Enhancing Nutrition through Social and Behavior Change Communication (SBCC) Programs in Indonesia

Reflection from the Better Investment for Stunting Alleviation (BISA) Program di Four Indonesian Districts

Save the Children Indonesia

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Executive Summary

Nutrition remains a critical public health challenge in Indonesia, with high rates of malnutrition, stunting, and other diet-related diseases.

These are majorly related to poor health and imbalanced dietary practices among pregnant and lactating women, issues related to exclusive breastfeeding, complementary feeding, and lack of WASH practices (hand washing with soap and hygienic environment).

Moreover, suboptimal nutrition practices among adolescent girls; and the importance of family support (fathers and grandmothers) are also observed as crucial issues to address.

Furthermore, lack of knowledges and understanding capacity, and skills of cadres and health service providers in providing information, education, and counseling were identified as the critical issues.

Better Investment for Stunting Alleviation (BISA), programme is a 5-years program implemented jointly by Save the Children and Nutrition International in two geographic areas with high stunting among children, West Java (31%) and East Nusa Tenggara (42%).[1]

It was designed to assist the Government of Indonesia (GoI) to achieve its target for stunting reduction outlined in the National Strategy for Stunting Alleviation (StraNas Stunting).

While efforts and resources have been focused at the national and District levels, BISA demonstrates how StraNas Stunting resources can be utilised, and interventions can be effectively implemented at the sub-District level.

The program focused on supporting community-level Social Behavior Change (SBC) and better utilization of resources for nutrition activities, improve service provision (counselling and supply chain management) as well as building local (village and district) capacity and leadership to sustain this approach with a view to providing the GoI with lessons learned for wider application.

[1]Riset Kesehatan Dasar (Riskesdas) Indonesia 2018

BISA programme was designed to improve nutrition for women, adolescent girls, and young children, and to reduce stunting with the key main objective:

#1 **Improve Awareness**

Develop and implement SBCC campaigns to raise awareness about the importance of proper nutrition, emphasizing key nutritional practices and their impact on health and nutrition outcome.

#2 **Change Attitudes and Beliefs**

Utilize SBCC strategies to challenge and transform existing societal norms, attitudes, and beliefs related to nutrition, fostering a positive shift towards adoption of optimum nutrition practices.

#3 **Increase Knowledge and Skills**

Design targeted SBCC interventions to enhance the knowledge and skills of individuals and communities in areas such as breastfeeding and complementary feeding, health and hygiene, planning and understanding diversified diets.

#4 **Promote Behavior Change**

Encourage positive behavior change by implementing evidence-based SBCC strategies that address barriers to adopting healthier lifestyles, ensuring sustained improvements in nutrition-related practices.

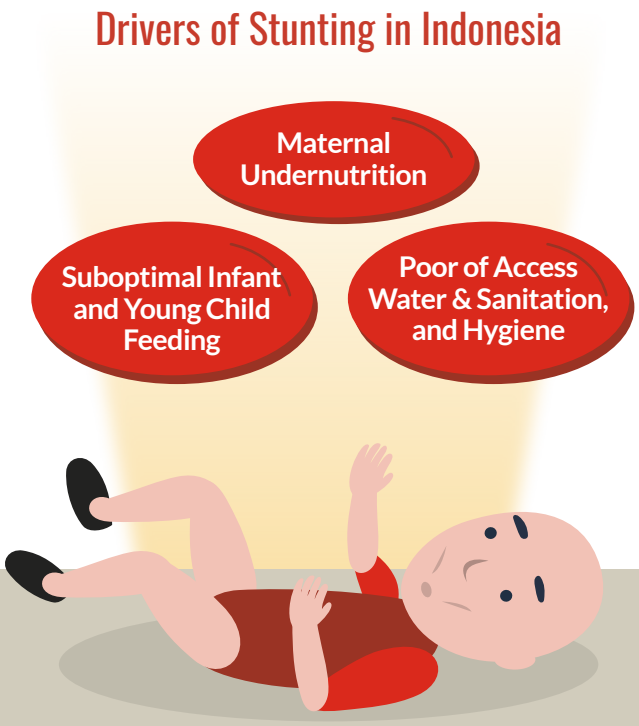
From the five-years program implementation and experience, we learnt that SBCC has proven to be an effective tool in addressing nutrition-related issues by influencing individual and community behaviors, understanding of the key implementers and policy makers.

This policy paper aims to outline a comprehensive recommendation for the design, implementation, and monitoring of SBCC programs in Indonesia to improve nutrition outcomes.

01
INTRODUCTION AND PROBLEM STATEMENT

In Indonesia childhood stunting rates are declining but remain high at nearly 32% nationally (Riskesdas 2018) and 21.6% (SSGI, 2022). Determinants of stunting in Indonesia are complex and multi-level.

The key drivers include maternal undernutrition, suboptimal infant and young child feeding practices (not exclusively breastfeeding, inadequate complementary feeding, food taboo, culture, and belief), and poor of access water & sanitation, and hygiene practices.



Indonesian Government has committed in reducing stunting to 14% by 2024 through the implementation of StraNas Stunting and National Action Plan to Accelerate Stunting Reduction (RAN PASTI).

Indonesia Sehat is one of the social transformation goals of Indonesia EMAS 2045 by building a resilient and responsive health system and ensuring long and healthy lives with a target of less than 5% stunting.

These necessitates a multifaceted approach, leveraging behaviour change strategies to encourage the adoption of healthy dietary practices, breastfeeding, and proper nutrition for vulnerable populations.

SBCC programs, through group based and one on one interpersonal communication (IPC) plays a pivotal role in promoting positive nutrition behaviors. group-based and one-on-one interpersonal communication.

Pillar 2 of StraNas Stunting focuses in increasing public awareness and promoting behavior change at various levels to achieve a consistent, sustainable behavioral change campaign for the public, interpersonal communication tailored to target groups, continuous advocacy to decision-makers, and capacity development for program managers.

Cadres are the first line of action to support mothers, infants, and young children during the first 1000 days, foundational to any SBC approach and Maternal, Infant, and Young Child Nutrition (MIYCN) interventions within the public health system sphere.

BISA finds that community-based programs are the best platforms in increasing the knowledge and capacities of local community, where maternal care can be integrated throughout women's lifespan from adolescence to conception and healthy pregnancy, especially throughout antenatal care and on to child health.

These programs are also effective in increasing community participation in Integrated Health Post (Posyandu) and support for promoting healthy practices, increasing breastfeeding success, and reducing early complementary feeding for children.

Community Health Workers (CHWs) thus play the lead role to implement interventions for promoting demand for healthy behaviors and linking community members with primary health care.

This is aligned with the MoH health transformation for Integrated Primary Health Care approach on promotive and prevention through lifecycle.

For SBCC approaches to be impactful, the approach need to be well designed and well delivered.

This policy paper draws on the experience of the BISA programme to highlight the CHWs potential and their impact on SBC of mothers, families, and communities, and speculates actions to remedy the current gaps.

Baseline survey, participatory focus group discussions, immersion research and Government data has been used to gather up to date, analyzed and contextualized the relevant insights or gaps in understanding of behaviours affecting stunting prevalence among the first 1000 days of life families and adolescents.

Nutrition and health status across the program areas were poor with a significant proportion of CU 2 stunted (between 17.5% and 33.9%).[2]

While early initiation of breastfeeding is higher (65-91%) particularly related to higher rates of institutional births, Exclusive Breastfeeding up to six months was relatively low (52-74%) due to mothers' perception that breastfeeding is uncomfortable.[3]

Mothers/caregivers have a widespread assumption that a crying baby is hungry and needs more than breastmilk, thus most of them were found to introduce complementary foods early (3-4 months of child's age).

Dietary diversity is low in complementary feeding, (35%-77%), that particularly dense in plain rice/ porridge but lack animal-sourced or iron-rich foods.[4]

[2]Studi Baseline BISA 2020
[3]Studi Baseline BISA 2020
[4]Studi Baseline BISA 2020

Minimum meal frequency among children is 62-72%, often fed only on demand, leading either to infrequent meals or frequent snacks to appease them.[5]

Families' understanding of stunting is weak and people generally do not perceive it to be an issue.[6]

Adolescent girls (14-20 years) are anaemic (between 68% and 83%). Adolescent girls are less concerned with their 'health' with very low (1-7%) adherence to Weekly Iron Folic Acid (WIFA) supplementation, since most consider WIFA unnecessary without any symptoms.[7]

Families including children and adolescents eat rice-heavy, low-protein diets without enough diversity in food groups. School going children and adolescents' girls prefer to buy fried, sweetened, and packaged food in schools rather than bringing health lunch pack from home.[8]

SMost pregnant women eat the same rice-heavy, low-protein diet as the rest of the family, some even increase consumption of rice in later stages of pregnancy. 17.3% pregnant women with chronic energy deficiency and 48.9% pregnant women are anemic.

During July to November 2023 monitoring, the progress on Iron Folic Acid (IFA) supplementation was slow to meet the annual target of the proportion of pregnant women who received at least 90 IFA in each district as described in the graph below:

[5]Studi Baseline BISA 2020
[6]Studi Baseline BISA 2020
[7]Studi Baseline BISA 2020
[8]Studi Baseline BISA 2020

Antenatal care visits, self-reported by pregnant women has been found to be low, while >50% consult a Traditional Birth Attendant instead of a health worker. Many pregnant women (and husbands) do not see any need to attend antenatal care unless they feel unwell.

Even though counseling / IPC is embedded in the Posyandu five table mechanism, counseling session in Posyandu is not routinely conducted for several reasons:

1. Posyandu is often held in one of the community's house with limited space
2. Mothers found Posyandu often uncomfortable, crowded and noisy and focused on measurements so little opportunity to ask questions
3. Only a few health providers (13-52%) and Posyandu cadres (12-29%) had knowledge on appropriate counselling methods[9]
4. Only around half of Posyandu cadres reported availability of job aids (59-67%)[10]
5. Most had no time to do counselling during Posyandu because of the need to manually fill records

Health facilities often suffer from stock shortages, poor distribution and out of date supplements said to be due to budgetary constraints.

Health workers still lack in knowledge regarding giving health education (specifically around anemia, iron folic acid) to pregnant women, adolescent girls.

Coordination between Puskesmas and school regarding WIFA is still lacking and WIFA program has not reached out-of school adolescent girls yet. [11]

[9]Studi Baseline BISA 2020
[10]Studi Baseline BISA 2020
[11]Pencapaian Y4 - Cakupan kumulatif untuk ibu hamil yang menerima setidaknya 90 tablet IFA: Bandung Barat 22%, Sumedang 22,3%, Kupang 31,5%, TTU 27%.

Most village governments still see stunting as underweight and wasting where frequently the solution takes is providing supplementary food to CU5 who are already stunted.

They do not understand that stunting is irreversible. The role and capacity of cadres is not considered to contribute greatly to stunting reduction efforts, so the budget for cadre incentives and training is not a focus for all villages.

Not all HDW (Human Development Worker) have knowledge and skills related to the use of the E-HDW application so that the results of the village scorecard are not significant to determine the priority causes of stunting at the village level.

Lack of understanding on stunting issue with its implementation at the Sub. District and village level, resulting in lack of 8 of stunting action convergence implementation (Action 1- 3).

Lack of Coordination among the TTPS (who do what, when and how) including budgeting and reporting on action convergence implementation. Lack of multisectoral coordination and programs to access the out of schools and disabilities (DHO, Social Affairs, DPMPD, Village and Sub District Levels, and organization of disabilities).

02
KEY OBJECTIVES

This recommendation paper from the BISA Program intents to

01

To obtain the value for BISA approach & intervention and the influence to the changes in knowledge, perception, and behavior & practice in the community towards nutrition issues (e.g., exclusive breastfeeding, complementary feeding, and lack of WASH practices (handwashing with soap and hygienic environment among caregivers of children under two)

02

To identify MIYCN behaviour change enabling factors, barriers, challenges (e.g., local policy/regulation, cultural/belief, gender and inclusion perspective, social norms, access to resources) experienced by the BISA program

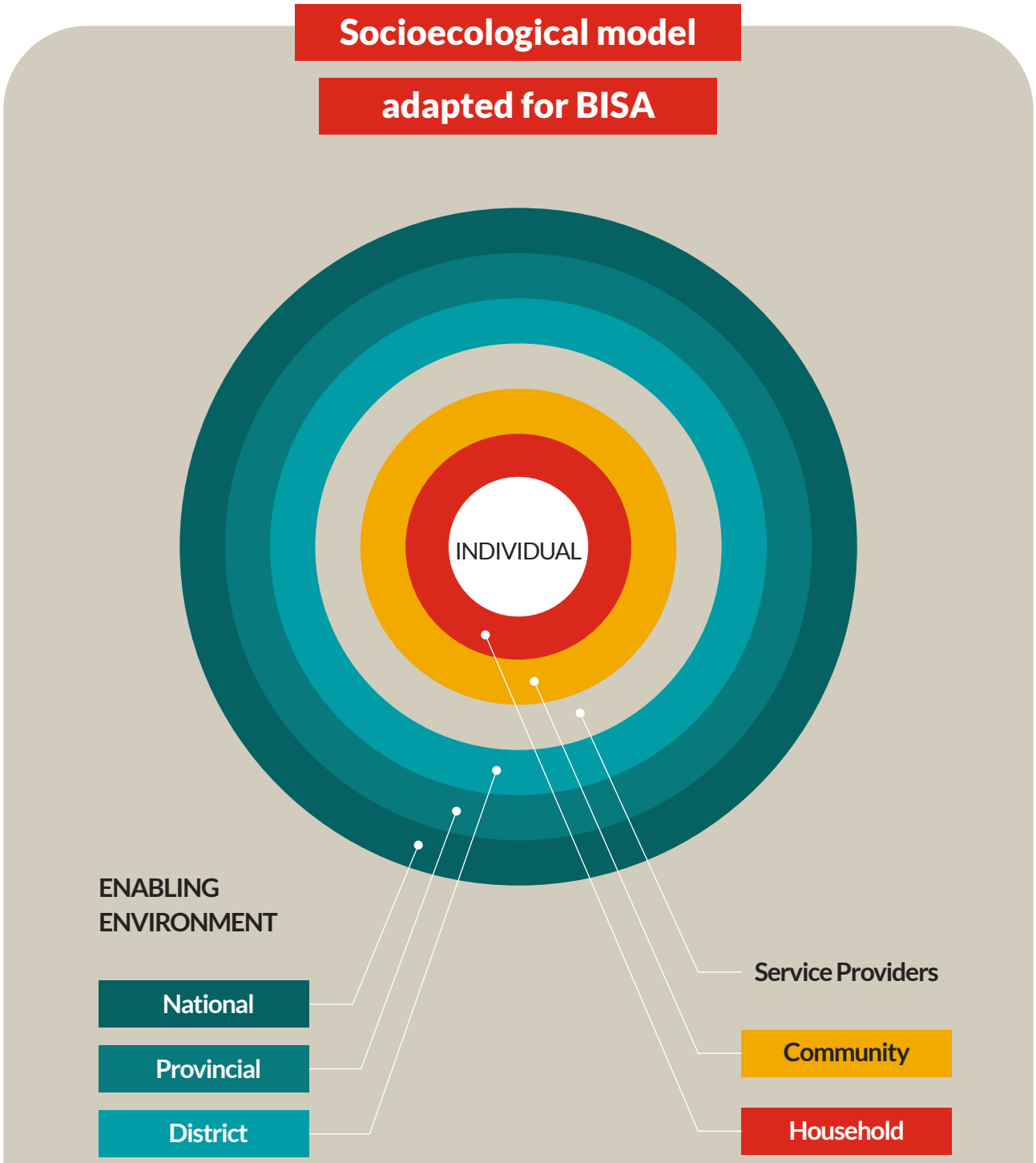
03

To provide recommendations of BISA to the policy makers in addressing the challenges as to accelerating the stunting reduction at National and sub national level

03
BISA'S EFFORTS TO ADDRESS THE PROBLEM

BISA's SBC approaches is based on the Social-Ecological model which emphasizes multiple levels of influence, such as individual, interpersonal, community, and public policy. It is based on the basic assumption that behaviours both shape and are shaped by the social environment.

The principles of the Social-Ecological model are consistent with social cognitive theory concepts, which suggest that creating an environment conducive to change is important to make it easier to adopt healthy behaviours.



HOUSEHOLD LEVEL

Inter-Personal Communication (IPC) is one-on-one counselling for the first 1000 days families by trained Posyandu cadres and village midwives via home visit and Posyandu.

BISA conducted training on negotiated behavior change communication for Posyandu cadres to strengthen the utilization of National Mother and Child Health (MCH) Handbook during Posyandu session and home visit.

Through negotiated behavior change communication, Posyandu cadres works together with pregnant and breastfeeding women to consider various options that might be realistic and appropriate considering their current situation.

Generally, home visits are conducted only for high-risk pregnant women, such as those with chronic energy deficiency, mothers who are too old to get pregnant and CU-2 who are sick or underweight.

To address this issue, BISA is piloting Care Group model in twelve villages within Puskesmas Mamsena working area, TTU District. On Care Group, cadres make home visits to all Posyandu targets in monthly basis to discuss one behavior related to essential nutrition and hygiene action.

Since February 2023, on average about 95% of Posyandu target have received home visits from Posyandu cadres every month and cadres have been able to monitor behavioral changes in pregnant women and caregivers CU2.

COMMUNITY LEVEL

BISA provided training for Posyandu cadres and HDW to conduct group education sessions at Posyandu.

Disability Inclusion is incorporated into IYCF (*Infant and Young Child Feeding)* Training by providing training facilitation guidance with the EmoDemo module.

In the guidance, Disability Inclusion is integrated into the key IYCF messages to address feeding difficulties for babies and children under two with disability.

The trainings are delivered for the district facilitators and village midwives by using the emo demo method, BISA targets four key behaviors to reduce stunting, namely exclusive breastfeeding, adequate complementary foods, iron-rich foods for pregnant women and washing hands with soap.

EmoDemo is an interactive educational session to convey simple messages by touching the emotions of the participants.

Together with District Village and Community Empowerment, BISA provides refresher training to improve Human Development Workers (HDW) knowledge and skills on e-HDW application in 66 villages. The e-HDW application is used for regular reporting on Stunting Intervention at village level.

Results of the reporting will be generated as Z Score and used for village stunting discussions to determine priority of stunting related issues to be resolved. BISA assist village midwives and Posyandu cadres in village development planning meetings for budget advocacy related to cadre capacity building and health and nutrition programs.

ORGANIZATIONAL LEVEL

At the school level, BISA trained secondary school teachers to conduct participatory educational and train student organization for peer-to-peer support in sessions regarding anemia, WIFA and handwashing with soap.

By conducting training school facilitators on adolescent nutrition, BISA also strengthening services related to WIFA supplementation especially for junior high schools since not all school familiar on this nd understand where to ask the stock for WIFA for its students.

At Puskesmas level, BISA conduct training and mentoring to improve management of nutrition commodities and program delivery for Vitamin A supplementation, IFA for Pregnant Women, diarrhea treatment for CU5 with zinc and ORS, and WIFAS program for adolescent girl; and to conduct supportive supervision for puskesmas and school staffs.

BISA also facilitated the establishment of local SUN CSOs in four assisted districts, making it the latest engagement of CSOs under SUN task force in the intervention districts.

The local CSOs are now working directly with the respective district governments and communities to identify focus villages with high stunting rates, provide the identified high-risk households with food support, and build awareness on nutrition and stunting in the village.

BISA advocates through CSAG to strengthen the role of TPPS in monitoring and reporting, particularly on the acceleration of stunting reduction at district level by ensuring the sufficient local capacities, human resources and monitoring to grant the quality of the stunting alleviation program until the village level.

POLICY LEVEL

- Together with local implementing partners, BISA advocate Ministry of Regional Affairs and District of Education within four district to develop Circular letter on HHWS and Adolescent Nutrition Session resulting in adolescent nutrition and HWWS session inserted as part of orientation for new academic year students as well as for WIFAs program to ensure adolescent girl student consume WIFA together in schools.

- BISA also has developed series of SBC materials on zinc, ORS , vitamin A, IFA and WIFA e.g. flipchart and WIFA compliance card that have been endorsed by Ministry of Health.

- Participation in MusrenbangPro and MusrenbangKab to influence planning, budgeting, and operations of nutrition related actions at district and provincial level; exposure visits to build understanding of the situation, explore innovations/practices of communities addressing stunting prevention, were successful local level advocacy.

04
LESSONS LEARNED

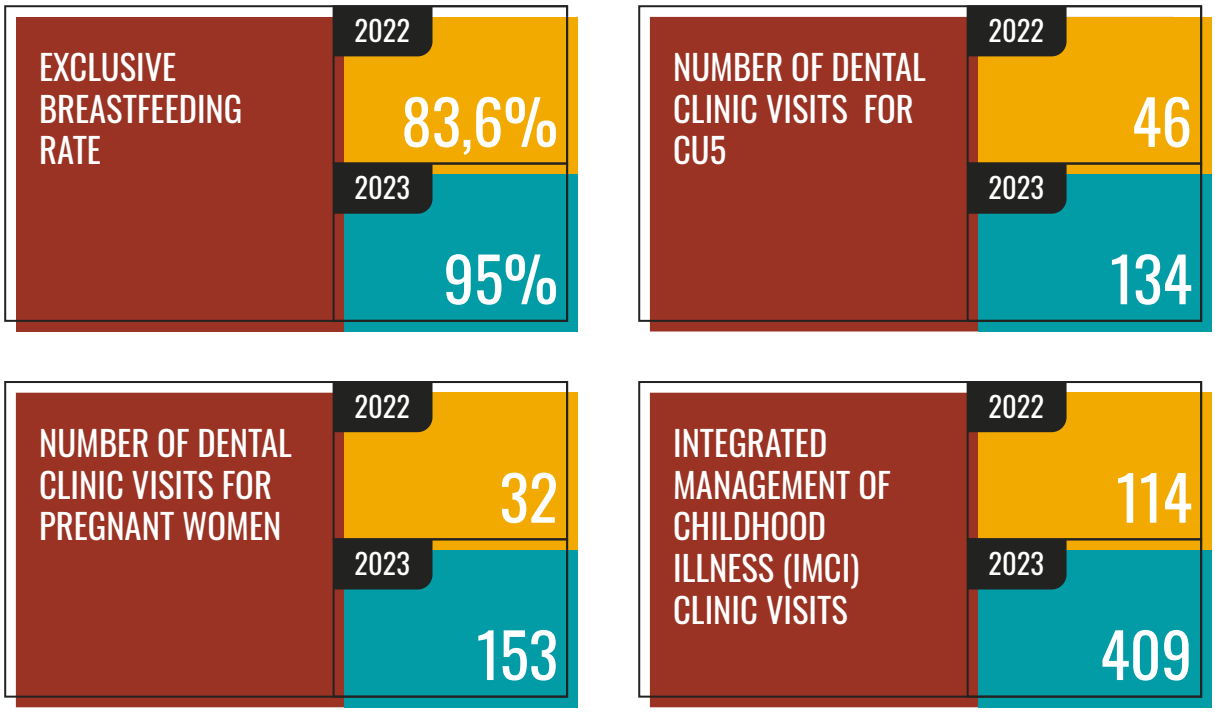
Point 1:

BISA's SBC strategy was based on a Social-Ecological model to promote changes in the existing behavior, attitude and practices among pregnant and lactating women, adolescent, mothers or caregivers of children U2, increasing their understanding in the importance of nutrition during 1000 days of child and improved infant and young child feeding, hygiene and maternal, adolescent and child health care practices.

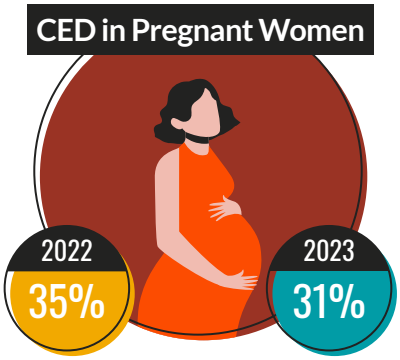
The Social-Ecological model helped to identify the gaps or factors affecting behaviours of different stakeholders at communities, health facilities, district and national level decision makers to design targeted programs for improving their knowledge, attitudes, and practices necessary to contribute to reducing the high stunting rates in Indonesia considering their influence at multiple levels.

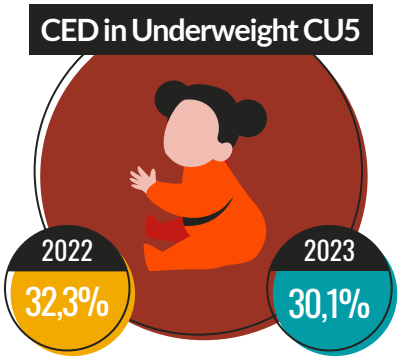
This model thus adopted a multilevel intervention emphasizing multiple levels of influence, such as individual, interpersonal, community, and public policy, potentially more effective and sustainable than individual-level interventions only.

During one year care group intervention at Puskesmas Mamsena showed significant changes in behaviors promoted through home visit such as:



Care group approach combined with supplementary feeding provided by village and Puskesmas for 30 up to 90 days for underweight CU5 and pregnant women with chronic energy deficiency (CED) has also reduced the rate of





Point 2:

Interpersonal communication needs to be emphasised for behaviour change and is the only approach shown to work on its own to exchange information, ideas and feelings one-on-one or in small groups lead to a mutual understanding. Multiple family contacts, especially fathers and grandmothers need to be engaged in such communication to ensure greater family support.

Interpersonal communication is key for SBC as it personalises and contextualises information and advice, enables two-way dialogue and participation and provides the best means to encourage behaviour change.

Interpersonal communication activities at individual, household and community levels should be supported by locally relevant SBC communications materials related to nutrition and stunting prevention.

Point 3:

Community mobilisation to engage wider participation and ownership requires public commitments and social proof to increase community support & promote the behaviour-change with the collective action to address community-wide issues.

BISA's SBC approach has allowed participants to design their own interventions, consensus and commitment around small doable actions needed and support for behaviour change that must exist. Not only should families and the community know what best practice is, social norms need to support change.

Engaging the community through participatory discussions, celebration of nutrition-related events and provision of small media which is context specific and relatable are key.

Point 4:

Continuous service strengthening and capacity building to equip key change agents (from community to national level) with skills and confidence required to implement and monitor SBC activities and support behaviour change.

Service providers like Posyandu cadres are under-used community level resource who could be able to broaden their activities for social behaviour change communication.

Using CHW AIM assessment tools, BISA research found that cadres do not feel the way training is given currently, which generally involves only one or two cadres from each Posyandu, was the best way as it excluded participation and often not geared to the needs.

Direct training in the form of participatory workshops and technical assistance in the form of mentoring, coaching, on the job support, supportive supervision etc. are still found to be the best way to build knowledge, skills, and confidence of the health workers.

However, this requires better resources availability including funding and a pool of district trainers.

05
RECOMMENDATION

This paper is intended to support key implementers and decision makers at National, Provincial and District Level who can take policy level actions to change and promote behaviours targeting stunting alleviation.

National

- Ministry of Health, BKKBN, Bappenas, Ministry of Education and Ministry of Villages will be the national level policy makers targeted by this paper to optimize its resources, function & coordination of TPPS in monitoring and implementation of stunting reduction at the Provincial & Districts level. In addition to ensure the alignment of stunting reduction program with the village program.

- Ministry of Health to make commitment with cross ministries in reviewing, applying the national policies on IYCF , Vitamin A Supplementation, IFA and WIFA for pregnant women and adolescent girl, Zinc and ORS for diarrhea treatment for CU5.

National

Provincial

- Ensure national level policies are socialized, cascaded and implemented in provincial and district level

- Ensure the implementation of monitoring evaluation and utilization of data monitoring for improvement actions of Behavior Change National Campaign and Communication to prevent stunting (pilar 2 National Strategy for stunting).

- Sharing information / innovations to accelerate stunting carried out in the district.

- TPPS become a focal point for identifying information updates and bridging multi-stakeholder collaboration including the private sector in accelerating stunting reduction.

District

- Ensure the compliance of public and corporate spaces to the national IYCF policies
- Alignment with Head of District regulation guiding policy direction. Enforcement of Commitments from subnational leaders, particularly on the acceleration of stunting reduction at district level by ensuring the sufficient local capacities, human resources and monitoring to grant the quality of the stunting alleviation program until the village level
- District Government to use the platform of Community Civil Society Action Group (CSAG)prioritize the capacity development of Village leaders, community representatives and local cadres to ignite the integration of stunting related programme to the village programme and monitor village budget planning implementation and the quality in regular basis

District

Community/ Village Level

- Community health workers and healthcare supervisors at Posyandu: CHW Assessment and Improvement Matrix (CHW AIM) conducted in BISA implementation areas found that this frontline cadres lack pre-service training to equip them with the necessary skills for their role. This paper thus advocate designing SBCC program that targets CHWs and support their capacity building by providing them necessary skills to ensure quality local context of Social Behaviour Change (SBC) interventions through commitment of local community leaders and influencers to replicate by integrating the SBC interventions into the village yearly program and allocation of sufficient resources (funding, human resources, measurable monitoring system).
- Prioritize effective communication channels including local community events (cultural arts event, religious events, public service announcement), digital and social media.

Community/ Village Level

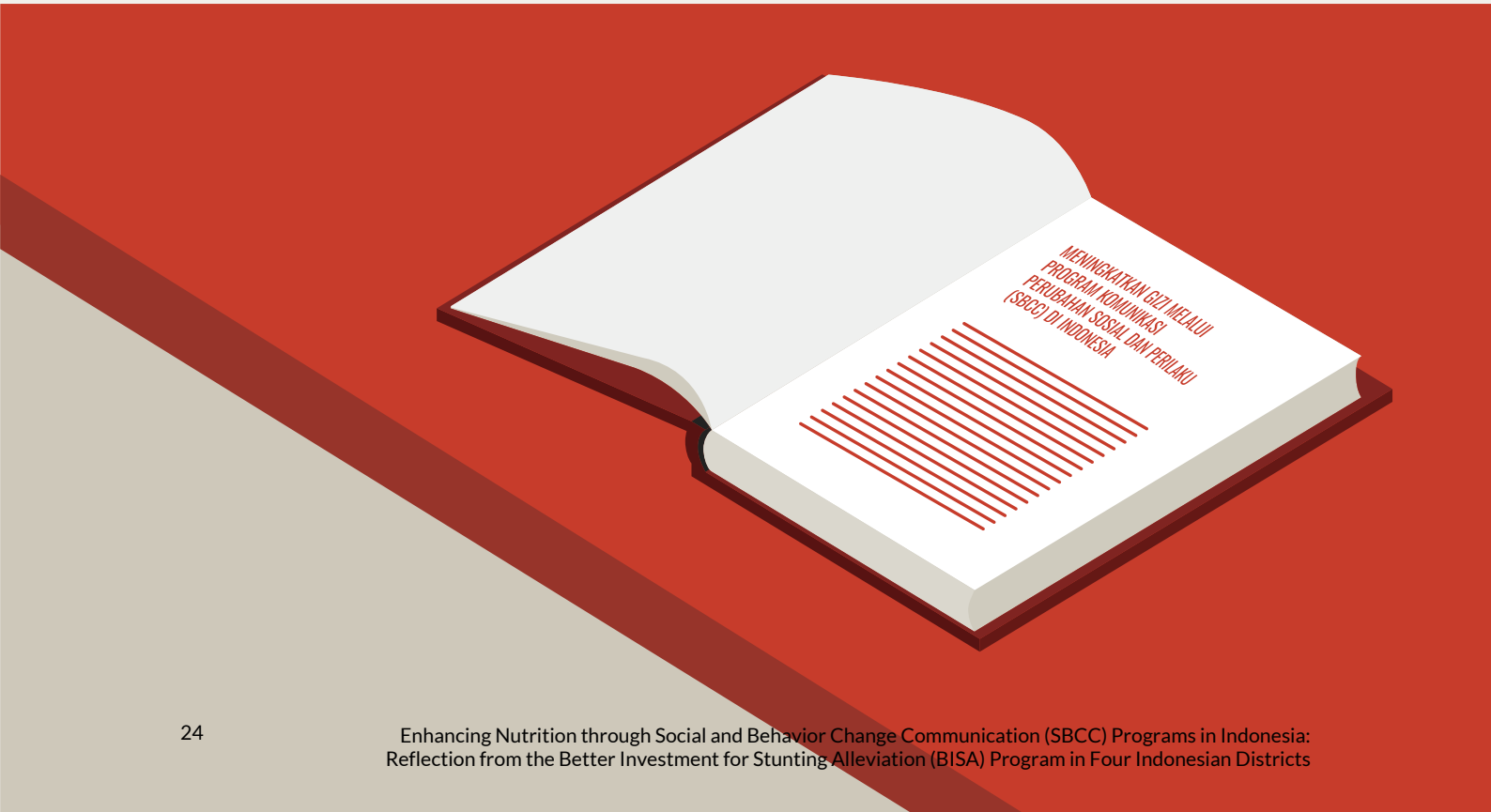
06
CONCLUSION

This policy paper advocates for a strategic and integrated approach to nutrition SBCC programs in Indonesia based on BISA's learnings from implementing SBC approaches in West Java and East Nusa Tenggara province.

By optimizing culturally sensitive and community-focused SBC approaches, the above recommendations have the potential to catalyze positive behavior change, ultimately improving the nutritional landscape and the overall health of the population.

Implementing this comprehensive framework will require the collaboration of government agencies, NGOs, academia / universities, media and the private sector, with a shared commitment to prioritizing the well-being of Indonesia's communities.

In sum, improvement in stunting among Indonesia children will prove difficult to achieve if development agencies and government fail to strengthen and invest in the bedrock of community health and nutrition, cadres.



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