvement at all levels was intense and included designing, financing, and staffing for project activities. Careful planning of a 3-year program to reduce vitamin A deficiency in Indonesia through capsules and foods continued throughout this project. National communications were important in establishing that the new MOH policy affects the nation as a whole, and a nation-wide communication strategy began in February 1991 with radio, TV, and printed materials. At the same time, the team began a phased approach for province-specific work by continuing activities in Central Java and beginning new capsule activities in Aceh, where there has already been a program for the social marketing of vitamin-A-rich foods.

In brief, the 4 principal objectives of the Somavita Project were:

- to identify factors that increased vitamin A capsule coverage rates in 2 Central Java regencies, from 1988-1990.

- to identify and evaluate constraints to increasing coverage rates (especially access to vitamin A capsules and access to information),

- to test new strategies (alternative distribution channels and improved communications), and

- to develop plans for expansion to all Central Java.

Added quantifiable objectives were:

- to increase VAC consumption in August 1990 from 40% to 60% of the target children in Demak and Jepara regencies in Central Java through continuing special campaign activities in those two areas

- to increase the knowledge of new capsule distribution months (February and August) among MOH nutrition staff and village leaders

Activities to Identify Factors that Increased Vitamin A Capsule Coverage Rates

The third wave of the KAP Survey in intervention and control areas was completed. By comparing the new 1990 Central Java data set with 1988 and 1989 sets, the team learned that mothers' awareness of vitamin A capsules continued to increase during the second year of interventions and that VAC coverage rates in Posyandu areas were maintained at the new 40% level. In the 1990 sample, the number of respondents reporting a Posyandu in their neighborhood was twice that in the 1988 and 1989 samples -- yet the same 40% coverage rates held, meaning that more children received a capsule.

A Distribution Alternatives Study looked at the important problem of making capsules more accessible to mothers by enlisting the Neighborhood Heads (Kepala RT) in the registration of children eligible for capsules, which in turn increased capsule consumption.

Communications activities

Because of the shift in national policy from open dispensing of vitamin A capsules throughout the year to dispensing during only 2 months each year, communications focussed on informing the public of the importance of capsules and the new distribution months.

To assist the MOH vitamin A program, the Somavita Project supported the development, production, and dissemination of:

- radio spots, announcements, and speeches,
- television fillers,
- printed materials directed to the general public
- special printed materials to stimulate interpersonal communications directed to Health Department officials in 13 high-risk provinces
- special printed materials to stimulate interpersonal communications directed to Health Post volunteers in 231,000 villages throughout the country
- special printed materials to stimulate interpersonal communications directed to formal village leaders (from the governors of 3 provinces with a total 1990 population of 67,311,000)

In addition, the Project continued to assist in the development of 2 companion posters/guides for preventing and treating vitamin A deficiency, which will be printed in August 1991.

To evaluate these communications, regular monitoring continued through interviews, focus group discussions, and the hiring of village residents to listen to radio, and 2 new approaches to using questionnaires were developed for potential village-level interviewers and for potential village-level respondents.

Developing Plans for Expansion

Planning continued throughout this one-year project. Written versions were submitted for funding to USAID and to a Netherlands NGO. USAID/Jakarta funded a revised plan that included collaboration with local NGOs -- who will play an increasingly important role in interpersonal communications and perhaps in helping to see that target children are given vitamin A capsules.

Other Activities

Several Indonesian NGOs working in villages were trained in vitamin A issues and learned the process of pretesting vitamin A materials for intended target audiences.

An annotated bibliography of research on the consumption of vitamin-A-rich foods in Indonesia was completed.

Successes

- Mothers' awareness of the product being marketed (vitamin A capsules) continued to rise in the second year of social marketing interventions.

- In Rovita intervention areas, the new 1989 capsule consumption rates were maintained in 1990 when the number of Health Posts increased. Factors were identified in the potential success of social marketing efforts to increase capsule consumption rates.

- In this project, new collaboration on vitamin A was initiated between the MOH and the Ministry of Home Affairs (covering provincial Governors and village administrators).

- Initial findings suggest that using printed materials can stimulate face-to-face communications.

- The MOH is beginning to be committed to the consumer-oriented social marketing process for health communications and to vitamin A for child survival. Some money for training in social marketing and for vitamin A communications has been planned and budgeted for the future.

- Dissemination of project results at the IVACG Meeting in June 1991, at the International Nutrition Planners Forum in September 1991, and in Montreal in October 1991 have highlighted Indonesia's pioneering efforts in vitamin A, especially social marketing of vitamin A capsules.

Weaknesses in Implementation

The MOH shift in scope from 2 regencies with a population of 1.5 million, to a nation of 179 million people happened too quickly for the thorough application of the social marketing process. Since the MOH, USAID, and HKI are long-time partners in health development activities, however, the Somavita Project team continued to advise careful planning, a phased approach and took the opportunity to help with and learn from the management issues involved in the large-scale expansion effort.

Under the pressure of the national VAC work, including continuing work to identify factors important to VAC consumption, project work on the consumption of vitamin A rich foods suffered: the planned questionnaire was not completed.

A third weakness in this project is that a system for health information was not established. Although information was collected, the analysis, compilation and results were completed much later than planned, and thus the usefulness was less than anticipated.

Conclusion

In spite of the weaknesses described above, USAID child survival funds were well-spent for the reasons cited below.

1. Vitamin A is an appropriate child survival intervention.

   Recent research results (some funded by USAID) are supporting earlier animal studies on the important role vitamin A by itself plays in reducing child mortality.

2. Vitamin A is an appropriate intervention for Indonesia.

   In Indonesia, a recent survey of xerophthalmia and blood serum vitamin A levels in 4 provinces has shown that even in provinces without significant xerophthalmia, blood serum analysis shows that the children are, by WHO standards, deficient in vitamin A. Vitamin A deficiency remains a public health problem in Indonesia. Through this project, USAID was able to show continued support for improving the MOH's vitamin A program by funding technical assistance and special operations research work. This allowed the MOH extra funds needed to try new refinements of its own regularly budgeted communications activities, to identify factors important to increasing vitamin A capsule consumption rates, to develop long-range plans for the large-scale social marketing of vitamin A capsules and to plan for the social marketing of vitamin-A-rich foods.

3. Social marketing using a mix of mass media and interpersonal communications is appropriate to Indonesia.

   Mass media, especially television, offers an economy-of-scale for the production and dissemination in this large country but needs to be combined with face-to-face communications specific to the wide variety of regions and cultures. The Somavita Project contributed to the quality and innovativeness of mass media and interpersonal communications channels.

4. Information learned about vitamin A programming and communications is applicable to other child survival and health programs in Indonesian and elsewhere.

   Information has been shared within Indonesia and at meetings such as the International Vitamin A Consultancy Group, the International Nutrition planners' Forum, and the Unicef/WHO Micronutrients Conference in Montreal.

SOMAVITA PROJECT ACTIVITIES
August 1990 - July 1991

Radio Interventions

- 1,550 Central Java radio spots broadcast in 2 regencies, August 1990
- radio spots developed, produced, distributed to, and broadcast in several provinces in February 1991 to announce February and August as the new capsule distribution months
- national February radio spot revised produced, and distributed for August 1991 campaign
- speeches broadcast in Aceh: written by the MOH-Aceh (one in February and one read by the Governor in late July).

Television Communications

- television coverage of the Food and Nutrition Awareness activities, including showing the Minister of Health giving a vitamin A capsule
- televised statement by the Minister of Health
- film, "Sebelum Terlambat" ("Before It's Too Late") about curing nightblindness with vitamin A
- a new 2-minute filler on capsules

Print Communications

- 480 Rovita Project banners displayed August 90 and February 91
- 15 banners produced and distributed in Aceh, July 91
- final draft of Vitamin A Deficiency Guide layout submitted to UNICEF for printing
- newspaper articles in February on nutrition and vitamin A activities

Print to Stimulate Interpersonal Communications

- collaboration with UNICEF, MOH, PKK, and HKI to develop, produce, and disseminate a Message to PKK Heads in 231,569 villages across Indonesia
- Central Java governor's flier to mobilize Village Heads in VAC distribution: printed and disseminated in January/February and in July/August

- Aceh governor's flier to mobilize Village Heads in VAC distribution: developed, produced, and disseminated in July/August

- West Java governor's flier: developed, produced, and disseminated in July/August

NGO Training

- on vitamin A

- in using the press for communications on vitamin A

- in social marketing techniques for pretesting materials

Capsule Distribution Alternatives Work

- Phase 1 conducted August-October 1990

- Phase 2 conducted February-April 1991

Capsules Logistics

- capsule supply study designed and questionnaire pretested

Vitamin-A-rich Foods

- compilation of a bibliography of nutrition research in Indonesia

- on-going work to developing a national strategy for foods

- first market research, on egg consumption by children <5

Health Information / Evaluation

- Survey III (October 1990) of mothers' knowledge, attitudes, and practices (KAP) regarding vitamin A capsules planned, conducted with T.A., and reported

- direct-mail questionnaires to monitor campaign activities

- vitamin A questions included in a private-sector Rural Omnibus Survey in 8 provinces

- monitoring the effects of the policy of giving new mothers a high-dose capsule in 2 Central Java regencies

Developing Plans for Expansion of Capsule Communications

- clarification of new policy and strategy
- writing and revising detailed plans

Dissemination & Presentations

- vitamin A social marketing presentations at Pimpro meetings
- NGO training on vitamin A
- formal presentation of vitamin A social marketing results to the International Vitamin A Consultancy Group Meeting in Ecuador, June 1991
- presentation at Ministry of Agriculture workshop on "Using Home Gardens to Improve Family Nutrition," Bogor, Indonesia, 12-15 March 1991
- project area chosen as site of part of a Lions-sponsored international film on the prevention of blindness

Appendices completed

HELEN KELLER INTERNATIONAL

Cooperative Agreement
No. OTR-0284-A-00-0117-00
Indonesia

SOMAVITA PROJECT

SOCIAL MARKETING OF VITAMIN A

1 August 1990 - 31 July 1991

APPENDICES

to

FINAL REPORT TO USAID

APPENDICES

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IV. DISPENSING OF CAPSULES TO NEW MOTHERS BY TBAs

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VIII. VITAMIN A DEFICIENCY GUIDE

IX. GUIDE TO POSYANDU PROMOTION CHARTS, PRETESTED BY NGOS

X. MATERIALS FOR THE FEBRUARY 1991 CAPSULES CAMPAIGN

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XII. ROVITA (1988-1989) PAPER PRESENTED AT IVACG

XIII. ROVITA (1988-1990) PAPER PRESENTED AT INPF

APPENDIX I

GLOSSARY OF TERMS

AED	Academy for Educational Development, source of long-term T.A. for Somavita
DIP	Detailed Implementation Plan
HQ	headquarters/ home office
kabupaten	regency = county
kecamatan	district
MOH	Ministry of Health
NTB	Nusa Tenggarah Barat province
PKK	Family Welfare Movement, a national women's organization reaching down to the village level
Posyandu	Post for Integrated Services = Village Health Post
Puskesmas	Community Health Center
Rovita	Rehidrasi Oral & Vitamin A: acronym for Rovita Project to promote oral rehydration therapy and vitamin A
Somavita	Social Marketing of Vitamin A
TBA	Traditional Birth Attendant
VAC	vitamin A capsule, 200,000 IU
WHO	The World Health Organization

APPENDIX II

SOMAVITA PROJECT ACTIVITIES
August 1990 - July 1991

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- project area chosen as site of part of a Lions-sponsored international film on prevention of blindness

APPENDIX III

DISTRIBUTION ALTERNATIVES STUDY

EXECUTIVE SUMMARY

Because of the Rovita Project finding that one serious constraint to increasing capsule consumption is the limited amount of time that capsules are available to mothers and children -- 2-3 hours every six months. Phase 1 of the Distribution Alternatives Study tested increasing the window of opportunity by asking Neighborhood Heads (Kepala R.T.) to help with the registration and then with the giving out of capsules for 6 days after the regular Health Post session. Based on interviews with mothers, capsule consumption rates increased but because the Neighborhood Head felt some responsibility for seeing that the registration was done and that mothers went to the Health Post session, not because they gave out capsules themselves.

Phase 2 of the Distribution Alternatives Study was conducted in Somavita Project and itself consisted of two parts. In the Phase 1 intervention areas, the only study intervention for February 1991 was to provide registration forms to the district (kecamatan) level in order to see if the improvements from Phase 1 interventions would be sustained with minimal intervention. In new areas, the Phase 1 interventions were repeated to see if they had the same effect as before.

Results showed that in the Phase 1 areas, the registration forms were easily updated and the capsule coverage rates remained high with the minimal re-intervention.

In the new areas, again the Heads of Neighborhoods did not personally hand out capsules, but everyone involved in the distribution worked harder. A continuing problem, however, is the focus on registration and "coverage" instead of on getting capsules into the mouths of as many children as possible.

Recommendations from this study are three: to strengthen the message that capsules must go into the mouth of each child, to simplify the registration form, and to direct communications to the Neighborhood Heads in order to use them to intensify the effectiveness of the current Health Post distribution system.

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EXECUTIVE SUMMARY

APPENDIX IV

DISPENSING OF CAPSULES TO NEW MOTHERS BY TBAs

Included in Health Department policy is the instruction to give mothers within 40 days of delivery one 200,000 IU vitamin A capsule. Since most deliveries are attended by a traditional birth attendant (TBA), and since many TBAs receive in-service training every 5 weeks from their local Community Health Center, Health Centers in 2 Central Java regencies began the program of supplying TBAs with high-dose capsules for new mothers. This report summarizes information from interviews in 3 Health Center service areas with Health Center midwives (who administer the TBA program), with 20 TBAs who attended the in-service trainings in September, and with 22 mothers of children under one year old.

Role of Health Centers in Training TBAs to give vitamin A capsules

About half of TBAs in the routine program attend each TBA training. Initial instruction in giving capsules at delivery required 45-60 minutes, and refresher information at successive sessions took less time. Training materials varied from Health Center to Health Center and included the Guide (poster), the Rovita Project training manual, and a flip chart. Out of 112 TBAs in the Health Center training programs, 101 were judged skilled enough to give out capsules. Sometimes TBAs ran out of capsules before the next in-service session. There were no report forms.

Ability of TBAs to give out capsules

All 20 TBAs interviewed worked also in farming; over half had worked as TBAs for 20 or more years, and half said they could read and write. Nineteen of the 20 TBAs remembered the name "vitamin A" capsule. All 20 said the capsules were for new mothers and 7 said they were also for children 1-4 years. Nine said neither pregnant women nor babies should get capsules, and 6 said just children < 12 months should not get a capsule. Twelve of 20 TBAs said that capsules were only for eyes.

TBAs received capsules in a bottle or a plastic bag and kept them at home (in their TBA kit if they had one). They reported dispensing to the Health Center, mostly orally. One said she hadn't reported at all.

Extent of coverage of vitamin A capsules among target mothers

Of the 22 mothers interviewed, 10 had received a capsule from their TBA, and 5 of them said their TBA had provided information about the capsule. Three of those who had not received a capsule were attended by the same TBA who had not gone to Health Center in-service training in a long time.

Recommendations

Integrate this program into in-service trainings, and strengthen motivation of TBAs to attend these trainings. Develop a uniform guide to field implementation, including reporting. Estimate & request capsule needs for new mothers. TBAs may need stronger training on not giving capsules to pregnant women and to children <5 and to tell mothers that VAC is for both their nursing baby's general health and their own.

APPENDIX V

VITAMIN A CAPSULES LOGISTICS STUDY

FIELD PRETEST[1]

Pretesting for the logistics study was delayed due to delay in arrival of letters authorizing the survey in West Java.

August Independence Day celebrations occupy the week before and the week after 17 August, with Posyandu activities delayed until the 25th. Data collection will begin 25 August, with the possibility for some Posyandu observations during the first week of September.

The pretest in West Java illustrated the organization of capsule distribution and highlighted the need for the name of the responsible person to contact at each level.

Respondents in the pretest were basically appropriate. MJM found more than one Posyandu in villages and Pos Desa.

Additional respondents will be added: mothers will be interviewed as a cross-check on posyandu data. The people responsible for the capsules gave less attention to the expiration date than to "change" in color and smell.

Interviewers found that transmittal and receipt slips did not indicate batch number or expiration dates on the bottles of capsules. In the pretest area, one kabupaten returned to the province 500 bottles of expired capsules, but the respondent could give no other information.

In the course of this pretest, MJM interviewed national level people and got a picture of the distribution system.

The four questionnaires drafted for the pretest need to be revised before the survey is conducted.

To be sure of maximum opportunity to observe the dispensing of vitamin A capsules at Posyandus, the schedule of fieldwork needs careful attention. The pretest showed that, excluding travel time, obtaining data requires 2-3 hours each location -- provincial, kabupaten, Puskesmas, and Posyandu.

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[1]This is a summary of the 4-page Indonesian-language report submitted by Manggala Jiwa Mukti to HKI on 20 August 1991.

APPENDIX VI

STATEMENT ON VITAMIN A

Benny A. Kodyat, Head of Nutrition Directorate
Lions Film Interview, 22 July 91

Transcript	Translation
Masalah gizi, termasuk masalah kekurangan vitamin A di Indonesia, masih merupakan masalah kesehatan masyarakat karena prevalensinya masih tinggi.	Nutritional problems, including vitamin A deficiency in Indonesia, are still a public health problem because prevalence is still high.
Memang keadaan produksi bahan makanan pun penyediaan bahan makanan itu sudah mencukupi penduduk, tetapi sampai sekarang masih dijumpai banyak kekurangan gizi dimasyarakat terutama anak-anak.	Although food production and availability are adequate for the population, so far there is still a lot of nutritional deficiency, especially among children.
Ini disebabkan antara lain karena belum meratanya pengertian gizi di masyarkat terutama ibu-ibu dan anak-anak. Oleh karena itu, kita lihat bahwa banyak bahan makanan sumber-sumber gizi yang baik, misalnya saja sayur-sayuran dan buah-buahan dimana-mana ada, tetapi dilihat masih banyak anak-anak yang kekurangan vitamin A karena mereka tidak diberikan sayur-sayuran maupun buah-buahan oleh orangtuanya.	This is because, among other things, nutrition is still not understood by the people, especially mothers and children. Because of this, we see that many foods are sources of good nutrition, such as fruits and vegetables found anywhere, but there are still many children with vitamin A deficiency because they aren't given fruits and vegetables by their parents.
Hal ini disebabkan karena itu kebiasaan-kebiasaan yang kurang baik, pantangan-pantangan karena kebiasa--, karena kepercayaan dimasyarakat itu sendiri ataupun karena anak-anak sendiri memang tidak suka pada sayur-sayuran.	This is a result of poor habits, because of popular beliefs or because the children themselves don't like vegetables.
Statement-2	
Nah, oleh karena itu, pemerintah -- dalam hal ini dalam meningkatkan status gizi, terutama untuk menanggulangi masalah kekurangan vitamin A --melaksanakan program.	Because of this, the government -- in order to improve nutritional status, particularly in taking care of the problem of vitamin A deficiency -- is implementing programs.

Itu program jangka pendek yaitu dengan distribusi kapsul vitamin A yang dilaksanakan oleh kader-kader di Posyandu,

Our short-range program is the distribution of high-dose vitamin A capsules by village Health Post volunteers,

dan distribusi kapsul vitamin A ini diberikan kepada anak-anak dibawah lima tahun setiap enam bulan sekali, yaitu Februari dan Agustus ...

and these vitamin A capsules are given to children under 5 years old twice a year, in February and August ...

Program menengah itu dengan fortifikasi terhadap bahan makanan umum dimakan oleh masyarakat, terutama oleh anak-anak; dan melalui penelitian ternyata MSG adalah bahan makanan yang sangat populer dan sangat disukai dan juga banyak dikonsumsi oleh masyarakat.

Our mid-range program is fortification of foods commonly eaten, particularly by children; according to research, MSG is the food which is very popular, well-liked, and eaten a lot.

Sehingga pemerintah berusaha untuk meningkatkan kualitas MSG dengan menambahkan vitamin A. Tetapi program ini sementara masih dalam "pilot project" sudah berhasil dan akan diteruskan.

Thus the government is working to increase the quality of MSG by adding vitamin A. This program is still a "pilot project" and has shown good results and will be continued.

Tetapi ada masalah teknis karena warna MSG menjadi kuning, maka masih dalam taraf penelitian di laboratorium.

There is a technical problem because the MSG became yellow; this is being researched in the laboratory.

Kemudian program jangka panjang ialah program dengan penyuluhan gizi atau pendidikan gizi kepada masyarakat untuk meningkatkan kesadaran masyarakat supaya banyak mengkonsumsi sumber vitamin A secara alami yaitu sayur-sayuran dan buah-buahan.

Then, our long-rang program uses nutrition extension or nutrition education to the people in order to increase awareness so that many will get vitamin A from natural sources -- fruits and vegetables.

Statement-3

Dan penyuluhan gizi ini dilaksanakan baik secara langsung maupun tidak langsung.

This nutrition education is done directly and indirectly.

Yang langsung dilaksanakan melalui televisi, radio, surat kabar, majalah dan lain-lainya,

It is done directly via television, radio, newspapers, magazines, and others,

sedangkan yang (tidak) langsung yaitu dilaksanakan dengan mengadakan training terhadap kader-kader, kemudian kader-kader memberikan penyuluhan kepada ibu-ibu.

and indirectly with training of volunteers who then provide extension to mothers.

Nah, didalam pelaksanaan penyuluhan gizi, banyak hambatan-hambatan yang kita jumpai. Misalnya saja ... adalah hambatan didalam ketenagaan karena terbatasnya tenaga-tenaga kesehatan yang bisa memberikan penyuluhan kepada masyarakat dan sekarang sedang digalakkan training terhadap petugas-petugas kesehatan.

In conducting nutrition education, we meet many hurdles. Just as an example ... we have the constraint of manpower because of the limitations of health workers who can teach the public; this problem is now being overcome through training for health providers.

Lalu masalah yang kedua adalah masalah dalam penyediaan bahan-bahan penyuluhan; ini dilaksanakan juga bersama-sama dengan instansi lain.

A second problem is with availability of training or extension materials; these are prepared in cooperation with other agencies.

Masalah yang ketiga adalah masalah yang dihadapi oleh para petugas karena kesulitan bahasa yang berbeda-beda sehingga kadang-kadang petugas itu harus menyesuaikan bahasa di daerah.

A third problem encountered by health providers is due to the variety of different languages, so that at times the providers must learn the local languages.

Masalah yang lain adalah masalah pantangan-pantangan kebiasaan-kebiasaan dari masyarakat, nah, ini yang perlu diubah oleh para petugas kesehatan.

Another problem concerns popular habits and taboos, namely those which need to be changed by health care providers.

BL34:benny91.vid
26nov91

APPENDIX VII

QUESTIONS INCLUDED IN SRI'S 1991 RURAL OMNIBUS

(see attached)

Somavita Questions in SRI 1991 Rural Omnibus

A N A K B A L I T A

Central Java, North Sumatera, West Sumatera and South Sumatera, West Kalimantan, South Kalimantan, Maluku and Bali.

FILTER QUESTION

Do you have any children who are 1 to 5 years old? (Already 12 or more months, but still under 5 years?)

Has child/children 1-5 years	1 (41)	GO TO Q.1-Q.5.
All kids under 1 year	2	
Has no children under 5	3	

RECORD NAME & AGE OF EACH CHILD FROM 1 YR. - 5 YR. OLDS, STARTING FROM THE YOUNGEST ONE.

NAME OF CHILDREN	T37	A G E (M)	
_____	1 (11)	[ ][ ]	MONTHS (12-13)
_____	2	[ ][ ]	MONTHS (14-15)
_____	3	[ ][ ]	MONTHS (16-17)
_____	4	[ ][ ]	MONTHS (18-19)
_____	5	[ ][ ]	MONTHS (20-21)
_____	6	[ ][ ]	MONTHS (22-23)

CIRCLE THE NAME OF THE CHILD 1-5 YEARS WHO IS YOUNGEST

QUESTIONS ON HEALTH

Q1. Is there a Posyandu or Pos Penimbangan or Kelompok Penimbangan in this dusun?

Yes	1 (24)	
No	2	
Don't know	3	

Q2. When is the last time you took your child under 5 to the Posyandu or Pos Penimbangan or Kelompok Penimbangan

Today or 1-30 days ago	1 (25)	
(~1 month ago) 31-60 days ago	2	
(~2 months ago) 61-90 days ago	3	
(~3 months ago) 91-120 days ago	4	
(~4 months ago) 121-150 days ago	5	
(~5 months ago) 151-180 days ago	6	
(~6 months ago) 181-210 days ago	7	
(>6 months ago) >211 days ago	8	
Never	9	
Don't know/forget	1	
Others (SPECIFY) _____	[ ] (26-30)	

Q3. What is the name of this? (SHOW THE PHOTO OF THE CAPSULES. DO NOT PROBE).

(capsule) Vitamin A	1 (31)	
(capsule) Vitamin/s	2	
(capsule) Minyak ikan	3	
Don't know/forget	4	
Others (SPECIFY) _____	[ ] (32-40)	

SKIP 42-50

Q4. Has any of your children 1-5 ever received a capsule like this? (SHOW THE CAPSULE PHOTO. DO NOT PROBE).

Yes	1 (51)
No	2
Don't know/forget	3

Q5. Now, I would like to ask about eggs. When is the last time ..... (NAME OF YOUNGEST CHILD 1-5, WHICH WAS CIRCLED IN FILTER QUESTION) ate egg(s)? I mean, chicken eggs or duck eggs or quail eggs, white and yolk. (DO NOT PROBE).

Today	1 (52)
Yesterday	2
2-7 days ago	3
2 weeks (8-14 days) ago	4
3 weeks (15-21 days) ago	5
1 month (4 weeks / 22-31 days) ago	6
>1 month (>4 weeks / >31 days) ago	7
Child has never eaten eggs	8
Don't know/forget	9

Random	1 (53)
Booster	2

SKIP 54-80

APPENDIX VIII

VITAMIN A DEFICIENCY GUIDE

This guide for Health Post Volunteers outlines prevention of vitamin A deficiency (with capsules and vitamin-A-rich foods) and referral for treatment at the nearest Community Health Center (Puskesmas) or hospital children with eye signs or measles. The guide was developed by the Rovita and Somavita teams in collaboration with Unicef. It will be disseminated throughout the country.

VITAMIN A DEFICIENCY GUIDE

PETUNJUK

tentang

KEKURANGAN VITAMIN A

PENCEGAHAN

* Anak Balita 1–5 tahun, sehat atau sakit setiap Pebruari dan Agustus di Posyandu: Beri satu kapsul Vitamin A dosis tinggi
* Ibu-ibu setelah melahirkan (masa nifas): Segera beri satu kapsul Vitamin A dosis tinggi
* Semua Penduduk dianjurkan makan sayuran hijau atau buah berwarna setiap hari

KIRIMLAH KE PUSKESMAS / RUMAH SAKIT

* Anak dengan salah satu tanda kekurangan Vitamin A:
  - Buta senja, *atau*
  - Mata kering, *atau*
  - Mata keruh, tidak mengkilap, *atau*
  - Mata kotor/bercak putih

  SEGERA KIRIMLAH KE PUSKESMAS ATAU RUMAH SAKIT !

* Anak Balita 1–5 tahun yang menderita Campak

  SEGERA KIRIMLAH KE PUSKESMAS ATAU RUMAH SAKIT !

Departemen Kesehatan
Universitas Diponegoro
Helen Keller International

Disarankan oleh WHO
Perbaikan 1988

APPENDIX IX

GUIDE TO POSYANDU PROMOTION CHARTS, PRETESTED BY NGOS

(see attached)

satpel

PERMAINAN PERAN SEGI TIGA

KARTU KONSULTASI
PROMOSI POSYANDU

A. Kata Pengantar :

Apakah Anda seorang petugas PUSKESMAS yang berkewajiban melatih Kader Posyandu? Atau, Anda seorang Ketua Kelompok Kader dan berhasarat untuk meningkatkan keterampilan kelompok Anda dalam melaksanakan kunjungan rumah? Mungkin Anda petugas lapangan yang ingin meningkatkan hasil kerja Anda dengan menggunakan alat baru ini? Barangkali Anda baru menerima satu paket Kartu Konsultasi dan Anda ingin mempelajari cara menggunakannya.

Betapapun, kami senang sekali dapat melengkapi Anda dengan suatu silabus, yaitu urutan pelajaran supaya bisa terampil menggunakan Kartu Konsultasi dalam kegiatan Promosi Posyandu. Pedoman kecil ini telah disusun untuk memperkaya keterampilan fasilitator yang harus melatih cara penggunaan Kartu Konsultasi.

Urutan belajar selama 2 jam sengaja dibuat sederhana agar bisa diterapkan dalam berbagai tingkat keterampilan melatih. Juga dapat memberikan gambaran mengenai maksud, waktu, metoda, dan media yang akan digunakan. Urutan belajar, dibagi dalam langkah-langkah yang menghendaki peranserta aktif pesertanya. Sejak langkah pengenalan sampai bermain peran secara bergiliran akan memberikan pemahaman dan keterampilan baru dalam mempromosikan berbagai pelayanan Posyandu.

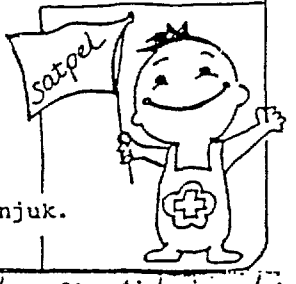
Mudah-mudahan silabus ini berguna bagi Anda. Bila Anda mempunyai saran atau umpanbalik untuk lebih menyempurnakannya, silahkan langsung menghubungi Pusat Penyuluhan Kesehatan Masyarakat, Departemen Kesehatan R.I.

B. Tujuan :

Setelah materi ini disajikan, peserta dapat memahami dan terampil menggunakan kartu-kartu konsultasi dalam penyuluhan Promosi Posyandu.

C. Metode dan Perkiraan waktu :

Permainan Peran Segi Tiga:		120 menit
1. Penjelasan awal		5 menit
2. Penugasan		10 menit
3. Diskusi tanya jawab		15 menit
4. a. Penjelasan (isntruksi)	5 menit	
b. Permainan peran	30 menit	
c. Rangkuman pengalaman	15 menit	70 menit
d. Pendapat kelompok	20 menit	
5. Kesimpulan		20 menit



D. Media (Lihat muka 6)

1. Lembar informasi garis besar penjelasan awal.
2. Paket penyuluhan kartu konsultasi termasuk petunjuk.
3. Almanak Kerja Promosi Posyandu.

bukan seperti kain pel; artinya: satuan pelajaran!

PROSES PENYAJIAN	WAKTU/MEDIA
PERMAINAN PERAN SEGI TIGA PENYULUHAN	120 menit
LANGKAH 1. PENJELASAN AWAL • Jelaskan kepada peserta latar belakang dan kebutuhan yang telah menjadi dasar Pusat Penyuluhan Kesehatan Masyarakat dalam melakukan kegiatan Promosi Posyandu. Gunakanlah lampiran 7.5.1. yaitu lembar informasi garis besar penjelasan awal.	5 menit Lamp. 1.
* Sebutkan beberapa media yang telah dikembangkan dan peranan media massa dalam usaha ini. Contoh poster, kaset, radio spot.	
• Perlihatkan kartu konsultasi dan kalender kegi - atan bulanan. Katakan bahwa peserta diberi waktu untuk mempelajari media ini secara lebih rinci.	Lamp. 2,3
• Tempelkan kalender di depan ruangan pertemuan.	
LANGKAH .2. PENUGASAN • Berikan kepada setiap peserta satu paket kartu konsultasi dan mintalah mereka mengeluarkan kartu-kartu petunjuk (ada tiga lembar).	10 menit Lamp. 2.
* Berikan kesempatan kepada peserta untuk membaca kartu petunjuk tersebut selama 10 menit. Katakan bahwa nanti akan diberi kesempatan untuk membahas dan tanya jawab tentang petunjuk dan lembar-lembar kartu konsultasi lainnya. Dampingi peserta dalam membaca lembar petunjuk dan melihat kartu-kartu konsultasi lainnya. (familiarization).	
CATATAN : Berikut ini adalah pola pendekatan lain untuk membantu para peserta yang mempunyai masalah dalam membaca (karena usia, penglihatan, atau keterampilan membaca). Pilihan ini adalah gabungan langkah 5.2 dan 5.3; jadi bisa dipakai 25 menit untuk melaksanakannya.	
* Ambil Kartu Petunjuk * Minta salah seorang peserta yang masalah membacanya tidak begitu berat untuk secara sukarela membacakan . Bagian I - Bentuk secara tenang dengan suara yang jelas dan keras. Tanya pada setiap peserta apakah bagian ini dapat dipahami.	
* Kemudian minta peserta lain membacakan Bagian II - Tujuan dan tanyakan lagi apakah bagian itujelas bagi tiap peserta.	
* Lanjutkan dengan cara yang sama untuk Bagian III - Penggunaan dan Bagian IV - Pedoman Untuk Memilih Kartu.	
* Beri kesempatan pada peserta untuk mengajukan pertanyaan, tapi selalu perhatian waktu yang digunakan. Karena mereka juga butuh waktu untuk mempraktekkan penggunaannya, sehingga pemahamannya dapat dimantapkan.	
* Akhiri langkah ini dengan pertanyaan-pertanyaan a,b,.c, dan d pada langkah 5.3.	

PROSES PENYAJIAN	WAKTU/MEDIA

LANGKAH 3. DISKUSI - TANYA JAWAB — 15 menit

* Tanyakan apakah peserta sudah selesai membaca kartu-kartu petunjuk paket penyuluhan kartu konsultasi.
- Tanyakan peserta apakah :
  a. secara umum media ini bisa diterima
  b. apa yang anda senangi tentang media ini dan mengapa?
  c. apa yang anda kurang senangi dan mengapa?
  d. apa yang kurang jelas dalam petunjukknya?

* Tanyakan siapa yang telah mengerti cara penggunaan kartu konsultasi dengan benar.
  Kalau ada yang belum memahami minta kepada peserta yang sudah memahami untuk menjelaskan hal tersebut.
  Katakan bahwa kita sekarang telah sepakat untuk bersama-sama menggunakan kartu konsultasi tersebut dengan mantap dan tepat.

4a. PENJELASAN — 5 menit

* Katakan semua peserta akan dilatih keterampilannya dalam menggunakan paket penyuluhan kartu konsultasi dengan permainan peran.

* Pesankan agar mereka melaksanakan permainan perah dengan sungguh-sungguh.

* Katakan permainan peran ini dinamakan segitiga penyuluhan dan setiap peserta akan turut ambil bagian secara aktif.

- Sebutkan waktu untuk permainan peran ini adalah 30 menit.

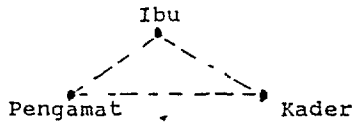
* Jelaskan bahwa sesudah setiap permainan peran selesai, masing-masing anggota dalam kelompok segitiga penyuluhan diminta mengemukakan pengalamanannya masing-masing dalam ketiga peranan yang dilakukannya untuk dirangkaum sebagai pengalaman kelompok.

* Jelaskan kelompok diminta pendapatnya untuk rencana tindak lanjut.

4b PELAKSANAAN PERMAINAN PERAN — 30 menit

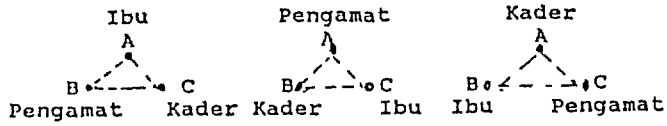
- Bagi habis peserta kedalam kelompok-kelompok Setiap kelompok terdiri dari 3 orang
- Tentukan giliran peranan setiap anggota kelompok (lihat gambar)
  Masing-masing anggota kelompok mendapat giliran sebagai kader, ibu yang disuluh, dan pengamat.

Penjelasan dan pembagian tugas



PROSES PENYAJIAN	WAKTU/MEDIA

Pelaksanaan permainan peran



* Katakan masing-masing peserta akan berperan sebagai kader penyuluh, sebagai ibu yang disuluh dan sebagai pengamat secara bergiliran, dengan memakai kartu merah dan kartu lain pilihan peserta sendiri.

4c *RANGKUMAN PENGALAMAN PESERTA DALAM KELOMPOK SEGI TIGA* — 15 menit

* Minta kepada setiap kelompok untuk mendiskusikan pertanyaan-pertanyaan sebagai berikut:

  Bagaimana kesan anda sebagai kader, ibu atau pengamat di dalam permainan peran itu?

  - Apakah menyenangkan atau tidak?
  - Mengapa?
  - Adakah hal-hal yang menonjol bagi anda, ceritakan?
  - Masalah apa yang anda dapatkan sewaktu menggunakan kartu konsultasi, berikan juga saran.

* Diskusikan kesan masing-masing dalam kelompok dan simpulkan sebagai kesan kelompok tentang ketiga peranan yang dimainkan dan akan dibahas dengan kelompok-kelompok lain.

4d *PENDAPAT KELOMPOK UNTUK RENCANA TINDAK LANJUT* — 20 menit

Minta kepada setiap kelompok untuk mendiskusikan pertanyaan berikut:

* Hal yang harus diperhatikan dalam menyebar - luaskan paket penyuluhan kartu konsultasi.

  1. Jumlah kader yang ada di daerah anda berapa? Misalnya, 100 orang kader.

  2. Bagaimana caranya menghubungi kader? Misalnya mengumpulkan 5 orang dalam satu kelompok.

  3. Bagaimana caranya menyampaikan paket penyuluhan kartu konsultasi? Misalnya mengobrol, melontarkan pertanyaan tentang isi pesan dan lain-lain.

  4. Kesempatan dan waktu yang akan digunakan. Misalnya setelah selesai Posyandu, siang hari setelah pekerjaan di rumah selesai dan lain-lain.

PROSES PENYAJIAN	WAKTU/MEDIA

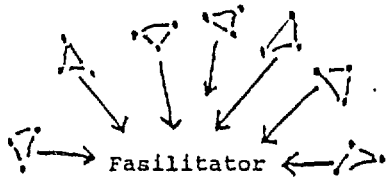
5. Sarana yang diperlukan. Misalnya konsultasi, almanak kerja, kertas dan lain-lain.

6. Frekuensi yang diperlukan misal 2 kali, 3 kali dan lain-lain.

* Simpulkan rencana tindak lanjut kelompok yang akan dibahas dalam kesempatan lain sebagai perencanaan Posyandu. Misal SPB 7.4.

5. KESIMPULAN — 20 menit

* Mintalah peserta untuk kembali ke kelompok besar dimana hal-hal yang penting dari masing-masing kelompok segi tiga akan dibahas bersama.



* Tanyakanlah kepada peserta untuk menyebutkan aspek-aspek yang paling menarik dari permainan peran penggunaan kartu konsultasi.

* Catat komentar-komentar peserta di lembaran kertas atau papan tulis.

* Fasilitator dapat memancing peserta untuk memberi komentar yang sama atau yang agak berbeda tentang aspek-aspek menarik. Ini juga dicatat di papan tulis. — Papan atau kertas lembar balik.

* Bahas bersama bila ada kesulitan dengan penggunaan kartu konsultasi dan katakan cara-cara yang baik dan tepat menurut hasil pengamatan fasilitator selama permainan peran.

* Minta kepada peserta untuk melaporkan berbagai cara/aturan yang akan mereka pakai untuk menyampaikan paket kartu konsultasi kepada kader PKK. Usulan ini dicatat di papan tulis sebagai "kemungkinan untuk menyebarluaskan kartu konsultasi".

* Minta kepada peserta saran-saran sebagai masukan dalam mencetak ulang kartu konsultasi; menyangkut beberapa hal: gambar-gambar, bentuk, bahasa, huruf, warna. (Komentar-komentar tersebut dicatat untuk disampaikan kepada petugas PKM Puskesmas).

* Sampaikanlah terima kasih kepada peserta atas partisipasinya dalam permainan peran ini.

(1) LEMBAR INFORMASI GARIS BESAR PENJELASAN AWAL

* Penjelasan awal ini diberikan kepada peserta, sebelum nantinya akan diberikan waktu yang cukup untuk mempelajari kartukonsultasi secara rinci. (Rujukan: Upaya Kita Untuk Melindungi Anak-Anak Dari Bencana).

* Posyandu adalah kegiatan yang dilaksanakan dari, oleh dan untuk masyarakat, agar masyarakat dapat menolong dirinya sendiri maupun keluarganya daam memecahkan masalah kesehatannya.

* Banyak cara untuk memotivasi dan menggerakkan masyarakat, salah satu diantaranya adalah dengan penyuluhan menggunakan kartu konsultasi yang telah disiapkan dalam rangka promosi Posyandu.

* Bagi kader-kader melaksanakan penyuluhan pada ibu-ibu tidaklah mudah. Walaupun kader PKK sudah dilengkapi dengan berbagai alat-alat peraga tetapi masih menemui kesukaran dalam menggunakannya. Baik pada kegiatan di Posyandu maupun waktu kunjungan ke rumah ibu-ibu yang perlu dibujuk supaya mau datang secara teratur ke Posyandu demi anaknya.

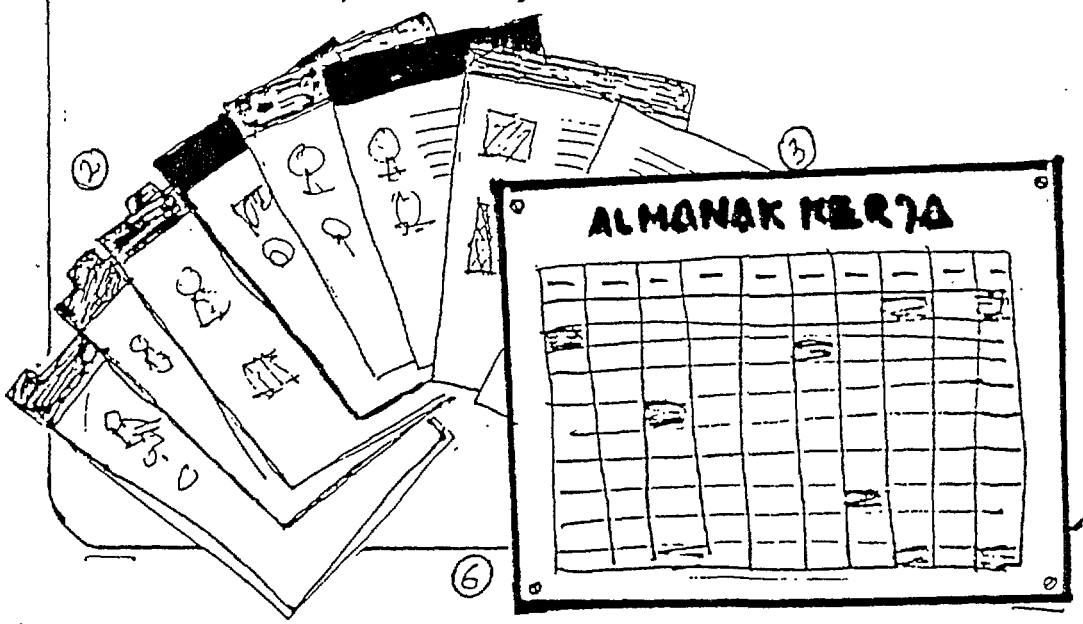
* Agar lebih banyak ibu berkunjung ke Posyandu dan untuk mendukung kader sebagai komunikator Pusat PKM Dep.Kes. telah memulai dengan kegiatan Promosi Posyandu.

* Dalam upaya Promosi Posyandu kader dilengkapi antara lain dengan paket penyuluhan Kartu Konsultasi untuk membantu kader PKK dalam berbicara dengan ibu-ibu di rumahnya, sebagai pengantar pesan-pesan tentang pelayanan yang tersedia di Posyandu. Media massa juga dapat mendorong usaha kader dengan titik berat pada salah satu kegiatan tertentu setiap bulan.

* Tiap melakukan kunjungan rumah kader cukup membawa dan membahas satu kartu yang sesuai dengan bulan kegiatan kader, ditambah satu kartu lain yang berwarna merah untuk mendorong ibu-ibu yang belum pernah datang ke Posyandu.

* Lembar-lembar Kartu Konsultasi memiliki warna yang berbeda, selain warna merah, dengan maksud agar kader dapat mengingat isi pesan khusus untuk bulan-bulan Promosi yang tercatat dalam almanak kerja.

* Pada buku panduan fasilitator PB 7 halaman 60, terdapat penjelasan tentang "peranan pemerintah, PKK, LKMD dan masyarakat di Posyandu:. Peranan PKK ini adalah dalam rangka penerapan hari H (Hari buka) Posyandu. Kegiatan kader menyuluh dengan Kartu Konsultasi, dimaksudkan sebagai peranan dalam menggerakkan dan memotivasi sasaran Posyandu agar mau datang dan mengingatkan bila ibu belum/tidak datang secara teratur.



APPENDIX X

MATERIALS FOR THE FEBRUARY 1991 CAPSULES CAMPAIGN

The following booklet on the National February 1991 Capsules Campaign was disseminated in both English and Indonesian. It includes:

National Materials

- Cover letter to Message from the Director-General of Public Health, Feb 91
- Message from the Director-General of Public Health, Feb 91
- Televised Statement by the Minister of Health, Feb 91
- National Radio Spot Typescript
- National Radio Spot Translation
- National-level Monitoring for February 1991:
  - Cover Letter
  - Sample questionnaire

Special Central Java Materials

- Governor's flier to village heads, Feb 91 (blue & white)
- banners

THE FEBRUARY 1991 CAMPAIGN TO INCREASE AWARENESS OF VITAMIN A CAPSULE DISTRIBUTION IN INDONESIA

SOMAVITA PROJECT

Department of Health
Diponegoro University
Helen Keller International

July 1991

FORWARD

The purpose of this booklet is to highlight the activities and materials which were part of the February 1991 national campaign to promote the increase consumption of vitamin A capsules by children age 1 up to 5 years. This booklet has been prepared for persons -- Indonesians and foreigners -- working in the field of public health in Indonesia.

We acknowledge with appreciation the support and financial contributions provided by the United States Agency for International Development (USAID), Helen Keller International, Hoffmann LaRoche Sight and Life, and UNICEF.

For further information, readers may contact Somavita Project c/o Helen Keller International, P.O. Box 4338, Jakarta, Indonesia.

Somavita Project

July 1991

I. INTRODUCTION AND BACKGROUND

The Government of Indonesia has recognized that vitamin A deficiency is the cause of serious health problems which affect the mortality rates of children between the ages of 1 and 5 years. Surveys in 1976-78 and in 1983-85 identified 13 provinces at risk for vitamin A deficiency.

In order to eradicate this problem, the Ministry of Health is currently implementing three strategies:

1. nation-wide distribution every six months of high-dose vitamin A capsules (200,000 I.U) to all children age 1 up to 5 years,

2. fortification with vitmain A of commonly eaten foods, and

3. improved diet including more vitamin-A-rich foods.

This booklet deals only with vitamin A capsules. It describes the activities and materials used during the February 1991 coordinated national campaign to increase awareness of the distribution of capsules during the months of February and August.

This national campaign was implemented within the context of the SOMAVITA Project. This one-year social marketing project began in 1990 and is a cooperative effort among the Ministry of Health (Directorate of Nutrition, Health Education Center, and Directorate for Community Participation), Diponegoro University, and Helen Keller International, collaborating with UNICEF and the Family Welfare Movement (PKK). Technical assistance was provided by the Academy for Educational Development. The underlying goal of this one-year project is to increase the distribution and consumption of high-dose vitamin A capsules to all children 1 up to 5. The immediate objective of the February 1991 communications campaign was to make more people aware of the important news that February and August are the months in which children can get vitamin A capsules at the Village Health Posts (Posyandu).

Preparations for the February 1991 national communications campaign began in November 1990, and the campaign was launched officially by the Minister of Health, Dr. Adhyatma, on 24 January 1991.

This booklet presents the activities which reached the nation, focusing on the 13 target provinces, and then presents additional activities in Central Java and in Aceh.

II. NATIONAL COMMUNICATIONS (FOCUS ON 13 PROVINCES)

Printed Media

To initiate activities, in July 1990, the Director-General for Community Health Development, Dr. S. L. Lemeina, sent a letter to provincial Health Departments to inform them of the new policy of capsule distribution every February and August.

Then, the project sent out a formal Message from Dr. Lemeina, suitable for framing and announcing that February and August are the new capsule distribution months throughout Indonesia. A cover letter from the Head of the Nutrition Directorate highlighted the reasons for the importance of vitamin A.

Journalists were invited to attend activities and a special press briefing; their articles on vitamin A appeared in Harian Terbit, Suara Karya, Berita Buana, and other newspapers.

Television

At the beginning of February, TVRI started broadcasting this February-and-August message nationally with a one-minute statement of the National News by the Minister of Health.

Two-minute "fillers" in the form of mini-dramas, were broadcast several times in February.

A portion of the television coverage of "Gerakan Sadar Pangan dan Gizi" focused on vitamin A capsules, and the Minister himself was filmed giving a capsule to a child at a Posyandu.

TVRI also broadcast "Sebelum Terlambat," a 20-minute drama about the problem of nightblindness and its treatment with vitamin A.

Radio

For this campaign, the project team, using social marketing techniques, developed a one-minute radio spot in the national language announcing February and August for capsule distribution. Cassette tapes of the spot were distributed to government and private radio stations, which broadcast this short message frequently during February.

Evaluation

Monitoring of the impact of the campaign was undertaken at the national level by sending direct mail questionnaires to 600 respondents in 12 target provinces. (Central Java conducted its own monitoring). These respondents included provincial and kabupaten health officials, and included a sample of Puskesmas (Community Health Center) doctors, village heads, and village PKK leaders. Questionnaires were mailed just before Lebaran; at the end of May, approximately one-half of the respondents had returned a completed questionnaire. Initial findings suggest that many people had seen or heard the television and radio broadcasts. Nearly all Puskesmas doctors and provincial and regency Nutriton respondents had seen the "Message from Dr. Lemeina," but many of the provincial Health Education respondents had not.

(translation from the Indonesian)

DEPARTMENT OF HEALTH, REPUBLIC OF INDONESIA

DIRECTOR GENERAL FOR PUBLIC HEALTH DEVELOPMENT
DIRECTORATE FOR COMMUNITY NUTRITION

Jl. Percetakan Negara No.32A JAKARTA 10560 Tel:414685,414693

No: 1780/BGM/LG/XII/90
Att.
Re: Distribution of capsules and double benefit of vitamin A

Jakarta, 18 December 1990

To:

Doctors in
Community Health Centers
throughout Indonesia

Regarding the letter from the Director General for Public Health Development of 11 July 1990 No. 848/Binkesmas/DJ/VII/90 along with the message from the Director General for Public Health Development of 1 December 1990 about the distribution of high-dose vitamin A capsules, we request your active participation, remembering that:

1. At the end of the Fifth Five-year Development Plan it is hoped that xerophthalmia will no longer be a public health problem;

2. The results of research in Indonesia which have been supported by results from research outside this country pointing out the double benefit of vitamin A, which not only has a role in preventing blindness but also can significantly reduce morbidity and mortality in young children.

We hope your dedication will be fruitful and beneficial in increasing the quality of life, especially for the future of Indonesia.

Head, Directorate for Community Nutrition

Drs. Benny A. Kodyat, MPA

disk Srpt1:S9091-T2.rpt
21mar91

DEPARTEMEN KESEHATAN R.I

PESAN
DIREKTUR JENDERAL PEMBINAAN KESEHATAN MASYARAKAT

Sesuai dengan surat edaran saya tanggal 11 Juli 1990 Nomor 848/Binkesmas/DJ/VII/90 kepada Kepala Kantor Wilayah Departemen Kesehatan di seluruh Propinsi; bulan Februari dan Agustus telah ditetapkan sebagai "bulan pembagian kapsul vitamin A" yang dilakukan secara serempak di seluruh tanah air. Ketentuan tersebut diputuskan supaya kegiatan dapat dilaksanakan secara lebih efektif dan lebih efisien, baik dari segi logistik maupun program.

Saya menghimbau seluruh petugas kesehatan dan semua kader Posyandu, agar bisa melaksanakan program tersebut sebaik-baiknya. Untuk itu saya-meminta kepada para petugas kesehatan dan kader Posyandu untuk :

- *Melaksanakan pembagian kapsul vitamin A pada semua anak Balita di wilayah kerjanya dalam bulan Februari dan Agustus.*
- *Mengajak para ibu membawa anak Balita mereka ke Posyandu setiap bulan, terutama pada bulan Februari dan Agustus guna mendapatkan kapsul vitamin A.*

Dharma-bakti Anda sekalian sangat penting sekali demi kesehatan dan kelangsungan hidup anak-anak kita. Jerih payah Anda sekalian sangat dihargai, dan semua pihak amat berterima kasih.

Jakarta, 1 Desember 1990
Direktur Jenderal
Pembinaan Kesehatan Masyarakat,

(Dr. S.L. Leimena, MPH)

65

(translation from the Indonesian)

MESSAGE

from

THE DIRECTOR-GENERAL FOR PUBLIC HEALTH DEVELOPMENT

In accordance with my letter of 11 July 1990 Number 848/Binkesmas/DJ/VII/90 to the Heads of Regional Health Department Offices in all Provinces, February and August are specified as "vitamin A capsule distribution months" which will be done simultaneously throughout our country. This specification was decided so that the capsule activity can be done more effectively and more efficiently, in terms of both logistics and program.

I appeal to all health officials and all Health Post volunteers to carry out this program as well as possible. For this reason I am requesting health officials and Health Post volunteers to:

- Implement distribution of vitamin A capsules to all children 1 to 5 in their service area in February and August.
- Invite mothers to bring their children 1 to 5 to the Health Post every month, especially in February and August to get vitamin A capsules.

Your dedication is extremely important to the good health and survival of our children. Your hard work is very valuable and is deeply appreciated by everyone.

Jakarta, 1 December 1990
Director-General
Public Health Development

(Dr. S. L. Leimena, MPH)

TELEVISED STATEMENT BY THE MINISTER OF HEALTH

Theme : Announcement of promotion of high-dose vitamin A capsules
Speaker : Minister of Health, Republic of Indonesia (Dr. Adyatma)
Broadcast : 24 January 1991
Program : National News
Time : 1 minute
Broadcast by : TVRI

The government is working towards adequate consumption of vitamin A by children under 5 years old by giving out high-dose vitamin A capsules at Posyandu (Village Health Posts).

These vitamin A capsules are given out free of charge every February and August.

So, to control vitamin A deficiency in children under 5, I ask every family with a child under five to:

first, remember consumption of vitamin A in daily foods;

second, get vitamin A capsules at the nearest Posyandu, every February and August.

These are my messages. May we heed them, because by developing our children we continue to build our nation.

RADIO SPOT KAPSUL VITAMIN A

. Februari 1991

MUSIK
GONG

L Ibu-ibu, Bapak-bapak. Coba dengarkan !

P Ya -- semuanya yang mencintai anak-anak, dengarkan!
Berita penting!

L Mulai sekarang, bulan Februari dan Agustus adalah
bulan pemberian kapsul vitamin A.
Bisa didapatkan di Posyandu tanpa membeli.

P Kapsul vitamin A penting untuk kesehatan anak balita kita.
Dapatkan tiap bulan Februari dan Agustus.

L. Ya. Segera dapatkan. Gratis ! [ECHO: gratis, gratis]

GONG

L Penting! Bulan Februari ini adalah bulan pemberian kapsul vitamin A.
Segera dapatkan di Posyandu tanpa membeli.

P Sampaikan berita penting ini kepada semua ibu yang mempunyai anak
balita.

MUSIK

final, from tape
sl:RadioVAC.91
22jan91

(translation from the Indonesian)

RADIO SPOT: VITAMIN A CAPSULES

February 1991

MUSIC
GONG

M Ladies and gentlemen. Please listen!

F Yes -- everyone who loves children, listen!
We have important news!

M Starting now, February and August are the months for distribution of vitamin A capsules.
You can get them at the Posyandu free of charge.

F Vitamin A capsules are important for the health of our young children.
Get them every February and August.

M Yes. Get them right away. Free! [ECHO: free, free]

GONG

M Important! This February is the month for distribution of vitamin A capsules. Get them right away at the Posyandu free of charge.

F Tell this important news to all mothers of young children.

MUSIC

translation of final
s1:RadioVAC.91
22jan91

III. SPECIAL CENTRAL JAVA COMMUNICATIONS

Central Java was the site of the pilot project, ROVITA Project. The team[1] from that project continued working together to implement the activities described below.

Printed Media

Two pages of information were prepared on the subject of vitamin A generally, vitamin A capsules, and the specific tasks for the February capsule distribution. This printed information was given to officials from 35 kabupaten at a special meeting held in early February.

170,000 fliers showing the Governor of Central Java and his wife giving a VAC to a child were distributed to all of Central Java's 8,450 villages by Health Department officials from 35 kabupaten.

Banners produced by the ROVITA Project in 1988 were again displayed at Puskesmas and in villages in the two ROVITA target kabupaten (Demak and Jepara).

Television

The Governor was also approached to record a 9-minute talk on vitamin A capsules and the February distribution. This was aired on 28 January.

Radio

PKM from each kabupaten selected a local station to broadcast the national radio spot 3-5 times each day during February.

Evaluation

Monitoring of broadcasts was managed by regency Health Education (PKM) personnel. As at the national level, monitoring of the impact of this campaign in Central Java was undertaken using direct mail questionnaires to 342 respondents selected from kabupaten health departments, Puskesmas, and village heads. So far, about 25% of the completed questionnaires have been returned. A detailed, complete report will follow completion of analysis.

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[1]Members of the Somavita Project team are from the Department of Health, Diponegoro University, Helen Keller International, and the Academy for Educational Development.

GUBERNUR KEPALA DAERAH TINGKAT I
JAWA TENGAH

Saudara Petugas
Pamong, dan
Kader,

Saya beritahukan bahwa
Kapsul Vitamin A sangat penting untuk
Kesehatan anak balita.

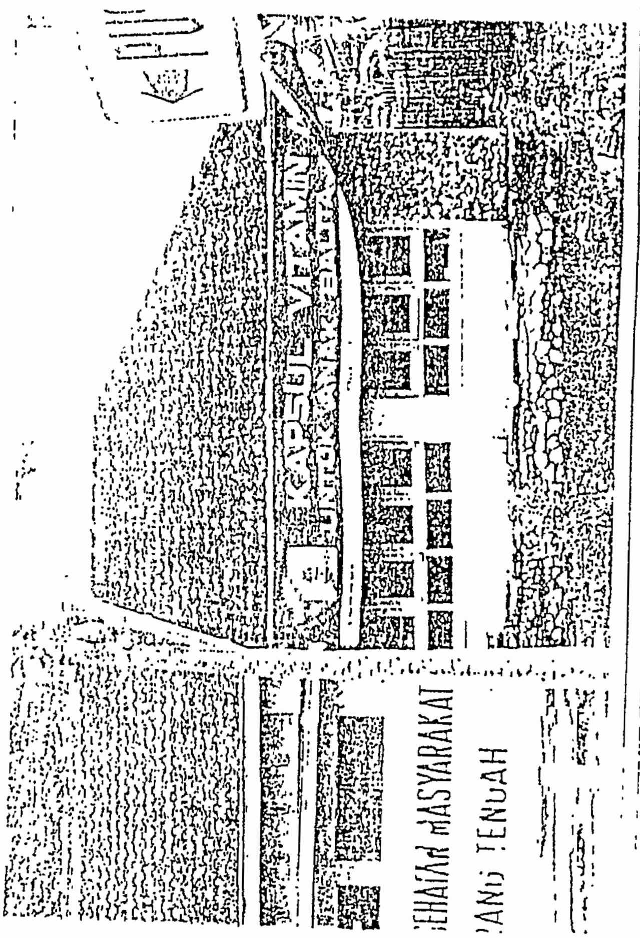
Bulan **Februari** dan **Agustus** ialah
bulan pembagian kapsul Vitamin A
melalui Posyandu tanpa membayar

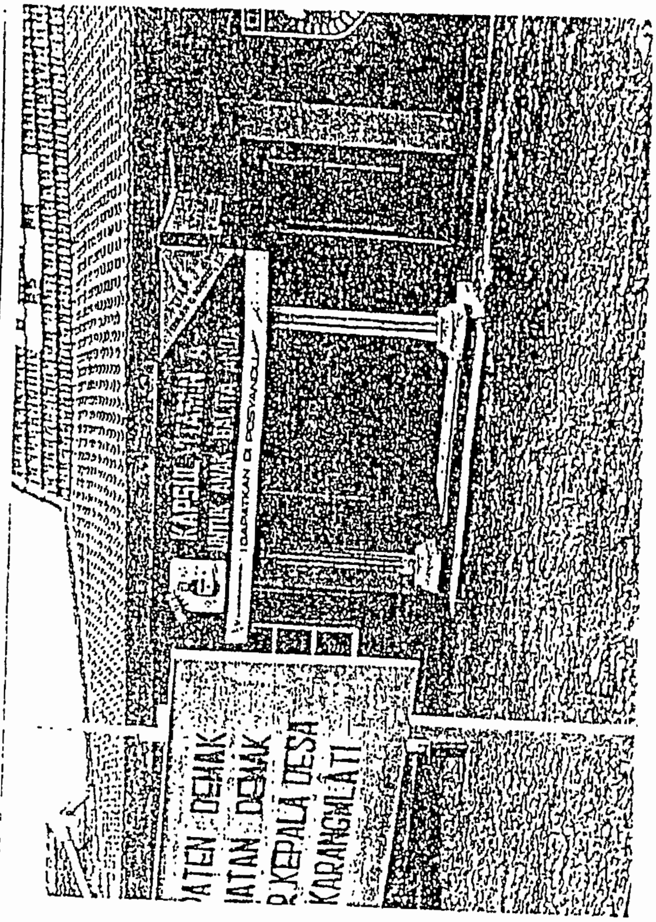
Tugas saudara ialah menjamin agar
SEMUA anak balita di wilayah kerja saudara
didaftar dalam Formulir Registrasi Kapsul Vitamin A,
dan mendapat Kapsul Vitamin A langsung
dari Kader

Gubernur Kepala Daerah Tingkat I
Jawa Tengah,

ISMAIL

71





BEST AVAILABLE COPY

APPENDIX XI

MATERIALS FOR THE AUGUST 1991 CAPSULES CAMPAIGN

A. National Communications Materials:

- National Radio Spot for August 1991
- Cover letter to Message from the Head of PKK, May 1991
- Message from the Head of PKK to villages nationwide, May 1991

B. Special Central Java Materials

- Central Java form for registering children 1 to 5 in villages
- Instructions for Central Java registration form
- Central Java Governor's flier (printed in color)

C. Special Aceh Materials

- Aceh Governor's flier (green & white)
- Vitamin A Banner, D.I. Aceh (1 per regency)

D. Special West Java Materials

- West Java Governor's flier (color)

NATIONAL RADIO SPOT: VITAMIN A CAPSULES
(translation)
August 1991

MUSIC
GONG

M Ladies and gentlemen. Please listen!

F Yes -- everyone who loves children, listen!
We have important news!

M Starting now, February and August are the months for distribution of vitamin A capsules.
You can get them at the Posyandu free of charge.

F Vitamin A capsules are important for the health of our young children.
Get them every February and August.

M Yes. Get them right away. Free! [ECHO: free, free]

GONG

M Important! This August is the month for distribution of vitamin A capsules. Get them right away at the Posyandu free of charge.

F Tell this important news to all mothers of young children.

MUSIC

Feb to Aug
s1:RadioVAC.91
22jan91

IV. SPECIAL D.I. ACEH COMMUNICATIONS

In 1978, D. I. Aceh had the highest rate of vitamin A deficiency in Indonesia and remains a high-priority province. The following activities were done in addition to the national program.

Radio

Ten radio stations in Aceh broadcast the national spot. In addition, a speech was prepared by the Head of the Nutrition Section of the provincial Health Department, and this speech was broadcast by 3 Banda Aceh stations.

Evaluation

Spot monitoring of radio broadcasts was done by selected individuals. Also, Aceh was included in the sample for the national-level direct-mail questionnaires.

FAMILY WELFARE MOVEMENT

PKK
NATIONAL ACTION TEAM

c/o Dir.Gen. Village Development, Jl. Pasar Minggu, Jakarta

No. 451/SKR/PKK.PST/V/1991
Enc. 1 page
Re. Sending Appeal for
Vitamin A at Health Posts

Jakarta, 20 May 1991.

To:
Heads of PKK
Provincial Action Teams

throughout Indonesia

In carrying out our role of assisting in health matters, particularly in the campaign for using vitamin A, with this letter we are sending our appeal regarding encouraging giving vitamin A capsules to children under five at the Health Posts.

Please note, this appeal is being sent by the Department of Health directly to the Heads of the Regency PKK Action Teams in your area.

Thus, we ask your help in monitoring the delivery of this appeal so that it can be used as required.

Thank you for your assistance and attention.

PKK National Action Team
Head

Mrs. Rudini

cc:

1. Dir.Gen. Community Health Dev't, MOH
2. Dir.Gen. Village Dev't
3. Heads of Regency PKK Action Teams
4. Head of National PKK Working Group IV
5. file

FAMILY WELFARE MOVEMENT

PKK
NATIONAL ACTION TEAM

APPEAL
HEAD OF THE NATIONAL ACTION TEAM
TO HEALTH POST VOLUNTEERS

For the health and survival of our children, to PKK volunteers who are active in Health Posts, I appeal to you:

- Every February and August, actively carry out the distribution of vitamin A capsules to all children under 5 at the Health Post in your area.

- Encourage mother to bring their children under 5 every month to the Health Post to look after the health of their children and to get a vitamin A capsule every February and August.

Your dedication will not be forgotten. Everyone involved thanks you very much and very much values your hard work.

May God bless your sincere dedication.

Jakarta, 1 May 1991
Head of the National PKK Action Team

Mrs. Rudini

s1-2:PKKaug91.eng

[FVA / JT / 1991]
Tahun 1991

Central Java Form for Registering Children 1 to 5

FORMULIR REGISTRASI KAPSUL VITAMIN A

UNTUK ANAK UMUR 1 - 5 TAHUN (12 - 60 BULAN)

RT / RW : ...../..... Dusun : .....

Posyandu : ..... Desa : .....

No. (1)	Nama Anak (2)	L/P (3)	Tgl. Lahir (4)	Orang Tua (5)	Tg. Pemberian Kapsul		Keterangan (7)
					Februari (6)	Agustus	

Ketua Kader
Posyandu

(.....)

Ketua
RT ...../RW .....

(.....)

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Instructions for Central Java Registration Form

PETUNJUK
PENGISIAN FORMULIR REGISTRASI KAPSUL VITAMIN A
dan
DISTRIBUSI KAPSUL VITAMIN A

1. Lakukan pendaftaran anak balita SATU BULAN sebelum bulan pembagian vitamin A (ialah bulan Januari dan bulan Juli).

2. Daftarlah SEMUA anak umur 1 - 5 tahun (12 bulan sampai dengan 60 bulan) di setiap wilayah kerja RT dalam Formulir di SEBALIK ini, dengan mengisi secara lengkap kolom 1 sampai dengan kolom 4.

3. Pendaftaran dilakukan dengan cara MENGUNJUNGI SEMUA RUMAH di seluruh wilayah RT.

4. Pendaftaran dapat dilakukan oleh Ketua RT, Pengurus RT yang lain, Kader Posyandu, atau siapa saja, asal DIKETAHUI oleh Ketua RT setempat.

5. Formulir Registrasi yang telah selesai diisi harus diserahkan kepada Kader Posyandu selambat - lambatnya SEHARI SEBELUM hari buka Posyandu (Hari H).

6. Kapsul Vitamin A dibagi di Posyandu, dengan menggunakan Formulir Registrasi sebagai PEDOMAN.

7. Dalam pemberian kapsul Vitamin A kepada anak, kader harus MEMASUKKAN SENDIRI kapsul tersebut ke MULUT ANAK.

8. Bila anak yang sudah terdaftar dalam Formulir Registrasi tak datang di Posyandu, kader harus memberikan kapsul Vitamin A kepada anak di RUMAH ANAK masing - masing.

9. Catat TANGGAL pemberian kapsul Vitamin A pada kolom yang tersedia (kolom 6).
   (Kolom 7 hanya diisi hal - hal yang sangat penting mengenai anak yang bersangkutan).

10. Kader Posyandu harus MENYIMPAN Formulir Registrasi yang sudah diisi dan sudah dipakai secara baik, agar dapat dipakai untuk:
    * pegangan pendaftaran 6 bulan yang akan datang.
    * penyusunan laporan pembagian kapsul Vitamin A.

----- (********) -----

Central Java Governor's Flier

GUBERNUR KEPALA DAERAH TINGKAT I
JAWA TENGAH

Saudara Petugas
Pamong, dan
Kader,

Saya beritahukan bahwa
Kapsul Vitamin A sangat penting untuk
Kesehatan anak balita.

Bulan **Februari** dan **Agustus** ialah
bulan pembagian kapsul Vitamin A
melalui Posyandu tanpa membayar

Tugas saudara ialah menjamin agar
SEMUA anak balita di wilayah kerja saudara
didaftar dalam Formulir Registrasi Kapsul Vitamin A,
dan mendapat Kapsul Vitamin A langsung
dari Kader

Gubernur Kepala Daerah Tingkat I
Jawa Tengah

ISMAIL

80

Aceh Governor's Flier

GUBERNUR KEPALA DAERAH ISTIMEWA
A C E H

SAUDARA PARA PETUGAS KESEHATAN, KEUCHIK,
TUHA PEUT, IMUM MEUNASAH DAN PARA
KADER POSYANDU.

KAMI INFORMASIKAN KEPADA SAUDARA-SAUDARA BAHWA VITAMIN A ADALAH SALAH SATU VITAMIN YANG SANGAT DIPERLUKAN UNTUK KESEHATAN ANAK BAYI DAN BALITA TERUTAMA UNTUK MENCEGAH KEBUTAAN.

BULAN FEBRUARI DAN AGUSTUS SETIAP TAHUNNYA INSYA ALLAH PEMERINTAH AKAN MEMBAGI KAPSUL VITAMIN A MELALUI POSYANDU-POSYANDU YANG TERSEBAR LUAS DISELURUH PELOSOK DAERAH ISTIMEWA ACEH SECARA GRATIS TANPA PERLU MEMBAYAR.

TUGAS KITA SEMUA ADALAH MENJAMIN AGAR SEMUA ANAK BAYI DAN BALITA YANG BERADA DI DAERAH ISTIMEWA ACEH MENDAPAT KAPSUL VITAMIN A PADA BULAN FEBRUARI DAN AGUSTUS TERSEBUT.

SEMOGA USAHA KITA UNTUK MENINGKATKAN KESEHATAN ANAK BAYI DAN BALITA TERUTAMA UNTUK MENCEGAH KEBUTAAN DIRIDHAI OLEH ALLAH SWT. AMIN.

GUBERNUR KEPALA DAERAH ISTIMEWA
A C E H,

IBRAHIM HASAN

81

Vitamin A Banner
D. I. Aceh
August 1991

- -

The Aceh team produced 15 banners and sent them to the regencies.

Message:

Take children 1-4 years old to the Posyandu
in August to get a vitamin A capsule
free to prevent blindness.

APPENDIX XII

ROVITA (1988-1989) PAPER PRESENTED AT IVACG

(see attached)

West Java Governor's Flier

GUBERNUR KEPALA DAERAH TINGKAT I
JAWA BARAT

Para Petugas,
Pamong, dan
Kader

Kapsul Vitamin A sangat penting untuk kesehatan anak Balita.

Pembagian kapsul Vitamin A melalui Posyandu tanpa membayar, akan dilaksanakan pada bulan Februari dan Agustus setiap tahun.

Tugas saudara-saudara adalah menjamin agar **SEMUA** anak Balita di wilayah kerja saudara memperoleh kapsul vitamin A.
Selamat bertugas.

Gubernur Kepala Daerah Tingkat I
Jawa Barat,

H.R. MOH. YOGIE S.M

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THE IMPACT OF SOCIAL MARKETING EFFORTS ON MEGADOSE VITAMIN A CAPSULE CONSUMPTION RATES: RESULTS OF A PILOT PROJECT IN CENTRAL JAVA[1]

Benny A. Kodyat, Head, Nutrition Directorate, Indonesia Ministry of Health; Judith A. McDivitt, Research Assistant Professor, Annenberg School for Communication; Anne C. Palmer, Grant Manager, Helen Keller International; Thomas K. Reis, Senior Program Officer, Academy for Educational Development; Satoto, School of Medicine, Diponegoro University, Indonesia; Steven E. Wilbur, Indonesia Country Director, Helen Keller International.

Background

Indonesia's vitamin A programs include nutrition education, fortification of food products, and a program to distribute vitamin A capsules to preschool children. This paper briefly discusses a pilot project to increase the number of children who are given megadose vitamin A capsules.

These capsules are provided by UNICEF and are shipped through the Department of Health system to Village Health Posts. At regular Health Post sessions, Volunteers give the capsules free of charge to children between the ages of 1 and 5 years. Other services provided at these Health Post sessions include growth monitoring, immunizations, counseling for family planning, iron tablets, nutrition education, and oral rehydration salts.

These Health Post sessions are ideally held once each month for 2 to 3 hours. Because the vitamin A capsules are given out only every six months, they are available to mothers and children only 2 mornings every year.

Project Description

Through the project, the Department of Health -- with assistance from a local university, Helen Keller International, and the Academy for Educational Development -- worked to identify effective means of increasing consumption of vitamin A capsules among the 150-thousand target children age 1-4 (12-59 months) in two coastal regencies of Central Java Province.

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[1]Rovita Project was funded by USAID FVA/PVC Grant No. PVC-0284-A-00-6131, Helen Keller International, and Hoffmann-LaRoche Sight and Life, with technical assistance for social marketing and evaluation funded by USAID/S&T, Office of Health and Office of Education, Contract No. DPE-1018-C-00-5063-00 and provided by the Academy for Educational Development supported by Annenberg School for Communication of the University of Pennsylvania.

The project objective was to use communications to get mothers to bring their children age 1-4 years to the Health Post for a capsule on the day of the session. To reach this goal, the project team followed a social marketing methodology, which incorporates principles from advertising and research to design, produce, communicate, and evaluate socially beneficial messages. The target group was the children, but the primary target audience was defined as their mothers, the group whose behavior we hoped to change. Ethnographic research provided information needed for developing effective communication strategies.

All of the project's vitamin A messages were based on a core of 5 key points:

- the product is vitamin A, in capsule form;
- the capsules are for your child from 1 up to 5 years old;
- they're available at the Health Post;
- they're available every February and August; and
- they're free.

To communicate these messages, the project integrated three media channels -- radio, print, and interpersonal. One-minute radio spots started ten days before a distribution month and continued throughout it, with 4 to 5 stations each broadcasting 10 spots per day, in the national and local language. Printed cloth banners were distributed to village heads and to Health Centers and were displayed during the capsule distribution months. In addition, paid and volunteer community health workers received special training and manuals to facilitate their health extension work with mothers.

These interventions were routinely monitored by the project team to ensure that messages were disseminated and understood.

Study Design

The objectives for this study were:

- to learn if there were changes in mothers' awareness and knowledge of vitamin A capsules,
- to learn if there were changes in the percentage of eligible children who received a capsule, and
- to learn if these changes were a result of project interventions.

The study design consisted of two surveys, one year apart. As can be seen in the following timeline, it was not possible to do the first survey before some communications activities had already started; thus, we don't have a true "pre-intervention" measurement. Because of this, a control community was chosen, and the surveys were conducted there also. In all, 1,600 mothers were interviewed, 800 each year.

Timeline for Rovita Project Evaluation

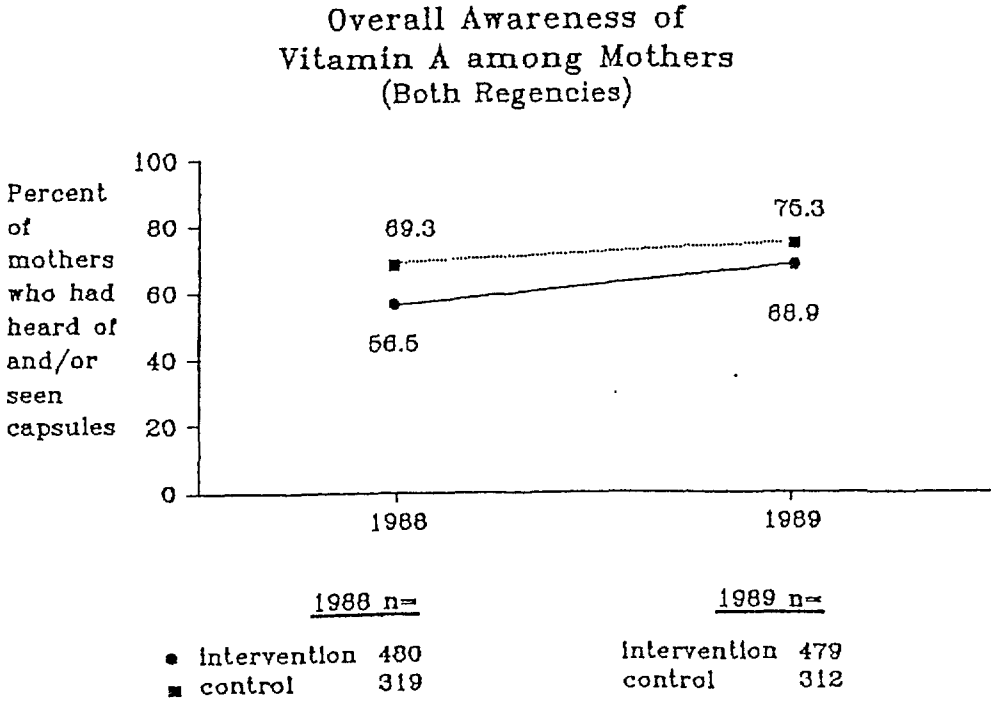
Begin Prep	Train'g VitA	Radio Banner VitA	DATA Time 1	Radio Banner VitA	Train'g VitA	Radio Banner VitA	DATA Time 2
Jan 1988	May-Jun 1988	Aug	Oct 88	Feb 1989	June	Aug	Oct 89

Results

The results of our research show that the project activities had a positive impact.

Mothers' Awareness

Overall awareness of the capsules -- either having heard of the term "vitamin A capsule" or having previously seen capsules like those shown by the interviewer -- increased significantly in the intervention but not in the control area. This increase in awareness was much larger in communities with a Health Post than in communities without.



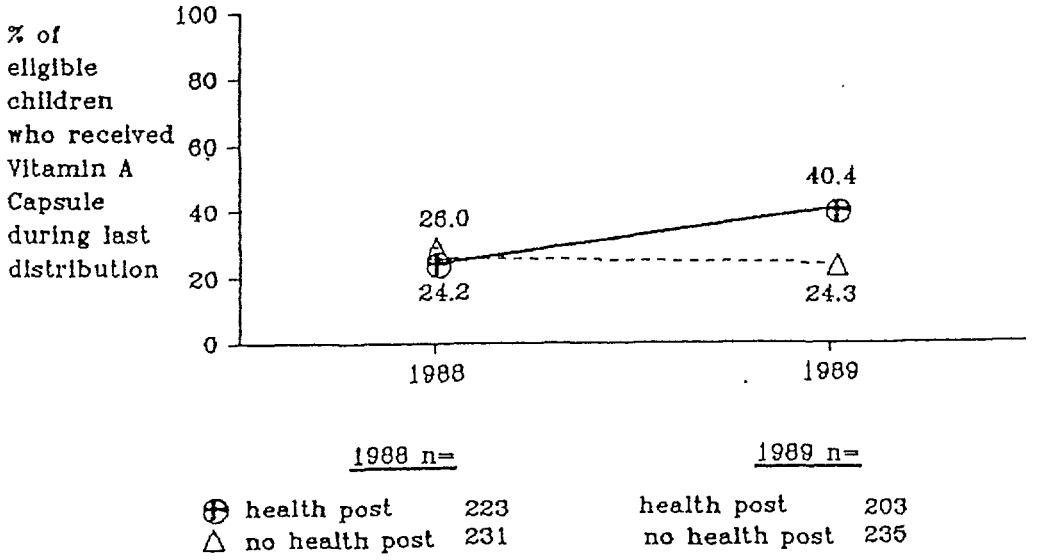
Mothers' Knowledge

Each mother was asked a number of questions to determine her knowledge of the information we communicated about capsules, including their availability at the Health Post during February and August. Analysis showed no significant difference between intervention and control areas in changes in mothers' basic knowledge of such information about capsules.

Capsule Consumption

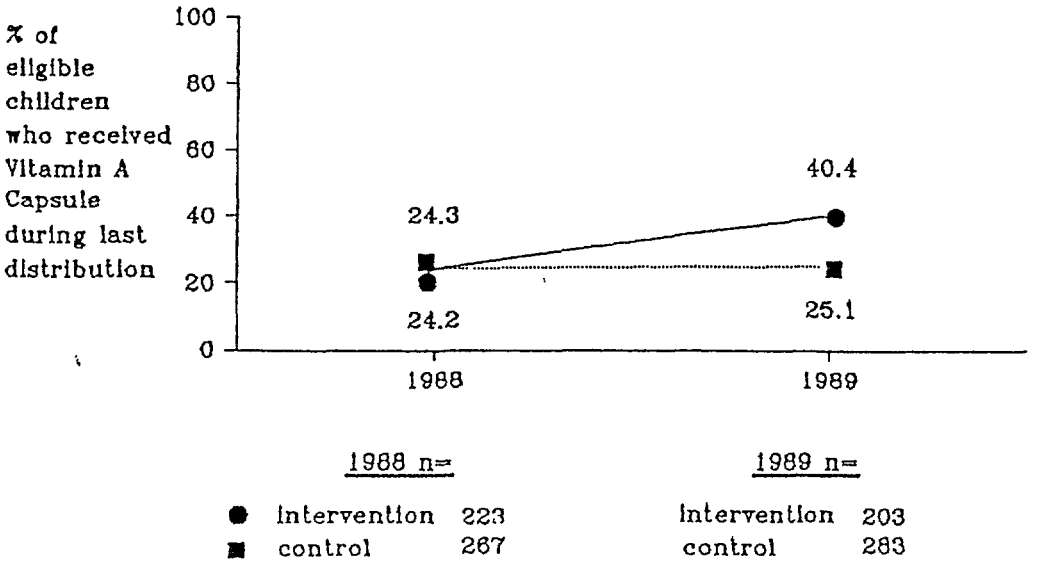
Comparisons of capsule consumption rates did show changes. In the intervention area, in communities with a Health Post, capsule consumption reported by mothers for their children age 1-4 years increased by two thirds -- from 24.2 percent to 40.4 percent. In intervention communities without a Health Post -- that is, without a fixed point-of-distribution for capsules -- capsule consumption rates remained the same from 1988 to 1989.

Vitamin A Capsule Consumption Rates by Whether the Community had a Health Post
(Intervention Regency)



When we compare only communities with Health Posts, we see a striking change in the intervention area and none in the control area:

Capsule Consumption in Communities with a Health Post
(Both Regencies)



Project Impact

Were these changes in awareness and consumption a result of project interventions? Yes: changes occurred in the intervention area and not in the control area, and we believe that there are no other activities which could explain these changes.

What aspects of the program worked? We believe that the project's communications were one factor. Awareness of capsules increased only in intervention areas, and this awareness was associated with exposure to radio messages and banners. Consumption of capsules also increased only in intervention areas; this capsule consumption was associated with contact with members of the health system. Thus, we believe that interpersonal communications made a difference.[2]

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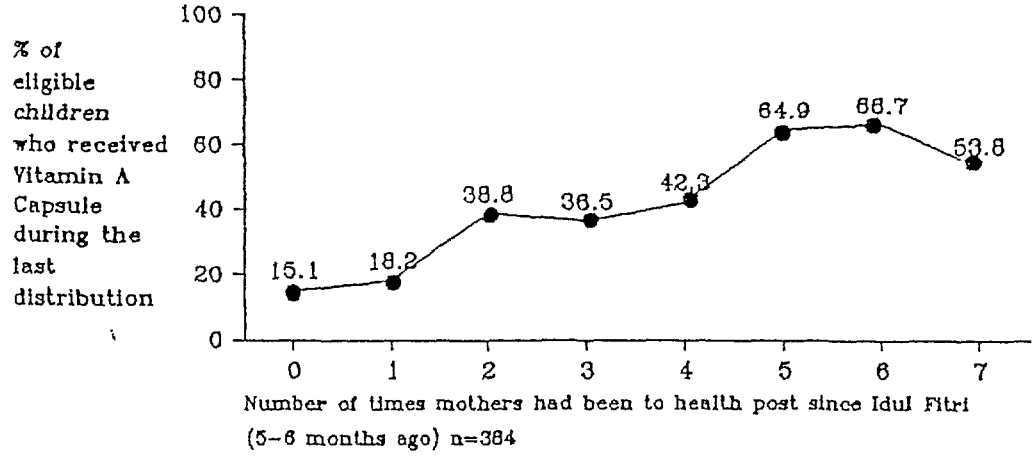
[2] These results on impact were found using logistic regression analyses while controlling for other factors which were associated with capsule consumption -- socio-economic status, isolation of the village, access to the health system, and age of the child. Contact with the health system was measured by immunization for the oldest child under five.

Related to health system contact, more frequent attendance at the Health Post was associated with higher capsule consumption rates.

Capsule Consumption during the Campaign by Attendance at Health Post among Mothers who had ever been to the Health Post (Intervention Regency, 1989)



In summary, with a Health Post in the neighborhood, it was possible for communications efforts to play a role in increasing the number of mothers who obtained capsules for their children.

Conclusions

Overall, the study has found that the major constraints to increasing vitamin A capsule consumption in the project area are access to the capsules and access to information about them.

The capsules themselves either must be readily available at both a time and a place that are convenient for mothers, or must be personally delivered to each child.

Needed information also must be accessible. Mothers can get some general information on vitamin A capsules through mass media, and they can get neighborhood-specific information through interpersonal communications channels. We learned that radio was more cost-effective than banners, and we learned of other channels to be explored. Because of the limitations of any single channel, we believe that it is important to continue to use a coordinated multi-channel approach, in order to

- reach more mothers, and
- provide them with specific information about when and where they can obtain vitamin A capsules in their neighborhood.

Follow-Up: Policy Impact

The study covers the period from 1988 to 1989.[3] Since then, Indonesia has taken a number of steps while continuing efforts to improve the interventions used in the project.

- We have made adequate consumption of vitamin A a high priority health program and are committed to eliminating xerophthalmia as a public health problem in Indonesia by 1993.
- We will emphasize distribution of megadose capsules in the short term and fortification and vitamin-A-rich foods in the long term.
- We have expanded the target area for our intensive program of mass media and interpersonal communications on vitamin A capsules, to include all 17 million Indonesian children age 1-4.
- We have increased the number of Health Posts across the country.
- We are examining the best way to improve the capsule supply system, in order to ensure that capsules are available at the Health Posts when mothers come for them.
- We have expanded the variety of vitamin A communications and are now using television, radio, printed fliers, paid and volunteer health workers, paid and volunteer administrative officials of the Department of Home Affairs, and paid and volunteer workers from the Family Welfare Movement.
- We have standardized capsule distribution timing to every February and August throughout the country, in order to facilitate the use of mass media for general information on capsules.
- We are coordinating the work of the Health Department, the Home Affairs Department, and non-government organizations (such as the Family Welfare Movement) so that village and neighborhood administrative officials and volunteers are providing specific information about time and location of the vitamin A capsule distribution in their areas.

With these actions, we are expanding and intensifying our efforts to reduce vitamin A deficiency by helping to increase the number of children who receive vitamin A capsules.

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[3] A more detailed report of this research, "Results from the Evaluation of the HEALTHCOM Project in Central Java, 1988-1989," will be available from Helen Keller International, Bina Mulia Building, 9th Floor, Jalan H.R. Rasuna Said Kav. 10, Kuningan, Jakarta 12950, Indonesia.

APPENDIX XIII

ROVITA (1988-1990) PAPER PRESENTED AT INPF

Sixth International Conference of International Nutrition Planners Forum UNESCO

(see attached)

THE IMPACT OF

SOCIAL MARKETING EFFORTS ON MEGADOSE VITAMIN A CAPSULE CONSUMPTION RATES:

1988-1990 RESULT OF A PILOT PROJECT IN CENTRAL JAVA

ROVITA PROJECT
INDONESIA
1991

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THE IMPACT OF SOCIAL MARKETING EFFORTS ON MEGADOSE VITAMIN A CAPSULE CONSUMPTION RATES: 1988-1990 RESULTS OF A PILOT PROJECT IN CENTRAL JAVA[1]

Satoto, B.A.Kodyat, J.A.McDivitt, T.K.Reis, A.C.Palmer, S.A.Wilbur[2]

Background

Vitamin A deficiency is one of the major nutritional problems in many developing countries. In Indonesia, although prevalence of clinical cases of vitamin A deficiency has decreased significantly, priority is still given to controlling the problem, particularly because of mounting evidence that even sub-clinical vitamin A deficiency may lead the increased child mortality.

Indonesia's vitamin A programs include nutrition education for consumption of vitamin A rich food, fortification of food products, and distribution of megadose vitamin A capsules to preschool children. This paper briefly discusses a pilot "Rovita" project which used social marketing to increase awareness of the capsules among mothers and to increase capsule consumption by preschool children.[3]

Megadose vitamin A capsules are provided by UNICEF and are distributed by the Ministry of Health through its health delivery system to Village Health Posts ("Posyandu"). At regular Health Post sessions, Health Volunteers give the capsules free of charge to children between the ages of 12 and 59 months. Other services provided at these Health Post sessions are growth monitoring, immunizations, prenatal care, nutrition counseling, family planning, distribution of iron tablets to pregnant women, oral rehydration salts for diarrheal cases, and other primary health services, particularly for mothers and children.

These Health Post sessions are ideally held once each month for 2 to 3 hours. Because vitamin A capsules are intended to be given out every six months, they are available to mothers and children only 2-3 hours twice each year. Consequently, only mothers and children who are accessible during those two 2-3 hour periods receive

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1 *This paper was presented to the Sixth International Conference of International Nutrition Planners Forum, UNESCO, Paris, 4-6 September 1991*

2 *The authors are from, respectively, Diponegoro University, the Ministry of Health, Annenberg School for Communication, the Academy for Educational Development, Helen Keller International, and Helen Keller International.*

3 *Rovita Project (Rehidrasi Oral and Vitamin A) was a collaborative effort of Ministry of Health, Diponegoro University, Helen Keller International, and the Academy for Educational Development, with technical assistance from Annenberg School for Communication.*

vitamin A capsules. Various ways have been considered to increase the above accesibility. One way tried in the project using a strategy of communications, specifically, social marketing.

Project Description

ROVITA Project was a pilot effort conducted to cover approximately 150,000 target children age 12-59 months in two coastal regencies of Central Java Province. The project objectives were to increase the consumption of megadose vitamin A capsules, to increase the practice of oral rehydration therapy (ORT), to apply a social marketing communication methodology, and to test a relationship between vitamin A capsule consumption and morbidity from diarrhea and acute respiratory infections. This paper discusses the social marketing of vitamin A capsules.

The specific objective for Rovita Project's vitamin A communications was to induce mothers to bring their children age 12-59 months to a Health Post for a vitamin A capsule on the day of the Health Post session. To reach this objective, the project team followed a social marketing methodology, which incorporates principles from advertising and research in order to design, produce, communicate, and evaluate socially beneficial messages.

The target group for the capsules was the children, but the primary target audience was defined as their mothers, the group whose behavior, it was hoped, would change so that the children would be given the opportunity to recieve vitamin A capsule. Ethnographic research provided information needed for developing effective communication strategies, focus group discussions provided more information on specific concepts for messages, and pretestings with mothers from the target group ensured that the messages could be understood correctly.

Each of the project's vitamin A messages was based on a core of 5 key points:

* the product is vitamin A, in capsule form;
* the capsules are for your child from 12 up to 59 months old;
* they're available at the Health Post (Posyandu);
* they're available every February and August; and
* they're free.

To communicate these messages, the project integrated three media channels -- radio, print, and interpersonal. One-minute radio spots started ten days before each distribution month (February and August every year) and continued throughout the

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month, with 4 to 5 stations each broadcasting 10 spots per day, in the national and local language. Printed cloth banners were distributed to village heads and to Community Health Centers and were displayed during the capsule distribution months. In addition, Health Center staff and community health volunteers received special training and handbook to facilitate their health extension work with mothers.

These interventions were routinely monitored by the project team to ensure that messages were disseminated and understood.

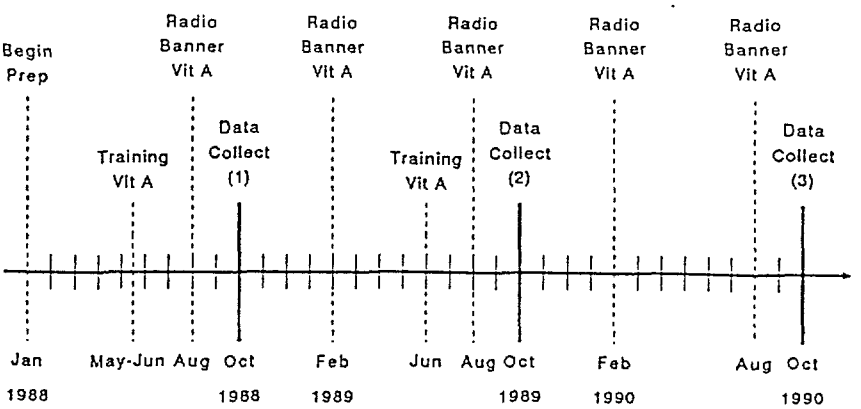
Study Design

The objectives for the study were:

* to measure the changes in mothers' awareness and knowledge of vitamin A capsules;
* to measure the changes in the percentage of eligible children who received a capsule; and
* to measure relationship between those changes and social marketing interventions and other confounding factors.

The design of the study was pre-post case-control comparison. It consisted of three surveys, one year apart. However, as can be seen in the following timeline (Figure 1), it was not possible to conduct the first survey before any project activities, thus, the survey was not a true "pre-intervention" measurement. Moreover, it was difficult to avoid contamination of the control area, which was chosen for its similarities to the intervention area and was necessarily located in the neighbouring regency. In all places, 2,400 mothers were interviewed, 500 in intervention area and 300 in the control area each year.

Figure 1. Timeline for Rovita Project Evaluation



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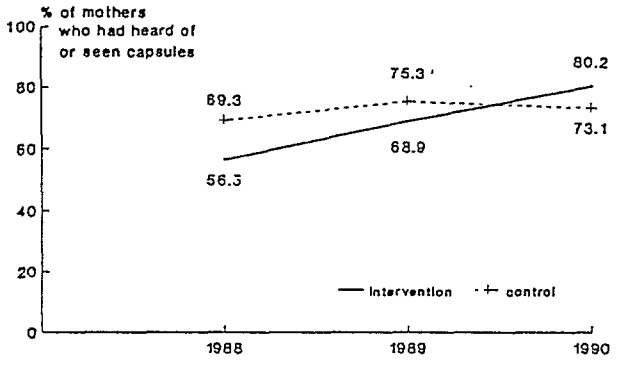
Results

The results of the study show that the project intervention had a positive impact, as described below.

Mother's Awareness

Overall awareness of the capsules -- either having heard of the term "vitamin A capsule" or having previously seen capsules like those shown by the interviewer -- increased significantly in the intervention regency, for two years. There was no significant change in the control area (Figure 2).

Figure 2.
Overall Awareness of vitamin A Capsules among Mothers (Both Regencies)



	1988 n =	1989 n =	1990 n =
● intervention	480	479	440
■ control	319	312	320

Comparing mothers only in communities with Health Posts shows the same pattern: awareness of capsules increased significantly each year in the intervention area and remained the same in the control area (Figure 3).

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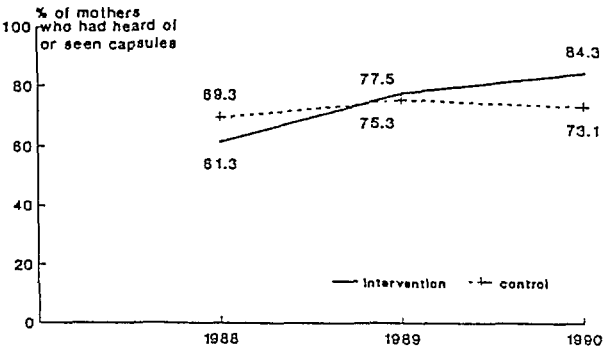
Figure 3. Awareness of vitamin A CApsules among Mothers in Communities with Health Post (Both Regencies)



	1988 n =	1989 n =	1990 n =
● intervention	240	240	432
■ control	303	296	320

Mothers' Knowledge

Each mother was asked a number of questions to determine her knowledge of the information we communicated about capsules, in- cluding their availability at the Health Post during February and August. Analysis showed no significant difference between intervention and control areas in changes in mother's basic knowledge of such specific information about capsules.

Capsule Consumption

Comparison of capsule consumption rates shows changes. Overall, after one year and two years of project intervention, the percentages of eligible children who were reported to have recieved capsules in the intervention regency were higher than those in the control regency. Analysis showed a significant ($p < .05$) increase in intervention area capsule consumption rates from 1988 to 1989 and an insignificant change form 1989 to 1990 (Figure 4).

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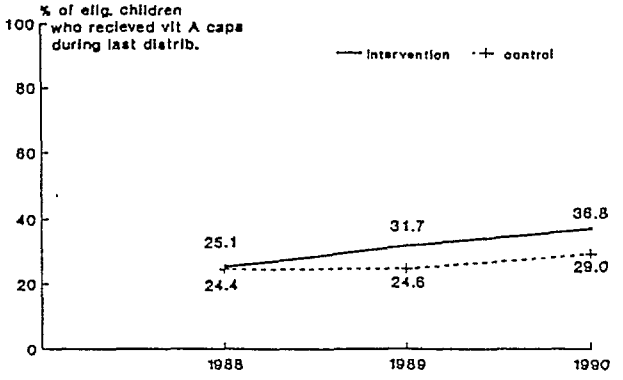
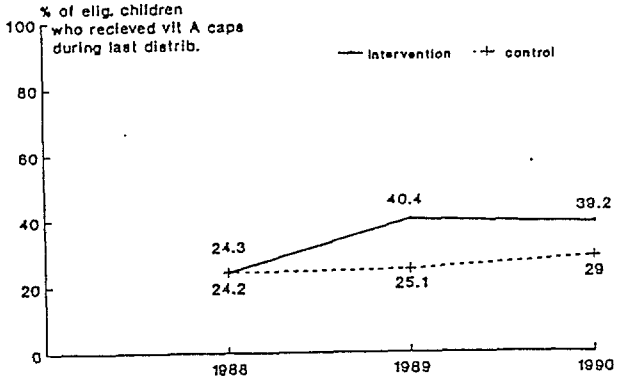
Figure 4. Overall Vitamin A Capsule Consumption (Both Regencies)



	1988 n=	1989 n=	1990 n=
● intervention	454	438	440
■ control	280	295	290

Looking only at communities with a Health Post (Figure 5), reported capsule consumption increased in the intervention area by two thirds in the first year -- from 24.2% to 40.4%, -- and remained high in the second year (39.2%). In the control regency, the percentages remained low and statistically unchanged from 1988 to 1989 to 1990

Figure 5. Capsule Comsumption in Communities with Health Post (Both Regencies)

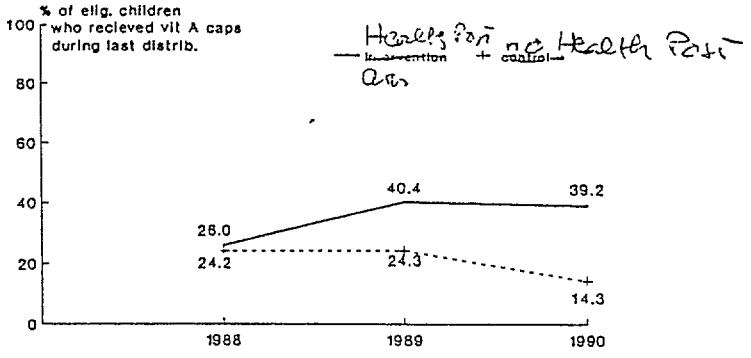


	1988 n=	1989 n=	1990 n=
● intervention	223	203	398
■ control	267	283	290

99

Figure 6 compares communities with and without a Health Post in the intervention area. In intervention communities without a Health Post -- that is, without fixed point-of-distribution for capsules -- capsule consumption rates remained the same from 1988 to 1989, and declined in the second year. In communities with Health Posts, consumption rates increased significantly from 1988 to 1989 and remained constant in the following year. While reported capsules consumption rates in communities with Health Posts remained steady at about 40% from 1989 to 1990, the number of Health Posts doubled; this means that 40 percent of a larger number of children recieved capsules.

Figure 6. Vitamin A Capsule Consumption Rates by Whether the Community had a Health Post (Intervention Regency)

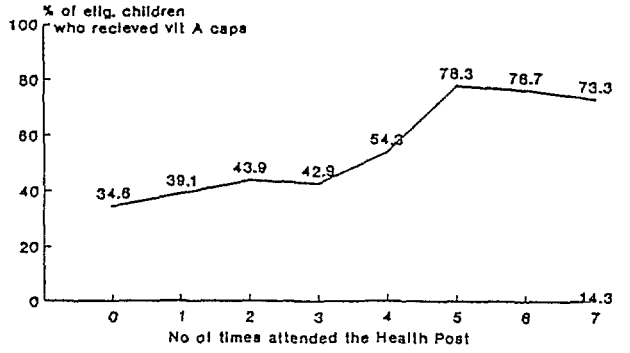


	1988 n =	1989 n =	1990 n =
⊕ health post	223	203	398
Δ no health post	231	235	42

The Role of Health Posts

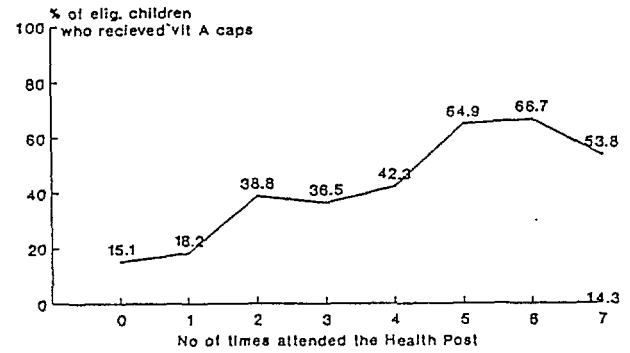
Throughout the analysis, it was clearly shown that having a Health Post in the community, was one of the most important factors in getting vitamin A capsules. Figure 7 and 8 provide additional evidence relating Health Post attendance to awareness and to reported capsule consumption. Related to health system contact, more frequent attendance at the Health Post was associated with higher awareness of vitamin A among mothers (Figure 7) and higher capsule consumption rates (Figure 8).

Figure 7. Awareness of Vitamin A among Mothers by Attendance at Health Post since Ied Holiday (Intervention Regency, 1989)



(n = 384)

Figure 8. Capsule Consumption by Attendance at Health Post since Ied Holiday (Intervention Regency, 1989)



(n = 384)

Project Outcome

It was important to determine whether the changes in awareness and consumption is described above were a result of project interventions. Because changes occurred in the intervention area and not in the control area, and because thereseems to be no other activity in either area which could explain these changes, it is reasonable to attribute them to the project intervention.

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Regarding which aspects of the program were effective, statistical analyses showed that the project's communications were one factor[4]. Awareness of capsules increased only in intervention areas, and this awareness was associated with exposure to radio messages and banners. Consumption of capsules also increased only in intervention areas; Since this capsule consumption was associated with contact with members of the health system, as measured by immunization and as reflected by the mother's reported attendance at the Health Post, it is hypothesized that interpersonal communications also made a difference.

Again, having a Health Post in the neighborhood and mothers' awareness of its existence played a key role in increasing the number of mothers who obtained capsules for their children.

Overall, the study has found that communications made a significant difference in increasing awareness of vitamin A capsules. The study has also found that, although communications played a role in increasing capsule consumption rates, the major constraints to increase in capsule consumption in the project area are access to the capsules and access to information about them.

The capsules themselves either must be readily available at both a time and a place that are convenient for mothers. In Indonesian context, this means that the Health Posts need to be accessible to and that it is important for mothers to accept Health Posts as places for health services, including capsule distribution.

Needed information about vitamin A capsules must also be accessible -- either general information through mass media, or neighborhood-specific information given by local health volunteers or community leaders. In the project, radio was found to be more cost-effective than banners, and other potentially effective channels of information were identified. Because of the limitations of any single mass-media or interpersonal communications channel, however, it is important to continue to use a coordinated multi-channel approach, in order to:

- reach more mothers, and
- provide them with specific information about when and where they can obtain vitamin A capsules in their neighborhood.

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4 *These results on impact were found using logistic regression analyses while controlling for other factors which were associated with capsule consumption--socioeconomic status, isolation of the village, access to the health system, and age of the child. Contact with the health system was measured by immunization for the oldest child under five.*

Follow-Up: Policy Impact

The study covers the period from 1988 to 1990. Based on the results of this and other studies in Indonesia and elswhere, the Governmnet of Indonesia has taken a number of steps as part of continuing work to improve the intervention used in the project, with the goal of expanding and intensifying current efforts to reduce vitamin A deficiency by helping to increase the number of children who consume adequate vitamin A.

The Ministry of Health is politically committed to eliminating xerophthalmia as a public health problem in Indonesia by 1993. Emphasis will be placed on distribution of megadose capsules in the short term, and in the long term, on fortification of foods and consumption of foods naturally rich in vitamin A.

To this end, various specific steps have already been taken. As of February 1991, the Ministry of Health has standardized the timing of capsule distribution to every February and August throughout the country in order to facilitate manangement and the use of mass media channels fot general information on vitamin A capsules. Closed coordination has been developed among the Ministry of Health, Ministry of Home Affairs, other ministries, and non-government organizations, particularly the Family Welfare Movement. It is hoped that village administrative officials, community leaders and volunteers will work hand in hand to provide specific information about vitamin A and to ensure that the distribution of the capsules occurs at the most appropriate and acceptable time and location (Health Post or aother place). Toward the long term goal of increasing consumption of vitamin A rich foods, work with community-based non-government organizations has begun. The variety of vitamin A communications has been increased and so far now includes television dramas, governors' speeches, and printed fliers, as well as radio, banners. Community Health Center staff, and volunteer health workers. To strengthen the impact of these efforts, a number of studies have been planned to provide additional needed information.

Rovita Project activities have been expanded, and work is continuing at all levels, beginning with a specific program of social marketing of vitamin A capsules and foods to be conducted nationwide over the next three years with extra attention given to the approximately 17 million children 12-59 months old in 13 high-risk provinces. The objectives of this expanded program (called "Somavita") focus on increasing the consumption of vitamin A capsules among target children and on developing a new program with the long-range goal of increasing the consumption of vitamin A rich foods.