ROADMAP FOR DEVELOPING AN ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR STUNTING REDUCTION IN INDONESIA

April 2018
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Acknowledgment

We gratefully acknowledge the technical input, guidance, and assistance of the following during the development of this document (in alphabetical order): Alive & Thrive – Fernando Garcia, Kristina Granger, Roger Mathisen, Andy Rigsby, Joy del Rosso, Christina Wong, Paul Zambrano; IMA World Health– Iwan Hasan; Millennium Challenge Account Indonesia – Farah Amini, Iing Mursalin, Bonaria Siahaan; UNICEF Indonesia – Jee Hyun Rah, Sri Sukotjo, Esthetika Wulandari; World Bank – Elviyanti Martini, Claudia Rokx, Ali Subandoro.

We would also like to express our gratitude to the Government of Indonesia, firstly to Dr. Ir. Subandi MSc. of the Ministry of National Development Planning (BAPPENAS) for setting the platform for this technical support, to Dr. Anung Sugihantono of the Ministry of Health, and to the Office of the President, Office of the Vice President, and The National Team for the Acceleration of Poverty Reduction (TNP2K) for their valuable input and guidance.
Acronyms

A&T – Alive & Thrive
BCC – Behaviour Change Communication
ECD – Early Childhood Development
IPC – Interpersonal Communication
GKIA – Gerakan Kesehatan Ibu dan Anak
GoI – Government of Indonesia
IEC – Information, Education, and Communication
INGO – International Non-Governmental Organization
IYCF – Infant and Young Child Feeding
M&E – Monitoring and Evaluation
MIYCN – Maternal Infant and Young Child Nutrition
NGO – Non-Governmental Organization
NNCC – National Nutrition Communication Campaign
PKH – Program Keluarga Harapan
PKK – Pemberdayaan Kesejahteraan Keluarga
SBCC – Social and Behaviour Change Communication
About this document

This document is a roadmap to provide a clear path and guidance for the government and other key stakeholders to develop a national advocacy and behaviour change communication strategy for stunting reduction. The roadmap aims to facilitate alignment, improve the sense of ownership, ensure relevant stakeholders are involved and set an appropriate structure for the process of putting together the communication strategy.

This document is not a developed communication strategy, as it does not identify target audiences, key messages or tactical elements such as communication channels.

Global best practices show that the first step to design and implement an effective communication strategy to change behaviour is support from stakeholders. This document advocates for a proper consensus-building process among relevant stakeholders prior to developing an integrated and developed strategy.

The roadmap is written for use by government officials at the national level and development partners, but sub-national government official will also benefit from the information presented in this document.
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Stunting Reduction has become a National Priority in Indonesia

The nutrition situation in Indonesia remains problematic despite the country’s good progress and the Government of Indonesia’s (GOI) commitment to reducing malnutrition. In 2013, approximately 9 million children under five (37%) were estimated to be stunted. To combat stunting the GOI issued a Presidential Decree no. 42/2013 to launch ‘Gerakan Nasional Percepatan Perbaikan Gizi’ (National Movement to Accelerate Nutrition Improvement) - focused on the first 1000 days of life, in line with the global SUN Movement.

Subsequently, the GOI launched the National Stunting Reduction Movement in 2017. With the aim of reducing stunting of under-two children to 28% by 2019, Rencana Pembangunan Jangka Menengah Nasional (RPJMN) (National Medium-Term Development Planning) 2015-2019 (Book II-2-97) stipulated that the Acceleration of Community Nutrition Improvement Strategy must promote behaviour change as one of its main components. Additionally, Vice President, Jusuf Kalla, as the head of Tim Nasional Percepatan Penanggulangan Kemiskinan (TNP2K) (National Team to Accelerate Poverty Alleviation) introduced the concept of the five pillars of stunting reduction. This included the implementation of a national campaign focusing on knowledge, behaviour change, political commitment and accountability for stunting reduction (Figure 1). The Government of Indonesia named 100 priority districts to receive interventions starting in 2018, and a plan to scale up in 2019 – 2021.

5 Pilar Penanganan Stunting

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*Figure 1. Five Pillars to Reduce Stunting by TNP2K*

The importance of communication and behaviour change has been repeatedly mentioned in various government policies, however, an integrated national communication strategy for stunting reduction has not been established. As a result, efforts to promote stunting reduction have been sporadic, leading stakeholders to develop their own efforts that are often inconsistent and at times include inaccurate information. The roles and responsibilities of different stakeholders in stunting reduction communication activities also have not been clearly defined, creating a challenging environment for coordination, decision making, and accountability.
Situational analysis

Maternal Infant and Young Child Nutrition (MIYCN) practices and communication

A desk review conducted by Alive and Thrive in 2017 summarized the existing literature on MIYCN practices in Indonesia focusing on the first ‘1000 days’ nutrition window of opportunity. Overall, disparities in all MIYCN indicators exist across Indonesia due to significant inequities in wealth, infrastructure, and levels of urbanity/rurality, with malnutrition worst in areas with limited access to schools, markets, and health facilities. Even among the wealthiest households, between 24 and 29% of children are stunted.

The review presents current MIYCN practices and what is known about determinants of key MIYCN and related health-seeking behaviours. Potential important knowledge gaps are identified. This review underscores the need for a comprehensive advocacy and behaviour change communication strategy to address the barriers to achieving optimal MIYCN in the first 1000 days. A summary of the highlights of this review is below, and a matrix providing more details is included in Appendix A.

Stunting (low height for age)

- Most people are not familiar with the term stunting.²
- Stunting is not currently seen as a public health problem among mothers, as well as healthcare workers and non-healthcare stakeholders.³
- Many believe it is caused by hereditary factors.²

Maternal nutrition

- Reduced eating and food taboos occur during pregnancy.²
- Diets are influenced by husbands and mothers/mothers-in-law who are decision makers on foods bought and consumed².
- Micronutrient deficiencies—iron and calcium affect pregnant women.⁴

Early initiation of breastfeeding (EIBF) and exclusive breastfeeding 0-6 months (EBF)

- Early initiation of breastfeeding is not the norm; only about half of mothers initiate breastfeeding within one hour of birth.⁴
- Only 1 out of 2 infants 0-6 months are exclusively breastfed.⁵
- Mothers assisted by a health professional during delivery are less likely to practice EIBF or within one day compared to mothers assisted by a TBA or by relatives.⁶
- Poor knowledge of breastfeeding practices, lack of motivation to breastfeed, and lack of confidence all served as barriers to exclusive breastfeeding.⁷
- There is a confidence gap in mothers’ ability to produce the right quality and quantity of breastmilk.³
- Working mothers experience challenges to exclusive breastfeeding; for example, lack of private lactational areas, lack of flexible schedule.⁸

Recommended studies include:

- Studies on the impact of conditional cash transfers on health and nutrition²
- Costing study for extending paid maternity leave to six months (also by the University of Padjadjaran in 2015).³
- Media scan that shows inappropriate marketing of breastmilk substitutes in South-East Asia²
- The Economic Cost of Not Breastfeeding in Indonesia conducted by the University of Padjadjaran in 2015.³
- National surveys on current nutrition practices and stunting prevalence (Riskesdas, Indonesia DHS).²
- Referencing global commitments – e.g. Indonesia’s progress in achieving the nutrition-related Sustainable Development Goals."
Promotional materials, BMS samples, and other Code violations are barriers to EBF.

Complementary feeding

- Early introduction of complementary foods is common, with half of all breastfed children age 4-5 months having already had some type of solid or semi-solid food.
- Adequate frequency of feeding children 6 to 24 months is an issue; only two-thirds of children are fed the recommended number of times per day.
- Half of the mothers report feeding only on demand.
- Only about one-third of children age 6-23 months are fed according to the WHO revised IYCF recommendations, including food and breastfeeding frequency and adequate dietary diversity.

Communication materials assessment

An assessment of existing communication materials related to stunting (Appendix B) indicates that:

- There is a clear need to establish a set of guidelines to make sure that all communication efforts deliver consistent and accurate information.
- Although stunting is a major problem in Indonesia, and lack of awareness is one of the key findings of the research studies referenced, no comprehensive campaign properly addressed the topic.
- The national campaign by MoH is mostly related to interventions to prevent stunting such as Exclusive Breastfeeding, Free Open Defecation, Hand Washing with Soap, etc.
- There is also a campaign at the sub-national level conducted by NGOs such as GAIN on Infant and Young Child Feeding.
- The only comprehensive behaviour change communication (BCC) effort at national level was conducted by IMA WorldHealth in 2016-2017, but since there is no statistical evidence of the performance of the program available at this time, it is hard to determine its effectiveness.
- A new awareness campaign about stunting started by IMA WorlHealth in December 2017, is a step in the right direction, although it should have been the initial campaign before running the BCC program.
- The different campaigns currently running, pointing in many directions and with many providing inaccurate information, underscore the need to create consensus on how to address stunting reduction, to coordinate efforts and speak with one voice on all fronts.
Why do we need behaviour change communication?

As indicated by the Government of Indonesia, advocacy and BCC are necessary components of a comprehensive nutrition program aimed at stunting reduction, which requires the adoption of key behaviours known to prevent undernutrition in the critical first 1,000 days – from the start of conception up to the first two years of a child’s life.

Improving nutrition outcomes through the adoption of new behaviours takes time and effort at many levels. It requires an approach combining advocacy to make BCC part of an overall GoI program to create awareness of malnutrition’s effect on children, as well as the social and behaviour change interventions needed to promote and support better MIYCN practices in the community and household.

To be able to scale and replicate this approach beyond the initial 100 districts initially targeted and ensure that other populations will also improve their nutrition, it is also essential to build the capacity of local and national stakeholders in the design and implementation of behaviour change methodologies. Their exposure and engagement as policymakers and at the community level is a key component of behaviour change towards nutrition promotion.

Within this context, BCC can have different but interrelated roles.

**Increase knowledge.** By ensuring that different audiences receive the basic facts about malnutrition as the main cause of stunting in an easy to understand manner.

**Stimulate community dialogue.** By encouraging community discussion on the basic facts of nutrition and the factors that contribute to the malnutrition problem, among them inappropriate behaviours, cultural practices related to food and eating habits, and family influences on nutrition in the ‘1000 Days’ period.
**Promote change.** By encouraging appropriate attitudinal and practices changes such as early initiation of breastfeeding, exclusive breastfeeding in the first six months, optimal feeding during the 6 to 23 month period, open-mindedness about social norms, and basic needs of pregnant/lactating women (maternal nutrition), to prevent stunting.

**Create demand for healthy food, information, and services.** By stimulating individuals and communities to request information on good nutritional practices and demand the support services needed to implement better practices.

**Improve skills.** By focusing on teaching or reinforcing new skills including counselling on new behaviours, such as prenatal care, exclusive breastfeeding and an age-appropriate nutritional diet for the whole family, among others.

To be effective, BCC requires the foundation of a comprehensive behaviour change strategy and program, sound implementation and continuous monitoring to enable adjustments as needed based on credible data and information.

### Behaviour change program design

Global best practice shows that for a change in behaviour to be adopted and sustained, any behaviour change strategy should contain advocacy, interpersonal communication (IPC) and community mobilization, mass media and the strategic use of data.

**Figure 2 - The A&T framework, a systematic, data-driven, collaborative approach to program design, provides a process to guide decisions on project design for behaviour change, dividing it into those four tactical elements.**
Advocacy

Advocacy is the process of educating and motivating influential audiences to take specific actions in support of an issue, in this case prioritizing stunting reduction by creating an enabling environment for mothers and families to adopt optimal MIYCN practices. This may include supporting laws, policies, financing, or planning for nutrition on a large scale. The exact need, goal, or policy action is shaped by Indonesia-specific barriers, its political system, and social context.

Advocacy is necessary because even when mothers and families are reached through health systems and mass media campaigns, environmental barriers remain. For example, mothers may have to return to work after only a few weeks after giving birth, making exclusive breastfeeding for six months difficult. A mother may receive misleading messages because of unregulated marketing practices by infant formula companies, leading her to give formula instead of breastfeeding.

Stunting reduction requires action from multiple sectors (health, nutrition, education, WASH, agriculture, social protection, etc.). In Indonesia, the decentralized government context means that advocacy needs to be harmonized across these sectors, at multiple levels of government, and across geographies. The central government can play a leadership role in motivating and leveraging commitments and actions from sub-national leaders and departments.

Some examples of successful advocacy efforts include:

Working closely with the Vietnam Women’s Union, stakeholders conducted an intensive advocacy campaign on paid maternity leave and the International Code of Marketing of Breastmilk Substitutes to parliamentarians in 2012. As a result, paid maternity leave duration was increased from 4 to 6 months in support of exclusive breastfeeding. Advertising of breastmilk substitutes marketed for children under 24 months was also banned, in line with global recommendations.

Interpersonal Communication and Community Mobilization

“People talking to people is still how the world’s standards change.” - Atul Gawande.

IPC, the most effective form of communication, involves face-to-face conversations and activities with mothers or family members. Through IPC, frontline workers can create awareness about the effects of malnutrition that lead to stunting, explain the importance of good nutrition during the different stages of the first 1000 days, and advice on ways to prevent stunting.

Through community mobilization, local opinion-leaders are mobilized to recognize the importance of proper nutrition for stunting reduction, support community-based workers, and promote adoption of recommended nutrition practices
In countries where A&T implemented its successful SBCC programs, IPC was key to reach pregnant women and women with a child under 2 years of age. In Bangladesh, mothers in over 220 sub-districts were reached through home visits, using workers from existing programs carried by a large local NGO. In Ethiopia, health workers and women’s organizations home visits, combined with community mobilization activities, were the main communication channels. In Vietnam, interpersonal counseling through social franchises and Infant and Young Child Feeding (IYCF) support groups played important roles in reaching mothers.

All three country programs increased access to health volunteers and health workers trained in counseling on IYCF, strengthening frontline workers and the health systems – reaching around 3.7 million mothers of children under the age of two.

Mass Communication

Mass communication campaigns (broadcast, out-of-home, and online) featuring the importance of key practices, combined with the other program components, help maximize reach and impact. Mass communication, the most efficient form of communication at large scale, is essential to reach audiences at the national level.

In Bangladesh, mass communication reached 6.5 million mothers of children under 2 years directly, over a three-year period, in Ethiopia it reached nearly 1 million, and in Vietnam 2.3 million. The mass media messages touched millions more who could support mothers’ behaviours, including fathers, grandmothers, health workers, doctors, and decision makers, with common, tested messages delivered in a consistent manner.

Mass communication campaigns lent credibility to frontline workers’ messages, making mothers more open to their support. The campaigns likely helped frontline workers remain true to the program’s priority messages.

The TV, radio spots and other materials featured key messages and promoted new behaviours, using images and stories of desirable infant feeding practices. In Ethiopia, a radio and TV campaign for men was developed because of their influence on feeding decisions and their access to mass media. Each TV and radio spot featured one IYCF action and how a father could support it. In Viet Nam, an award-winning TV campaign featuring “Talking Babies” addressed misperceptions about the adequacy of breastmilk and the need for water. The campaign also promoted iron-rich foods and advised mothers to use the IYCF counselling services of the social franchises.

The internet, social media, and mobile phone applications targeted mothers in urban areas.
Strategic Use of Data

Data-informed decisions result in better programs. Research is conducted to guide the program design, focusing on interventions proven to be effective at reducing stunting. Baseline data collection helps set realistic targets, specific and relevant to the geographic areas targeted by the program.

Data helps to develop and sustain partnerships, shape advocacy priorities, and program decision making. Formative research studies, landscape analysis, media scans, surveys, and stakeholder mapping help design country-tailored programs. Special studies and routinely collected data guide revisions in program design and implementation. Internal monitoring units and external evaluation teams collect and cross-check core indicators and track program reach. Monitoring systems help determine if corrective actions should be taken or if the program is on track.

Behaviour Change Communication Step by Step

A BCC strategic planning process starts with a joint national collaborative planning effort for strategic communication, bringing to the table different sectors, perspectives, and experiences from various parts of the country representing the wide diversity of communities in Indonesia.

The process is divided into five phases.

- **Understand the situation**
  - Situation assessments, consultations, formative research, national surveys

- **Focus and Design**
  - Identifying **priority behaviors** to promote and service delivery models

- **Create communication materials**
  - Support materials, job-aids, training manuals

- **Implement and Monitor**
  - Performance monitoring and supportive supervision

- **Use data for strategic adjustments**
  - Mid-course corrections, adjust plans

A situational analysis including stakeholder consultations, reviews of existing data sets and reports to identify strategic choices and gaps in the data, media audits, review of the health system, formative research and a baseline survey.

The key to successful BCC is focusing on a small number of behaviours and the disciplined commitment to stay “on message” with each of the program’s communication activities.

Mass communication campaigns and support materials developed in partnership with other stakeholders and created by advertising agencies.

Data from routine monitoring systems and special studies to improve understanding of the strengths and weaknesses in program implementation and what corrective actions are needed.

For evaluation and corrections, baseline, midline, and endline cross-sectional surveys are key elements of any SBCC program.
Why do we need advocacy?

Advocacy and communication, while different, complement and reinforce each other. The main distinction is not just the target audiences, but also what communication channels and materials are used to reach them. While communication targets individual changes in knowledge and behaviour, advocacy is directed at policymakers, leaders, and decision-makers at different levels, to affect change of a specific policy, law or program.

In defining its objectives, an advocacy program must take into consideration:

- The political, economic, social, and/or cultural motivations of the target audience.
- Available resources such as money, people, and political support.
- The barriers and obstacles preventing audiences from acting.
- The program’s ability to help to find a solution for removing barriers and obstacles.

Planning for the advocacy strategy and defining advocacy goals

1. **Policy and decision-making landscape analysis**: Examine relevant policy actions that need to be made at each level of government, as well as the key decision-makers for each policy action.
   - What has been done in Indonesia: Nutrition landscape analysis, nutrition sector review.
   - Recommendations: Legal reviews (including legislative procedures), expanding policy scans to include nutrition-sensitive areas

2. **Stakeholder mapping**: Building from the policy and decision-making landscape analysis, a stakeholder map can be developed for each policy goal identified (the stakeholders will change depending on the advocacy priority).
   - Recommendation: Conduct or update issue-specific stakeholder mapping for including sub-national level. This may be done through consultative meetings.

3. **Opinion leader and decision-maker assessments**: This rapid assessment effort is a quick way to gather insights from decision-makers through interviews to better understand their knowledge and views of undernutrition and stunting; motivations in favor of supporting stunting as a priority; barriers to greater political and public will for undernutrition and stunting reduction; and views and momentum related to specific policy actions.
   - What has been done in Indonesia: Opinion Leader Research on IYCF conducted by SMERU Research Institute (April 2016).

4. **Example Advocacy Goals and Objectives**
   
   1. At least 50 districts from 100 districts targeted in Indonesia adopt stunting reduction as a development target through their District Medium Term Development Plan RPJMD by the end of 2018.
2. At least X% of local funding allocated for evidence-based nutrition-specific and sensitive activities with concrete and measurable implementation plans by the end of 2019

Objectives:

1. Raise awareness of stunting’s impact on health, social and economic outcomes for families, provinces, and the nation among key decision-makers at national and sub-national level
2. Clearly communicate evidence-based solutions to reduce stunting
3. Clearly communicate the roles and actions that specific sub-national leaders, at different levels, must take to implement stunting reduction solutions

See Appendix C for the Process to Achieve Advocacy Goals

Suggested steps

A comprehensive stunting prevention effort should be addressed on several fronts.

Leadership and Coordination

1. To establish a committee on advocacy and BCC for stunting reduction

Effective coordination among multi-sectoral stakeholders is key to the success of the National Stunting Reduction Movement. With thirteen line-ministries directly included in the Presidential Decree no. 42/2013 as implementers of national stunting movement (Gernas PPG1000HPK), coordination and integration have been challenging.

![Figure 6. Structure of Gernas PPG1000HPK](image)
The current structure of the Gernas PPG 1000 HPK (figure 6) indicates two working groups being directly related to advocacy and behaviour change communication, namely the 1) Campaign and 2) Advocacy. These working groups need to be revitalized and, if possible, streamlined into just one working group on advocacy and behaviour change communication to ensure an integrated approach to the issue.

A committee or an ultimate decision-making body on advocacy and behaviour change communication will also need to be established to facilitate effective strategic decision-making processes. This committee can be small enough to function efficiently, comprising the heads of the three (two?) relevant working groups and other government institutions. Ideally, the committee may include representatives from the Ministry of Development Planning (BAPPENAS), Ministry of Health, Ministry of Communication and Informatics, Ministry of Home Affairs, Ministry of Village, Disadvantaged Regions and Transmigration, as well as Presidential Staff Office (KSP), National Team for the Acceleration of Poverty Reduction (TNP2K), Public Health and Communication experts to ensure communication efforts are coordinated both at the national and sub-national levels.

**Communication Strategic Planning**

2. To prepare a stunting awareness communication strategy by conducting a stakeholder workshop that will prepare national guidelines for terminology and key messages.

Convening a group of nutrition and communication experts from the SUN Movement and development partners to brainstorm and agree on key messages for different audiences, while establishing a set of communication guidelines related to stunting, will not only lead to uniformity of communication but will also achieve consensus among stakeholders. This will ensure that all stunting reduction communication campaigns will deliver clear and consistent messages.

Rationale:
Existing formative research and other sources identified in the literature analysis provide enough information to guide the design of a stunting awareness communication strategy. There is a need to establish a set of stunting communication guidelines at the national level for all communication efforts to deliver consistent and accurate information. There is a need to standardize the terminology and key messages at the national level. A workshop will bring together national and local stakeholders to achieve consensus on the strategy and national stunting communication guidelines. The stakeholder workshop will also help build capacity among stakeholders, preparing them for future nutrition communication efforts.

3. To prepare a BCC strategy by convening a national and regional group of stakeholders to draft a strategy and conduct a consultation process to confirm it at the regional and local levels.

As a next step, it is recommended to hold a separate Advocacy and BCC working group workshop to brainstorm on what behaviours should be the focus of a behaviour change effort aimed at reducing stunting and draft a communication strategy. The draft strategy agreed upon will be tested by conducting focus group discussions with different stakeholders in different districts. The results of the consultation effort will help confirm or revise the BCC strategy to come up with a final version that will be used to develop the BCC campaign.

Rationale:
- Existing research findings provide useful information that, combined with the stakeholders’ expertise will help put together a draft BCC strategy2,3.
- A consultation with local stakeholders around the country will help confirm and adjust the strategy to local needs while achieving consensus.
- Using this methodology will allow conducting the qualitative research within a relatively short period of time, speeding up producing the communication materials and the launching of the BCC campaign.
- The SBCC strategy developed will be culturally sensitive and targeted to connect with the appropriate audiences.
- The stakeholder workshop and the consultation methodology will help build capacity among stakeholders.
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ROADMAP FOR DEVELOPING AN ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR STUNTING REDUCTION IN INDONESIA

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3. There is a need to standardize the terminology and key messages at the national level.

4. A workshop will bring together national and local stakeholders to achieve consensus on the strategy and national stunting communication guidelines.

5. The stakeholder workshop will also help build capacity among stakeholders, preparing them for future nutrition communication efforts.

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4. The SBCC strategy developed will be culturally sensitive and targeted to connect with the appropriate audiences.

5. The stakeholder workshop and the consultation methodology will help build capacity among stakeholders.
Communication

Two complementary stunting reduction efforts should run in two stages. A mass media stunting awareness campaign, followed by a BCC program addressing the most complex issues of the stunting problem at the community level to affect behaviour change.

4. To implement a mass media awareness campaign on stunting and the first 1000 days

Stage one of a stunting reduction effort is to make the audiences aware that malnutrition may lead to stunting among children in Indonesia as well as the effects of stunting on children's development.

This campaign should be created by a professional communication organization, based on the stunting awareness communication strategy, following the agreed upon guidelines. The communications materials need to be pre-tested among the target audience before putting together the final campaign materials.

Rationale:

- Existing research indicates that lack of awareness of stunting, its cause and consequences by mothers, family members, and health workers is one of the barriers to prevent stunting.
- Existing research indicates lack of understanding of what the first 1000 days refer to.
- Before individuals and communities can change their behaviour, the first step is to make them aware of how malnutrition affects their family and community.
- Mass media is the most efficient vehicle to create awareness among the target audiences.

5. To implement a national BCC stunting prevention campaign

The second stage of a stunting reduction effort, once the audiences are aware of causes and effects of stunting among children, is to try to change the key behaviours that lead to stunting.

A mass media campaign should be part of comprehensive BCC program including advocacy, interpersonal communication and community mobilization, supported by government institutions and stakeholders at the national and local level.

Again, all communication materials should be created by a professional communication organization and approved by the committee, based on the BCC strategy agreed upon, and the materials need to be pre-tested among the target audience before putting together the final BCC campaign materials.

Rationale

- Running a stunting awareness campaign alone will not affect behaviour change.
- A well-orchestrated and properly implemented BCC program will affect behaviours to help reduce stunting.
- Once individuals and communities learn the basics about the effects of malnutrition and its prevention, they will be susceptible to adopt new behaviours and learn a set of skills to improve nutrition when receiving additional information through IPC and community mobilization efforts.
Advocacy

Advocacy and communication complement and reinforce each other as part of a comprehensive BCC program. Advocacy is directed at policymakers, leaders, and decision-makers at different levels, to affect change in a specific policy, law or program.

6. To design and implement a national advocacy strategy to drive policy- and decision-maker actions at national and sub-national levels

Based on existing studies or proposed analysis (e.g. stakeholder mapping), this strategy should define specific advocacy goals and objectives, identify specific target audiences among decision-makers and specific actions for them, adopt as much as possible a four-part process founded on good evidence and strong partnerships (see Annex C), and align with the broader stunting reduction strategy through centralized coordination and accountability measures.

Rationale:

- Support from sub-national leaders to adopt stunting reduction strategies and plans, and to allocate sufficient resources to them, will be critical to achieving reach and scale.
- Advocacy is sometimes addressed within other activities, but to achieve its full strategic potential it needs clear and specific goals, segmented by audiences and supported by harmonized activities among stakeholders.

Monitoring and Evaluation

The implementation of an initial BCC intervention in 100 districts, should aim to generate the evidence base to inform policy around effective models for improved nutrition around the country to ensure that the evidence generated is proactively utilized when scaling up the program throughout Indonesia.

7. To ensure that a Monitoring and Evaluation (M&E) framework is included as a major component of any future strategies

To track, adjust and measure the success of the intervention, a combination of evaluation studies and routine monitoring are required. A few considerations for the M&E framework are the following:

1. Monitoring

   a. Design and implement a monitoring framework, using various data sources including routine monitoring data, where available, to identify the strengths, weaknesses, gaps, issues, and problems faced during implementation.

   b. Outcome monitoring (e.g. monitoring changes in practices or knowledge) can be done through

      i. Sentinel site surveys in target areas to determine reception and recall of key messages from media campaigns and interpersonal counselling, trends in practices (e.g. increase in breastfeeding rates)
ii. More localized analysis of nationally representative surveys (e.g. Riskesdas, Indonesia DHS) in priority districts

iii. Mass media performance reports, activity monitoring, penetration studies, media scans and saturation studies can be conducted by local media tracking firms such as Nielsen but will often require external funding to conduct the analysis.

2. Evaluation

   a. A baseline, mid-term and endline evaluation can complement routine monitoring to determine the extent to which the stated objectives have been achieved, the effects and eventual impact of the advocacy or communication efforts, the effects and eventual impact of the advocacy or communication efforts.

   b. Possible approaches:

      i. Repeated surveys to determine practices, behaviours, and change in determinants

      ii. Special studies to determine the association of exposure to interventions (e.g. mass media spots and inter-personal counselling) to MIYCN practices

   c. Rigorous impact evaluations can be very costly and will require a high-level of technical capacity. While ideal, this option should only be considered if the resources are available.

Rationale:

■ There is a need to provide evidence of the success or failure of the BCC program.

■ Tracking allows for adjustments along the way, in terms of communication as well as media placement and effectiveness of communication channels.

■ Statistical evidence will help guide future BCC programs’ design and implementation.

■ Implementing an advocacy or BCC program requires continuous feedback and evaluation.

■ The implementation of an initial BCC intervention in 100 districts, should aim to generate the evidence base to inform policy around effective models for improved nutrition around the country.

■ Evidence generated will be utilized when scaling up the program throughout Indonesia.
ROADMAP FOR DEVELOPING AN ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY
FOR STUNTING REDUCTION IN INDONESIA

Suggested Timeline

<table>
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<tr>
<th>Activity</th>
<th>2018</th>
<th>2019</th>
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<tr>
<td></td>
<td>Apr May</td>
<td>Jun Jul</td>
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<tr>
<td>Brainstorming session to prepare stunting awareness communication strategy</td>
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<td>Baseline survey</td>
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<td>Mass media stunting awareness campaign</td>
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<td>Brainstorming session to prepare BCC strategy</td>
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<td>Consult stakeholders to confirm and get consensus on BCC strategy</td>
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<td>Preparatory phase for Advocacy (stakeholder analysis, etc.)</td>
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<td>Advocacy for priority decision-maker actions</td>
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<td>Mid-term evaluation</td>
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<td>National BCC stunting prevention campaign</td>
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<td>Endline Survey</td>
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<td>Monitoring</td>
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Note: While the purpose of this document is to guide the preparation of a BCC strategy, the timeline includes the estimated time required to implement the recommended components, for illustration purposes. A more detailed plan of action is required to prepare an actual timeline for those activities, based on the time it will take to put together the communication strategies.

Challenges to be considered

A Common Term for Stunting

There is no direct translation of the word “stunting” in Bahasa Indonesia, which explains why many terms were used to describe the concept. Various documents and communication materials produced by line ministries and other stakeholders have used the English term “stunting” or “pendek” (short), while others refer to the condition as “kerdil” (midget) or “stunting”. Instead of sending a consistent message to the public, the use of various terms can potentially cause confusion and decrease the effectiveness of message dissemination. To ensure effective communication, it is imperative that stakeholders agree upon one common term to be used in all the communication materials.

Geography and Cultural Diversity

Statistics Indonesia had identified 1,340 ethnic groups and Ministry of Education has documented 733 languages being spoken across the country, with many in Papua, West Papua, Maluku, North
Maluku and East Nusa Tenggara still unidentified. As one of the most diverse countries in the world, Indonesia is facing a real challenge in disseminating messages on stunting. Many ethnic groups have their own beliefs and values regarding health, illness, the value of a child, food, and nutrition. These will need to be taken into consideration when developing a communication strategy and key messages will need to be tailored to best appeal to different target audiences.

Decentralization

Based on the data from Ministry of Home Affairs, Indonesia consists of 34 provinces and 514 districts/municipalities. In the Law no. 23/2014 regarding regional government, health is a categorized as a concurrent issue, which means the responsibilities are shared between the central and the sub-national governments.

The central government already included stunting in its medium-term development plan (RPJMN 2015-2019) and launched the National Food and Nutrition Action Plan (RANPG 2015-2019). Most of the provincial and district governments included in the assessment do not have updated Food and Nutrition Action Plan, nor do they include stunting as an indicator in their regional medium-term development plan. This indicates the need for advocacy efforts directed at regional governments to make stunting a priority.

Multi-Sectoral Partnerships and Alignment

Involvement of the stakeholders is necessary to reduce stunting, but it also presents a challenge in decision making and coordination. Based on the lessons learned during the National Nutrition Communication Campaign implemented by MCA Indonesia, it is quite clear that a decision-making mechanism needs to be developed, especially if a national communication strategy is to be implemented in the future. Roles, responsibilities, and procedure to obtain approval must be in place to allow efficient flow of activities as well as avoid confusion and conflicts between stakeholders.
ROADMAP FOR DEVELOPING AN ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR STUNTING REDUCTION IN INDONESIA

References

5. Preliminary Result IDHS 2017
## Appendix A

### Maternal, Infant and Young Child Nutrition Practices

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<th>Ideal behavior</th>
<th>Current practices</th>
<th>Determinants and influences</th>
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</table>
| Attend four antenatal care (ANC) visits — 1 in first trimester, 1 in second trimester, and 2 in the third trimester | • About 94% of pregnant women received ANC serviced by a health worker, with 77.4% of pregnant women attending at least four ANC visits. (2017) Ref: 140One in five do not attend an ANC appointment until the second trimester. Ref: 21  
• Almost all provinces met the 2015 Strategic Plan goal of 72% attend for visits; exceptions are: Central Sulawesi, East Nusa Tenggara (ENT), Maluku, West Papua, and Papua. Ref: 11  
• 99% of women in East Java received ANC from a skilled provider; 58% of women in Papua. Ref: 50  
• Women from urban areas are more likely to attend 4 ANC visits; women from the highest wealth quintile are almost one and a half times more likely to receive at least four ANC visits. Ref: 41  
• An analysis of seven regions indicates Sulawesi, Maluku, Papua and West Papua islands are at a disadvantage accessing ANC. | • Women in West Nusa Tenggara (WNT), East Java, and Papua report beliefs that they should keep their pregnancies secret until their belly is showing. Ref: 50  
• Social shame contributes to stigma of pregnancy outside of marriage. These women are less likely to seek out ANC or facility-based delivery, putting them at an increased risk of maternal or neonatal mortality. Ref: 50  
• Staff/volunteers at Integrated Health Service Post, Posyandu, document pregnant women’s visits and encourage ANC appointments. Refs: 43,50 | How to encourage early ANC — during the first trimester  
Ways to reach and motivate ANC participation among the most disadvantaged including pregnancy outside of marriage |
| Consume an adequate maternal diet | Evidence suggests prenatal deficiencies in iron and calcium. Refs: 14,15 East Java evidence showed that during pregnancy, caloric intake drops to 75% of the recommended 1900 kcal and 44g of protein a day. In Central Java 26% of pregnant women responded on a survey to avoid many nutritionally beneficial foods, due to food taboos. Ref: 21 Survey in West Java showed 37% of respondents restrict some fruit and vegetables during pregnancy. Common restrictions include pineapple, avocado, pomegranate, guava, orange squash, durian, jack fruit, papaya, sugar cane, and eggplant, goat meat, durian, glutinous rice (ketan), spicy foods, coffee, peanuts, eggs, tofu, and lentils. Ref: 50 | • Traditional beliefs on prenatal nutrition as well as food insecurity contributes to the decrease in caloric intake during pregnancy. Ref: 12  
• Women affected by influencers; they usually buy and prepare food, but often have to get permission from husbands or mothers/mothers-in-law on what to buy. Ref: 28  
• In some households, women typically eat last including during pregnancy. Ref: 28  
• Common to limit food intake during pregnancy, believe less food produces a smaller baby, and makes birth easier. Ref: 28  
• Grandmothers perpetuate food myths/restrictions. ‘Hot’ or ‘cool’ food belief systems are common. Often ‘hot’ foods avoided in the first trimester. Ref: 135  
• Rice is encouraged during pregnancy; thought to provide strength during pregnancy and delivery.  
• Pregnancy-related nausea affects consumption. Ref: 135 | Adolescent nutrition  
Women most susceptible to “eating down during pregnancy”  
Motivations for encouraging better maternal diet and adequate calorie consumption overall? |
<table>
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<tr>
<td>IFA supplementation during pregnancy (at least 90 days)</td>
<td>• In 2012, 33% of women were supplemented with 90 iron folate tablets during their pregnancy, but significant provincial disparities exist, particularly in Central Sulawesi, West Papua, Maluku, and Papua. Ref: 141&lt;br&gt;• In 2012 women self-report showed 30.9% took iron folate for less than 60 days, 7.1% took it between 60 and 89 days, and 32.7% took recommended 90 days. Almost 23% reported not taking any iron folate (IDHS 2012). Ref: 21&lt;br&gt;• Iron-folate (IFA) tablets are provided to pregnant women for free by the government and distributed through Puskesmas and private-practice midwives.&lt;br&gt;• Government switched to to blister packs over sachets containing 60 mg ferrous fumarate and 400 mcg folic acid in an effort to improve compliance.&lt;br&gt;• Limited counseling on supplements at health facilities and the MCH Book (every woman receives at an ANC visit at a government health facility) simply mentions that “iron tablets are not dangerous for your baby”. Refs: 12,135&lt;br&gt;• Side effects including nausea and the bad taste and smell associated with the tablets cause many women to discontinue use. Ref: 136&lt;br&gt;• Women reported preferring herbal remedies over supplements or medicines; believed safer and had no side effects. Refs: 17,27&lt;br&gt;• Belief that supplements will cause increased birthweight and a more difficult delivery. Ref: 12&lt;br&gt;• Reported confusion among both the community and providers regarding the concept of anemia, or “kurang darah”, which translates to “not enough blood”, and low blood pressure, known as “low blood”. The government issued iron-folate tablets are called Tablet Tambah Darah, or “Tablets to Increase Blood”, leading some people to associate these tablets as “increasing blood” and are mistakenly associated with hypertension (2014 assessment). Ref: 12</td>
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<td>Improvements at level of service delivery and in families to support compliance with iron supplements during pregnancy</td>
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<td>Facility-Assisted Delivery</td>
<td>• 79% of women deliver in a health facility.&lt;br&gt;• Not meeting 75% target of births being facility-assisted: Papua 44%, Papua Barat 50.5%, Maluku Utara 34.1%, Maluku 28.5%, Sulawesi Barat 63%, Sulawesi Tenggara 48.3%, Sulawesi Tengah 58.1%, Kalimantan Selatan 66.9%, Kalimantan Tengah 40.9%, Kalimantan Barat 59.9%, Nusa Tenggara Timur 65.8%, Banten 72.8%, Bengkulu 66%, Jambi 56.4%; Riau 52.9%, Sumatera Utara 61.1% (2017 IDHS Preliminary indicators). Ref: 140&lt;br&gt;• Nationally, the poorest 40% of women have a higher tendency to deliver at home. Ref: 47&lt;br&gt;• Another nationally representative study identified Sulawesi, Maluku, Papua and West Papua as being particularly disadvantaged in terms of access to safe delivery services. Ref: 15&lt;br&gt;• Preference for TBAs-- more experience, trust, older, and adherence to cultural practices. Comfort of delivering at home.&lt;br&gt;• Traditional beliefs – including herbal remedies and the importance of ancestors’ involvement in birth.&lt;br&gt;• Adherence to local traditions (ex: warm water for ritual bathing is not available at many facilities).&lt;br&gt;• Distance to healthcare facilities, including poor road conditions&lt;br&gt;• Cost of travel (ambulances are free of however difficulties in calling an ambulance or reports of no fuel)&lt;br&gt;• Indirect costs (food and accommodations for family members at facility). Ref: 36</td>
<td><strong>Facility-Assisted Delivery Barriers</strong>&lt;br&gt;• TBAs are closer to the woman and her home at the time of birth, and adhere to traditional practices during pregnancy and delivery, not followed by midwives. Ref: 31 35&lt;br&gt;• TBAs are trusted more than midwives because they live in their community, speak the same language, and share the same culture.&lt;br&gt;• TBAs are regarded as elders with more experience, while midwives are viewed as young and less experienced.&lt;br&gt;• Low perceived risk of giving birth with TBAs. Ref: 35</td>
<td><strong>TBA capacity and skills supportive of early newborn care and nutrition</strong></td>
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<td>Health Personnel-Assisted Delivery</td>
<td>• Coverage of deliveries assisted by trained health providers increased from 73% in 2005 to 90.9% in 2017. Ref: 140&lt;br&gt;• Over 50% of births in rural areas are assisted by TBAs who have the least amount of training. Ref: 33&lt;br&gt;• TBAs are trusted more than midwives because they live in their community, speak the same language, and share the same culture.&lt;br&gt;• TBAs are regarded as elders with more experience, while midwives are viewed as young and less experienced.&lt;br&gt;• Low perceived risk of giving birth with TBAs. Ref: 35</td>
<td><strong>TBA capacity and skills supportive of early newborn care and nutrition</strong></td>
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| Assisted delivery by health personnel in a health facility | • MoH initially discouraged use of TBAs. Joint engagement of TBAs and midwives is gaining popularity to promote facility-based deliveries and the uptake of postnatal care in community health centers. Ref: 43 | • Extended care: TBAs stay with the mother from the time contractions start and provide services up to one week after the baby is born.  
• Perceptions that TBAs are cheaper than midwives, even though giving birth in government hospitals is free and encouraged under the JKN insurance.  
• Logistical hassles involved with facility-births, where most midwives practice. | Quality of TBA provision of any PNC, and timely PNC  
Access to and quality of timely PNC care provided by nurses and others—focus on areas of low coverage  
Ways to identify and prioritize LBW infants |
| Participate in postpartum and Early Newborn Care visits | • Approximately 31% of women receive “timely” postnatal care—within six to 48 hours after birth. Refs: 11,14  
• Attendance at all 3 postpartum appointments was 87% in 2015. Ref: 11  
• Twenty-six percent of all mothers in Indonesia receive no postnatal care. Ref: 14  
• Approximately 86% of urban women receive timely postnatal care, compared to 74% of rural women.  
• Lowest coverage of mothers receiving timely postnatal care: Riau (63%), Maluku (44%), West Papua (29%), and Papua (28%).  
• Seventy percent of mothers in Papua receive no postnatal checkup in the first two days after birth. Ref: 21  
• 84% of newborns in Indonesia receiving their first neonatal visit within the first two days of birth. Refs: 11,14  
• Provinces most lagging behind include Maluku 44%, ENT 42%, West Papua 20%, Papua 15% and South Sulawesi 11%. Ref: 11  
• Attendance at all 3 postpartum care appointments has improved due to better support of Puskesmas and Posyandus by the MoH, including intensifying home visits for those who miss their appointments. Ref: 11  
• Post-natal care is most often done by nurses, midwives, or village midwives. Fewer TBAs perform the first maternal post-natal check-up, ranging from zero to 12% across all provinces Ref: 21  
• Food restrictions practiced during the 40 days postnatally; Eating animal products thought to harm both mother and baby. Refs: 39,40 | • Mothers report preferring TBAs over midwives because they provide post-natal services up to one week after birth such as bathing the mother and baby, washing clothing and bedding from the birth, ensuring clean detachment of the umbilical cord, and massage the mother. Ref: 35  
• Barriers to postnatal care utilization in villages: mother and family members’ health literacy on postnatal care, sociocultural beliefs and practices, and health service responses.  
• Parents, parents-in-law, and other elder extended family members perpetuate myths and misconceptions about PNC. Mothers who lived in the same households as these influencers are more likely to abide by myths.  
• The likelihood of a child being reported as very small or smaller than average at birth does not vary much by the child’s birth order, mother’s smoking status, or urban-rural residence. Children of mothers in the highest wealth quintile are less likely than other children to be reported as having less than average birth size. Ref: 21  
• Low birth weight (LBW) was determined to be the most significant determinant of stunting, with infants who were born LBW being 1.74 times more likely to be stunted than those born with normal weight. Ref: 42 |
### Ideal behavior vs. Current practices: Health Services and Early Initiation of Breastfeeding (EIBF) < 1 hr after birth

<table>
<thead>
<tr>
<th>Ideal behavior</th>
<th>Current practices</th>
<th>Determinants and influences</th>
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<tr>
<td>Seek health services when necessary</td>
<td>• The richest, urban population is seven times more likely to access health services than the poorest.</td>
<td>• High cost of medical care, uneven distribution of health providers, and of public insurance, often serves as barriers to accessing health care in rural and socially disadvantaged women. Refs: 33, 36</td>
<td>Understanding of the connection between service quality, its perception among pregnant women, and its subsequent uptake</td>
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<td>• Widest disparities in health service delivery in Eastern provinces: Papua and West Papua, Nusa Tenggara, and Maluku. More than 9,700 Community health centers (Puskesmas) are central point of care, serving 25,000 to 30,000 people each; require at least one physician on staff. Refs: 11, 49</td>
<td>• Primary care centers conveniently located; but long wait times and short hours of operation. Ref: 45</td>
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<td>• National Health Insurance Program, Jaminan Kesehatan Nasional (JKN), insures 164 million Indonesians as of April 2016. Ref: 47</td>
<td>• Women in Papua, West Papua, and East Java report distance to health facilities, road conditions hinder accessing care. Refs: 21, 36</td>
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<td>• Eighty-five percent of women having pregnancy care insurance coverage. Ref: 11</td>
<td>• Poor staff attendance, lack of operational funds, poor quality of equipment, accountability issues, disrespectful staff barrier to demand for community health center services. Refs: 50, 51</td>
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<td>• Approximately 44 midwives per 100,000 people; significantly short of the 2019 target of 120 per 100,000. Ref: 11</td>
<td>• Maternal perceptions of low quality health services by midwives at the Puskesmas, not attentive or patient-centered care, no rapport. Refs: 21, 36, 39</td>
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<td>• Sixteen percent of over 9,700 health centers have been registered or licensed to provide traditional health services (2015). Ref: 11</td>
<td>• Husbands make decisions on seeking health services, varies by province; getting permission for treatment barrier to care. Refs: 21, 36</td>
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<tr>
<td>Early Initiation of Breastfeeding (EIBF) &lt; 1 hr after birth</td>
<td>• High cost of medical care, uneven distribution of health providers, and of public insurance, often serves as barriers to accessing health care in rural and socially disadvantaged women. Refs: 33, 36</td>
<td>• Money for treatment is a problem. Women of low SES with government-financed health insurance were 19% more likely to deliver in a health facility and 17% more likely to deliver with a skilled birth attendant compared to poor women without insurance. Refs: 48, 21</td>
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<td>• 61.2% of babies put to the breast immediately after birth and 59% of babies had skin-to-skin contact with their mothers immediately after birth (2017 IDHS preliminary indicators). Ref: 140</td>
<td>• Mother assisted by a health professional during delivery less likely to EIBF or within one day compared to mothers assisted by a TBA or by relatives.</td>
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<td>• About half (49.3%) of all children were breastfed within one hour of birth; two-thirds (66%) were breastfed within one day of birth. (2012 IDHS)</td>
<td>• Delayed initiation of BF associated with higher wealth quintiles. Ref: 58</td>
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<td>• EIBF varies by province with a low of 26% in Riau to a high of 74% in West Nusa Tenggara.</td>
<td>• Delayed initiation of BF more common in Sumatera region, Caesarean section birth, and deliveries in government-owned and a non-health facility. Ref: 58</td>
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<td>• Newborns breastfed within the first day ranges from a low of 39% in West Sumatera to a high of 85% in West Nusa Tenggara.</td>
<td>• Prelacteal feeding most common among urban children, children delivered by a health professional, children of mothers with more education, and children in the highest wealth quintile. Ref: 21</td>
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<td>• Sixty percent of children received a prelacteal feed during the first three days of life. (2012 IDHS) Prelacteal foods such as softened dates, honey, banana, biscuit and breast milk substitutes (BMS) are commonly given to newborn babies in both urban and rural areas. Ref: 142</td>
<td>• Prelacteal feeding feeding most common among urban children, children delivered by a health professional, children of mothers with more education, and children in the highest wealth quintile. Ref: 21</td>
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<td>• Some mothers do not feed colostrum to newborns perceiving it to be “dirty,” “cheesy,” “indigestible” and of no nutritional value and that their newborn was fed colostrum, their baby would suffer from stomachache, illness such as fever and that their child would not be intelligent. Ref: 57</td>
<td>• Health facility practices that inhibit EIBF</td>
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<td>Ideal behavior</td>
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| Exclusive Breastfeeding for 6 months (EBF) | • 96% of children under two have been breastfed.  
• 74% of mothers offer supplementary liquids besides breast milk somewhere between 7 days and 6 months.  
• EBF increased to 51.5% of all infants under six months in 2017 from 42% in 2012. Ref: 140  
• Rates vary by province: low of 25% in Kepulauan Bangka Belitung to a high of 70% in both DI Yogyakarta and Nusa Tenggara Barat. Only 9 provinces have reached the World Health Assembly global target of EBF prevalence of at least 50%; Lampung, Sumatera Selatan, Jawa Tengah, Sulawesi Selatan, Sulawesi Barat, Kalimantan Utara, Nusa Tenggara Timur, DI Yogyakarta and Nusa Tenggara Barat. Ref: 143  
• Infants 0-5 months old who are breastfed are also being fed a variety of liquids and foods: breast milk and water (6.3%), breast milk and fluids that is not milk (0.6%), breast milk and other types of milk (15.5%), and breast milk and complementary foods (13.7%). Ref: 140  
• Older mothers more likely to EBF compared to younger mothers  
• Higher educated mothers more likely to EBF  
• Unemployed mothers more likely to EBF; Mothers who are employed have a lower chance of exclusive breastfeeding. Full-time working mothers were 1.54 times less likely to exclusively breastfeed than unemployed mothers.  
• Mothers with a high wealth index less likely to EBF  
• Infants who receive early breastfeeding initiation have a higher likelihood of being exclusively breastfed.  
• In one study, the presence of a dedicated breastfeeding facility increased EBF practice almost threefold. Knowledge of the breastfeeding support program increased EBF practice by almost six times. Refs: 68, 69  
• Children who are ill during the first 28 days of life or during the neonatal period are less likely to receive exclusive breastfeeding.  
• The 2003 Labor Law gave three months of paid maternity leave to working mothers and employers must provide opportunities to breastfeed during working hours. At least 1.5 months of this maternity leave must be taken after the birth of the child.  
• A 2009 law states that every infant be breastfed or be given breast milk from donors or milk banks exclusively for the first six months and be given time and special facilities. Enforcement of provision for special facilities is weak. | • Perception that breast milk is nutritionally insufficient and that supplementary food is needed. Infant formula is believed to be equally good. Widespread belief that honey is good for the baby. Ref: 135  
• Family members give food such as bananas, honey, softened dates, sweetened condensed milk, sugar water and rice flour is still popular in rural areas for infants under 6 months.  
• Poor knowledge, inadequate skills such as positioning and latching on, motivation, and lack of confidence inhibit EBF.  
• Grandmothers’ lack of support, receiving formula samples from midwives at hospital discharge, and maternal breast engorgement shortened duration of EBF.  
• Increased breastfeeding knowledge was associated with longer duration of EBF.  
• Mothers almost universally know and believe that breast milk is the best food for babies, there is a confidence gap in their own ability to produce the right quality and quantity of breast milk. Ref: 139  
• Most mothers are unaware that decreased breast milk production is linked to consumption of formula by their child. Ref: 139  
• Reasons women stopped breastfeeding or supplemented breast milk: perceived obstacles (“Baby is restless”), mother’s feelings and emotions (“I feel groggy and numb”), negative influences from family members (“My mother-in-law said if I exclusively breastfeed my baby will be hungry”), sore nipples and breast engorgement, lack of skills, formula samples provided by clinics, discouraging words from relatives, beliefs regarding breastfeeding (“You know, I have small breasts”), and early complementary feeding practices. Ref: 72  
• Poor breastfeeding counseling during ANC visits and insufficient training of birth attendants. Ref: 135  
• Barriers cited include: lack of private lactational areas, lack of flexible schedule, bad relationships with employer or supervisor, declining productivity and financial concern. Ref: 73  
• A 2014 compliance report, documented that only 12 out of 67 garment factories in the Greater Jakarta Area provided facilities, policies or procedures for breastfeeding breaks.  
• A 2011 study reported that only 10% of government offices and 11% of private offices provide places to breastfeed or pump. | Most important reasons for introducing BMS and/or supplementary food before 6 months—how varies by region |
### Ideal behavior

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<td><strong>Continued Breastfeeding through 2 years</strong></td>
<td><em>Mean duration of exclusive breastfeeding is 3.7 months; overall duration of any breastfeeding is 21.4 months and the mean duration is 20.5 months. (2012 IDHS)</em>&lt;br&gt;<em>77% of infants continue to breastfeed at one year and 55% of children are breastfed at two years (IDHS 2012).</em>&lt;br&gt;<em>Median duration of breastfeeding varies by province; low of 9.4 months of any breastfeeding in Riau Islands to a high of 29.7 months of any breastfeeding in West Kalimantan. Ref: 21</em>&lt;br&gt;<em>A 2012 study looking at feeding practices of mildly wasted children in Nias Island, North Sumatra Province, found that only 10% of children were breastfed at least two years. Ref: 57</em></td>
<td><em>In East Java, continued breastfeeding patterns related to mother’s confidence or lack thereof; feeding was primarily child-led; and mothers faced pressure from family, friends, and neighbors to try to stop crying babies by any means necessary to avoid judgment of the mother’s skills.</em>&lt;br&gt;<em>Child-rearing was often described as communal with family and friends influencing the feeding of young children.</em>&lt;br&gt;<em>The majority perceive that the older the baby, the less the priority to breastfeed. Breastfeeding no longer becomes a priority after the baby turns 6 months. It is only for comfort and sleep time. Ref: 139</em></td>
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| **No bottle feeding** | *More than one-third of breastfed children under 2 months were given formula (2012). Ref: 76*<br>*37% of infants age 0-23 months were bottle-fed. Ref: 76*<br>*Many poor families who use formula or breastfeeding substitutes can barely afford to do so. Because of this financial burden, families dilute the breast milk substitutes. Ref: 78*<br>*Women who delivered in health facilities (43%) had a higher prevalence of bottle feeding than those who delivered at home (24%). This may be because wealthier women, who are more likely to bottle feed also are more likely to deliver in health facilities, or that health facilities do not give appropriate counseling on EBF and EBF. Ref: 78*<br>*Disasters can contribute to the use of BMS. After the 2006 earthquake in Yogyakarta, the initial recovery response included distribution of large quantities of BMS without regard to whether the household had been using BMS before the earthquake or not.* | *Some mothers report seeing commercials that they believe say formula milk is better.*<br>*Some women feel that they cannot produce enough milk because of using an oral contraceptive or because she is not eating enough herself. Ref: 78*<br>*Community-based workers and village health centers or Posyandus are not covered by the regulations preventing inappropriate marketing of BMS. These Posyandus are almost always women providing services related to monitoring mother and child health, nutrition, immunization, diarrhea control and family planning. They are set up once a month and can be an important delivery platform for counseling mothers on breastfeeding. Ref: 99*<br>*A study found that 20% of women had received advice and information about BMS and 72% had seen promotional materials for BMS. About 15% reported receiving free samples from health workers or from company staff, and 16% received gifts. Almost a quarter of health care staff reported receiving visits from formula companies.* |

<p>| <strong>Timely and adequate (amount, frequency, consistency, diversity) complementary feeding beginning at 6 months</strong> | <em>52% of mothers have adequate knowledge of appropriate child feeding practices based on WHO recommendations.</em>&lt;br&gt;<em>79% to 81% of children were introduced solid, semi-solid, or soft foods before six months of age, with a mean age of complementary food introduction at 4.4 months across studies reviewed.</em>&lt;br&gt;<em>At 4-5 months of age more than one-third of babies were being fed fortified baby foods as the most common early complementary food. Ref: 21</em>&lt;br&gt;<em>75% of infants and young children, age 6 to 23 months who are not breastfed, consume a diverse diet, compared to 51.8% of breastfed children (2012 IDHS).</em>&lt;br&gt;<em>Diverse diet varies by province: lowest performing parts of Sulawesi, East and West Nusa Tenggara, and the islands of Maluku and Papua.</em> | <em>Working mothers who have access to family caregivers showed an increased lack of confidence in performing child care and good food practices (including breastfeeding, scheduled feeding, monitored food intake, and purchase of health foods, among others), depending increasingly on caregivers. Ref: 93</em>&lt;br&gt;<em>Child-driven feeding practices. Ref: 135</em>&lt;br&gt;<em>Mothers reluctant to force feed to avoid crying. Ref: 135</em>&lt;br&gt;<em>Poor feeding practices more prevalent among those mothers who lacked family support (particularly from husbands) and those who carry a greater share of domestic work. Ref: 135</em>&lt;br&gt;<em>In North Sumatra Province a perceived lack of supply of breastmilk was the main reason mentioned for the early introduction of complementary foods in the study area. Ref: 57</em> | <em>Influence of snacking on quality of diets in children 6-24 months</em>&lt;br&gt;<em>Quality of first foods and ways to enhance quality</em>&lt;br&gt;<em>Feeding practices across the 6-24 month period; how changes, where opportunities for improvements</em>&lt;br&gt;<em>Impact of other caregivers on complementary feeding when mothers work/unavailable</em> |</p>
<table>
<thead>
<tr>
<th>Ideal behavior</th>
<th>Current practices</th>
<th>Determinants and influences</th>
<th>Potential important knowledge gaps</th>
</tr>
</thead>
</table>
| Timely and adequate (amount, frequency, consistency, diversity) complementary feeding beginning at 6 months | • 67% of children age 6 to 23 months are offered complementary foods the minimum times per day by age group in addition to breastmilk. Ref: 95  
• 61% of breastfed children met their minimum meal frequency, as opposed to 79% of non-breastfed children.  
• Half of mothers reported feeding only on demand. 135  
• Most mothers fed only two food groups, grains (typically rice) and vegetables. Animal protein was rare. Ref: 135  
• 37% of children age 6-23 months were fed according to the WHO revised IYCF recommendations (including food and breastfeeding frequency and diversity of diet). The percentage was lower for breastfed children (34%) than non-breastfed children (43%). Ref: 21  
• Overall, 81% of breastfed children age 6-23 months consumed food made from grains, 72% consumed fruits and vegetables rich in vitamin A, 50% had meat, fish and poultry, and 46% consumed eggs. Ref: 21  
• 82.7% of Indonesian children age 6-23 months consumed foods rich in vitamin A in the last 24 hours. This ranges from 64.3% in North Maluku to 88.9% in the Riau Islands. Ref: 21  
• About 68% of children age 6-23 months consumed foods rich in iron ranging from 50.8% in West Sulawesi to 78.3% in Jakarta (2012 IDHS).  
• 2012 reports show 45 to 74% of rural children and 28 to 57% of urban children had a protein intake below the local recommended daily amount (RDA). 54.2% (0-59 months) received high protein sufficiency, 11.5% average, and 34.2% low or severely low protein sufficiency (2012). Ref: 11  
• Babies are typically fed during family meal times but snacking is common and child-led. Ref: 139 | • MoH established food groups for infants and young children includes infant formula in a food group and not breastmilk, sending the message that infant formula is part of a complete and balanced diet. Ref: 21  
• Unlike the consumption of foods rich in vitamin A, the consumption of foods rich in iron increases markedly with the mother’s education. Ref: 11  
• To improve dietary diversity, GAIN and the MOH supported a mass media and community-based intervention, Gerakan Rumpi Sehat (the Health Gossip Movement), in Sidoarjo, East Java. Results indicate that mass media can have a measurable effect on nutrition-related behavior change; effects are enhanced through complementary community activation. Ref: 100 | |
| Follow recommended Feeding During and After Illness | • 14.3% of mothers surveyed reported their children under five had diarrhea in the past two weeks (2012). Ref: 21  
• 40% of children reportedly given more fluids than normal, 43% given the same amount, and 17% receiving fewer or no liquids at all. Ref: 21  
• Only 10% of children received more food than usual during diarrhea, with 39% receiving the same amount, and 46% were given less or no food at all. Ref: 21  
• 9% of mothers surveyed believed that giving foods during illness will worsen it, and that children are less hungry when they are ill. Ref: 92 | No information noted | Limited literature addressed this topic, more research needs to be done to understand the attitudes and drivers behind these practices. |
### Ideal behavior

<table>
<thead>
<tr>
<th>Current practices</th>
<th>Determinants and influences</th>
<th>Potential important knowledge gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementation of key vitamins and minerals.</td>
<td>Some studies suggest that it is difficult to achieve desired density for key nutrients – including calcium, iron, niacin, and zinc – in complementary feeding diets, due to physical or economic access or acceptability of nutrient-dense foods.</td>
<td></td>
</tr>
<tr>
<td>• 86% of children age 6-59 months received recommended two doses of vitamin A supplementation at six months apart. Ref: 10</td>
<td>• One study to promote key nutrient intake among children in Lombak suggests that to overcome the cost constraints of feeding young Indonesian children nutrient-dense complementary feeding diets, additional affordable strategies to improve nutrient densities of complementary foods, particularly for iron and calcium, need to be considered, including home fortification, formulated or fortified complementary foods, and fortified staple foods. Ref: 128</td>
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<tr>
<td>• If 31 provinces submitting data (2015 Indonesia Health Profile): eleven provinces (35%) achieved 90% coverage of vitamin A. Highest coverage of vitamin A supplementation on 6-59 months infants was DI Yogyakarta (98.8%); North Sumatera lowest coverage (53.2%). Ref: 11</td>
<td>• Maternal knowledge of anemia is associated with lower odds of anemia in children and with some health behaviors related to reducing anemia. Ref: 113</td>
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</tr>
<tr>
<td>• 13.6% of mothers of children age 6-59 months gave iron supplementation in the past seven days preceding the 2012 IDHS survey.</td>
<td>• Study found that targeting new mothers for handwashing interventions may be useful in establishing key handwashing behaviors while a child is still young and mothers’ routines are changing to meet the needs of their new baby. Ref: 119</td>
<td></td>
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<tr>
<td>• High coverage of vitamin A supplementation partly due to geographical conditions and access to the Posyandu in distributing vitamin A. Provinces with high coverage usually have a high coverage of children under five weighed at Posyandu. Low coverage (Papua and West Papua) have low public participation in weighing and additional geographical constraints.</td>
<td>• Handwashing at critical times for IYCF is engaged in handwashing, with 89% of those instances using soap and water. Ref: 21</td>
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</tr>
<tr>
<td>• Vitamin A supplementation in the provinces of DKI Jakarta and North Sumatera is very low due to incomplete records and reports.</td>
<td>• Maternal knowledge of anemia is associated with lower odds of anemia in children and with some health behaviors related to reducing anemia. Ref: 113</td>
<td></td>
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<tr>
<td>• Children living in urban areas, those born to highly educated mothers, children of mothers age 20 or older at the child’s birth, and children in the highest wealth quintiles were more likely to have received vitamin A supplements than other children. Ref: 21</td>
<td>• Handwashing at critical times for IYCF is engaged in handwashing, with 89% of those instances using soap and water. Ref: 21</td>
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</table>

### Handwashing at critical times for IYCF

<table>
<thead>
<tr>
<th>Current practices</th>
<th>Determinants and influences</th>
<th>Potential important knowledge gaps</th>
</tr>
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<tbody>
<tr>
<td>• 92% of households use soap and water in the place most often used for handwashing. Ref: 21</td>
<td>• Surveys found good knowledge of hand washing with soap, but poor practice: 34% washed hands after defecation; 29% after child’s defecation; 73% before a meal; and 60% after a meal. Ref: 136</td>
<td>Food hygiene practices and determinants</td>
</tr>
<tr>
<td>• 87% of urban households practiced observable handwashing in urban residences, with 96% of those who hand wash using soap and water. Ref: 21</td>
<td>• A study in Serang in Batan province found new mothers reported rarely washing their hands before food preparation, while serving others, or before eating. Ref: 119</td>
<td></td>
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<tr>
<td>• Rural areas found approximately 72% of residences are engaged in handwashing, with 89% of those instances using soap and water. Ref: 21</td>
<td>• • Study found that targeting new mothers for handwashing interventions may be useful in establishing key handwashing behaviors while a child is still young and mothers’ routines are changing to meet the needs of their new baby. Ref: 119</td>
<td></td>
</tr>
</tbody>
</table>
Some studies suggest that it is difficult to achieve desired feeding diets, due to physical or economic access or acceptability of nutrient-dense foods.

One study to promote key nutrient intake among children in Lombak suggests that to overcome the cost constraints of feeding young children, the following considerations could be adopted, including home fortification, formulated or fortified complementary foods, and fortified staple foods. Ref: 128

- Maternal knowledge of anemia is associated with lower odds of anemia.
- Of 31 provinces submitting data (2015 Indonesia Health Profile): eleven provinces (35%) achieved 90% coverage of vitamin A. Highest coverage was in DKI Jakarta, where 94% of children age 6-59 months received recommended two doses of vitamin A supplementation at six months apart. Ref: 10

ROADMAP FOR DEVELOPING AN ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR STUNTING REDUCTION IN INDONESIA

- Study found that targeting new mothers for handwashing interventions may be useful in establishing key handwashing behaviors while a child is still young and mothers' routines are changing to meet the needs of their new baby. Ref: 119

- Surveys found good knowledge of hand washing with soap, but findings were mixed regarding handwashing at critical times for IYCF practices. For example, 89% of those instances using soap were associated with handwashing before a child’s defecation; 73% before a meal; and 60% after a meal. Ref: 136

- High coverage of vitamin A supplementation partly due to geographical conditions and access to the Posyandu in distributing vitamin A. Handwashing at critical times for IYCF practices was associated with delayed initiation of exclusive breastfeeding and lower odds of maternal anemia.

References

- Setyowati (2010). "An ethnography study of nutritional conditions of pregnant women in Banten Indonesia, according to the users in the rural area." Jurnal Kebidanan 16(4).


Appendix B

Communication Materials Assessment

The following are findings from an assessment of existing communication materials related to stunting, from a communication perspective, conducted by Alive & Thrive. As such, this analysis is not about content but about clarity and consistency of communication, as well as the appeal of the campaigns. Special emphasis is put on the IMA WorldHealth National Nutrition Campaign because it is the most prominent SBCC campaign identified.

The assessment is based on information from the following sources:

- Report on content analysis of communication materials for early childhood development, prepared for UNICEF and Bappenas.
- My Plate Stunting Campaign just launched by the Ministry of Health.
- Analysis of MIYCN practices in Indonesia conducted by Alive & Thrive (2018)

1. Communication Materials for Early Childhood Development

Taken from the report on “Content Analysis of Communication Materials for Early Childhood Development”, prepared for UNICEF and Bappenas.

The report analyses 47 ECD materials and 18 IED materials collected from different organizations such as Ministry of Health, Ministry of Education, Family Planning Board, Program Keluarga Harapan (PKH), SUN Secretariat, Ministry of Village, Ministry of Women Empowerment and Child Protection, and Coordinating Ministry of Human Development and Culture.

Highlights

Most of the ECD programs’ materials target parents, covering topics such as parenting, healthy behaviours, 1000 days, child development, nutrition, antenatal care, under-five care, sanitation, health, and education.

The term stunting is only mentioned in the material featured in Figure 1. However, some ECD materials mention antenatal nutrition and exclusive breastfeeding:

- MoH’s Early Stimulation, Detection, and Intervention in Childhood Development program:
  - “Nutrition intake of pregnant women, especially during the last trimester of pregnancy, will affect fetal growth. For the appropriate development, adequate food intake is needed”
  - “Exclusive breastfeeding for the first 6 months, age-appropriate complementary feeding, scheduled immunization, and proper parenting.”
Roadmap for Developing an Advocacy and Behaviour Change Communication Strategy for Stunting Reduction in Indonesia

- Family Planning Board:
  - “To ensure appropriate health and growth, pregnant women need to be healthy, give exclusive breastfeeding, practice a healthy lifestyle, consume balanced nutrition and immunize children as early as possible”

The first 1000 days explanation is featured in IEC materials as well.

- Ministry of Education:
  - “The first 1000 days is the golden opportunity to shape a healthy and smart child in the future. During the first 1000 days, nutrition is the main focus. If nutrition is inadequate, then plasticity and functional capacity of the fetus will be compromised”

- Family Planning Board:
  - “The first 1000 days includes 270 days during pregnancy and 730 days from birth until 2 years old”
  - “Targets of the first 1000 days: pregnant women, breastfeeding women and children from 0-23 mos”
  - “What happens within 1000 days? Brain development, physical development, development of metabolism and adequate immune system”
  - “Long-term effects of under-nutrition includes stunting (short stature due to under-nutrition)”
  - “The first 1000 days are the golden opportunity to develop quality human resources”
  - “By implementing the first 1000 days program, children will grow healthy, smart and in high quality”

Key findings include:

- Messages on ECD are mostly focused on: Parenting and healthy behavior (ECD programs), antenatal care and nutrition (general early child development)

- Most of the messages on ECD are conveyed using the “healthy family” theme,

- Messages are mostly focused on WHAT needs to be done but do not give concrete behavioural recommendations on HOW to do it.

- Stunting messages are inconsistent and there is only one mention of stunting.

- Some materials contain inaccurate information.

2. Develop the Evidence Base. In addition to the earlier studies recommended, economic research could help guide decisions on policies with funding implications (e.g. extending maternity leave duration). Formative research points out the major barriers to improved feeding practices.

Here are examples of such studies or sources of evidence from Indonesia:

- National surveys on current nutrition practices and stunting prevalence (Riskesdas, Indonesia DHS)
- The Economic Cost of Not Breastfeeding in Indonesia conducted by the University of Padjadjaran in 2015
- Costing study for extending paid maternity leave to six months (also by the University of Padjadjaran in 2015)
- Media scan that shows inappropriate marketing of breastmilk substitutes in South-East Asia including Indonesia (2016)
- Indonesia-specific data in global databases such as NutriDash (UNICEF) and the Global Nutrition Report
- Studies on the impact of conditional cash transfers on health and nutrition
- Recommended studies include:
  - Costing studies to guide budget decisions at the district level

3. Develop compelling, targeted, and tested messages and materials. Consistent, persuasive messages used by all partners makes them more memorable and credible. Advocacy materials and messages are responsive to policymakers’ needs and preferred formats. Sustained media engagement to tell the story of the impact of policies or programs is also critical.

Examples of effective message frames from nutrition advocacy in Southeast Asia include:

- Investing in human capital and human resources
- Reinforcing civic, religious or cultural themes – e.g. breastfeeding is encouraged in the Quran
- Referencing global commitments – e.g. Indonesia’s progress in achieving the nutrition-related Sustainable Development Goals
2. National Nutrition Communication Campaign

The NNCC is a Social and Behaviour Change (SBCC) program, funded by MCAI and implemented by IMA WorldHealth Indonesia.

Mass Media Campaign Messages - In 2016 and 2017, the NNCC mass media campaign focused on two main areas: family involvement in baby’s feeding time and proper nutrition, and proper use of latrines using two themes: Complementary Feeding (Let’s help the child to eat) and Sanitation (Now it is time to use healthy latrines). Theme line: Achieve High Nutrition.

Pros

- The production value of all the materials is excellent.
- Each piece of the mass media campaign delivers a single and very clear message.
- As an SBCC campaign, the look and feel of all the materials are very uniform helping to achieve a synergistic effect.
- The IPC training videos and printed support materials are good tools for counsellors and trainers at the community level.

Cons

- The use of national level television to reach only 11 districts, although efficient in terms of cost-per-thousand persons reached, seems like a waste of impressions if all the elements of the SBCC campaign were not in place nationwide.
- Although focused on stunting, the mass media campaign does not provide an explanation of what is stunting, what causes it and how it can be prevented, missing a good opportunity to create awareness, not only in the 11 districts targeted but at a national level.
- Although based on the first 1000 days, the media campaign does not explain what that means, again, missing an opportunity to create awareness at the national level.

Starting in December 2017, the NNCC shifted the focus of their mass media campaign, to create awareness about stunting and the importance of the first 1000 days.

The television and online campaign feature testimonials from influential figures and personalities such as the Vice-president of Indonesia, the Chairman of the Indonesian Nutritionist Association, and the Chairman of Fatayat NU, among others. The campaign’s theme line is “Let’s Prevent Stunting, It Is Important!”

Pros

- The campaign shifts the focus to stunting.
- The use of influential figures and personalities lends credibility to the messages.
- The theme line highlights the importance of stunting prevention.

Cons
- The look and feel are different from the previous campaign, losing its synergistic effect.
- Some spots feature several messages making them confusing.
- The stunting message is very inconsistent from one TV spot to the other.
- There is no explanation of what causes stunting and potential solutions.
- Stunting effects are associated with height while barely mentioning effects on the brain.
- The use of the term dwarf/dwarfism in one of the TV spots is incorrect and confusing.
- Confusion of the terms chronic malnutrition and stunting.

3. My Plate Stunting Campaign

A separate stunting campaign just launched by the Ministry of Health seems to consist of two different sets of posters, one explaining stunting and a set of posters illustrating a balanced diet.

Stunting poster - Poster makes emphasis on height as an indicator of stunting, addressing nutrition components such as parenting (breastfeeding and immunization) and sanitation (clean water, hand washing, and use of latrines). Slogan: Prevent Stunting, That’s Important. At the bottom, it reads: Get enough nutrition, complete immunization and improve sanitation.

Pros
- The visual is easy to understand.
- The icons on the side are easily recognizable.
- The use of the word stunting in the heading.

Cons
- The stunting explanation only refers to undersized (height) children. It does not address other issues related to stunting that may be relevant to parents.
- The term “midget” (Kerdil) referring to stunted children may create confusion of terms.
- It mentions the first 1000 days but there is little explanation of what that means. This only distracts from the main message and it is not relevant in this context.

My Plate Poster – It features a plate with coloured sections representing four food groups: fruits, vegetables, tubers, and protein sources. As secondary messages, it illustrates three areas related to nutrition: handwashing, physical activity, and drinking water. It also indicates the recommended proportion of each of the food groups.
Pros

- The visual is attractive and easy to understand.
- The headline is simple and easy to remember.
- The icons on the side are easily understood.
- It provides national guidelines adapting them to different regions.
- Based on Indonesia-specific dietary guidelines.

Cons

- My Plate was not originally designed for a stunting campaign but is a pre-existing campaign for healthy lifestyle and diet. It only features a nutritional diet educational message.
- There is no visual or written explanation to associate the posters with the stunting campaign, except for the poster design which is similar.
- The written explanation of the recommended proportion of each food group is confusing, using fractions that are hard to understand.
- The written explanation of the lunch in the regional posters mentioning calories and portion size in grams may not be understood by the average person.
- There is no indication of age-group and may confuse people because it does not reflect plates for different age groups.
- There is no call to action.

Although part of the same campaign, the stunting and the “My Plate” posters seem to be stand-alone pieces which defeat the purpose of having a unified campaign.

Conclusions

- There is a clear need to establish a set of guidelines to make sure that all communication efforts deliver consistent and accurate information.
- Although stunting is a major problem in Indonesia, and lack of awareness is one of the key findings of the research studies referenced, no campaign properly addressed the topic.
- The only comprehensive behaviour change communication effort was conducted by IMA WorldHealth in 2016-2017 but, because there is no statistical evidence of the performance of the program available at this time, it is hard to determine its effectiveness.
- The new campaign about stunting started by IMA WorlHealth in December 2017, is a step in the right direction, although it should have been the initial campaign before running the SBCC program.
- The different campaigns currently running, pointing in many directions and providing inaccurate information, underscore the need to create consensus on how to address stunting reduction, to coordinate efforts and speak with one voice on all fronts.

Figure 1. The process for Policy Change
Appendix C

The process to achieve advocacy goals

Once the Advocacy Goals are defined, the following four-part process can be used to achieve them:

1. **ESTABLISH AND SUSTAIN PARTNERSHIPS.** Each partner brings unique resources that contribute to advancing the advocacy agenda.

   **Existing networks for advocacy in Indonesia:**
   - SUN networks and working groups
   - Gerakan Kesehatan Ibu dan Anak (GKIA)/Maternal and Child Health Movement
   - Professional associations
   - INGO networks (e.g. SUN Civil Society Alliance)
   - Faith-based organisations
   - Media agencies
   - Academic networks
   - Labor Unions

   **Recommendations include:**
   - Identify the “moderator” or main coordinator for the Advocacy strategy
   - Identify potential partnerships for sub-national advocacy (e.g. with Ministry of Home Affairs, others such as formal associations of Bupatis if such are in place)

2. **DEVELOP THE EVIDENCE BASE.** In addition to the earlier studies recommended, economic research could help guide decisions on policies with funding implications (e.g. extending maternity leave duration). Formative research points out the major barriers to improved feeding practices.

   **Here are examples of such studies or sources of evidence from Indonesia:**
   - National surveys on current nutrition practices and stunting prevalence (Riskesdas, Indonesia DHS)
   - The Economic Cost of Not Breastfeeding in Indonesia conducted by the University of Padjadjaran in 2015
   - Costing study for extending paid maternity leave to six months (also by the University of Padjadjaran in 2015)
   - Media scan that shows inappropriate marketing of breastmilk substitutes in South-East Asia including Indonesia (2016)
   - Indonesia-specific data in global databases such as NutriDash (UNICEF) and the Global Nutrition Report
   - Studies on the impact of conditional cash transfers on health and nutrition

3. **DEVELOP COMPELLING, TARGETED, AND TESTED MESSAGES AND MATERIALS.** Consistent, persuasive messages used by all partners makes them more memorable and credible. Advocacy materials and messages are responsive to policymakers' needs and preferred formats. Sustained media engagement to tell the story of the impact of policies or programs is also critical.

   **Examples of effective message frames from nutrition advocacy in Southeast Asia include:**
   - Investing in human capital and human resources
   - Reinforcing civic, religious or cultural themes – e.g. breastfeeding is encouraged in the Quran
   - Referencing global commitments – e.g. Indonesia’s progress in achieving the nutrition-related Sustainable Development Goals
Once the Advocacy Goals are defined, the following four-part process can be used to achieve them:

- Revitalize existing partnership networks for coordination of Advocacy efforts (e.g. SUN Advocacy Working Group)
- Establish regular nutrition advocacy coordination meetings with key stakeholders and influencers
- Develop and maintain a contact list to support outreach around key milestones
- (e.g. Stunting Summits, World Breastfeeding Week, Nutrition Month, relevant national holidays)

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- Reinforcing civic, religious or cultural themes – e.g. breastfeeding is encouraged in the Quran
- Referencing global commitments – e.g. Indonesia’s progress in achieving the nutrition-related Sustainable Development Goals
■ Referencing growth and leadership status of Indonesia as a country

Example activities include:

■ Develop and test messages in support of each advocacy goal and objective, taking into consideration tailoring them to specific audiences
■ Develop policy briefs on key topics, with supporting PowerPoints for meetings and events tailored to specific target audiences
■ Develop a Champions toolkit with key messages and talking points
■ Produce high-quality, motivational materials to inspire action (e.g. videos, a message from the President, etc.)

4. BUILD CONSENSUS. Consensus-building involves meetings with policymakers, presentations in large and small meetings or as part of dedicated national and regional advocacy events, participation in working groups, scientific workshops, and training of champions on effective stunting reduction and messaging skills.

Examples of opportunities to build consensus in Indonesia include:

■ Stunting or Nutrition “Summits” or “Bootcamps”
■ SUN working group meetings
■ Champion recruitment, training, and activation to ensure that champions use their influence to deliver consistent advocacy messages (last round conducted in 2017)
■ Medical association events,
■ Global advocacy events (e.g. Indonesia World Breastfeeding Week, Nutrition Month)
■ Parliamentarian engagement (e.g. Parliamentary seminars)
■ Media engagement strategy + activities
■ Social media engagement + activities

While advocacy will help to keep stunting reduction as a priority, there is also a need to stimulate behaviour change focusing on the actions that need to be taken by a mother, her family, her employer, community and many others in support of stunting reduction and MIYCN practices.
ROADMAP FOR DEVELOPING AN ADVOCACY AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR STUNTING REDUCTION IN INDONESIA

■ Referencing growth and leadership status of Indonesia as a country

■ Example activities include:

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