Improving Nutrition Security in Indonesia:

District Actions to Improve Infant and Young Child Feeding

unicef

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EXECUTIVE SUMMARY

Executive Summary

Indonesia faces serious challenges in stunting and other forms of malnutrition. Nationally, 37 per cent of Indonesia's children under five years were stunted in 2013, which means they were short for their age and 12 per cent were wasted or had a low weight for their height.[1] In 2012, only 49 per cent of infants were breastfed immediately after delivery, only 42 per cent of infants younger than six months were exclusively breastfed and just 37 per cent of children aged 6-23 months received appropriate complementary food.[2]

Progress against malnutrition has been slow at the national level and disparities in stunting prevalence between the poorest and richest households have been widening. This is a national concern because the effects of poor nutrition in early childhood can last a lifetime; it increases vulnerability to infection, affects brain development and undermines educational achievement and economic productivity.

Since 2011, concerted action in three focus districts (Klaten, Sikka and Jayawijaya) of the Maternal and Young Child Nutrition Security in Asia (MYCNSIA) programme delivered significant and rapid results in reducing malnutrition. Within three years, these districts showed a five percentage points (29.6 to 23.9 per cent) reduction in stunting in children younger than three years old while the proportion of infants under six months old who were exclusively breastfed increased by 20 percentage points (52.2 to 72.3 per cent). The most notable progress was achieved in the poorest households where stunting declined by 10 percentage points, exclusive breastfeeding improved by 30 percentage points, and complementary feeding practices also improved.

Analysis of the key factors contributing to the positive nutrition outcomes in these districts highlighted the importance of the following:

Success factor 1 – An enabling legislative environment: During the 2000s, health facilities and health workers frequently promoted infant formula to mothers of young children. Sales of infant formula rose steadily while exclusive breastfeeding declined. The 2009 Health Law paved the way for change that was reinforced by the release of the 2012 Government Regulations (33/2012) on exclusive breastfeeding. District-level legislation, notably in Klaten District, added further protections by monitoring compliance with district laws and regulations on exclusive breastfeeding.

Success factor 2 – Planning and budgeting at national and sub-national levels: In 2011, Indonesia launched the National Strategy for Infant and Young Child Feeding that was subsequently integrated into national plans. Indonesia's strongly decentralized government meant that the strategy also needed to be reflected in district plans and budgets. In Klaten and Sikka Districts, actions to improve infant and young child feeding (IYCF) practices were incorporated and prioritized in district plans of action on food and nutrition, and subsequently in annual plans and budgets. Both districts dramatically increased their budget allocations for IYCF and other nutrition services. Meanwhile, a participatory learning and action process was introduced to help communities analyse nutrition problems, define solutions, and translate these into realistic action plans with funding provided from village or district funds. These measures contribute to the long-term sustainability of nutrition interventions.

Success factor 3 – Multisectoral approaches to synergize effects and multiply channels for promotion: Multisectoral approaches, involving health, education, agriculture, social protection and water and sanitation, among others, are central to all national nutrition strategies. The Child Friendly Cities initiative in Klaten mobilized a wide range of sectors,

institutions and organizations on children's issues including stunting and IYCF. Integration of nutrition actions with a conditional cash transfer programme aimed to increase the demand for nutrition services and change IYCF behaviours among vulnerable households, thereby augmenting the impact of the cash transfers. Districts have integrated IYCF counselling into family planning, agricultural extension and early childhood development programmes. These initiatives increased the likelihood that the multiple underlying causes of malnutrition were simultaneously addressed, and multiplied the channels for reaching and engaging households on IYCF.

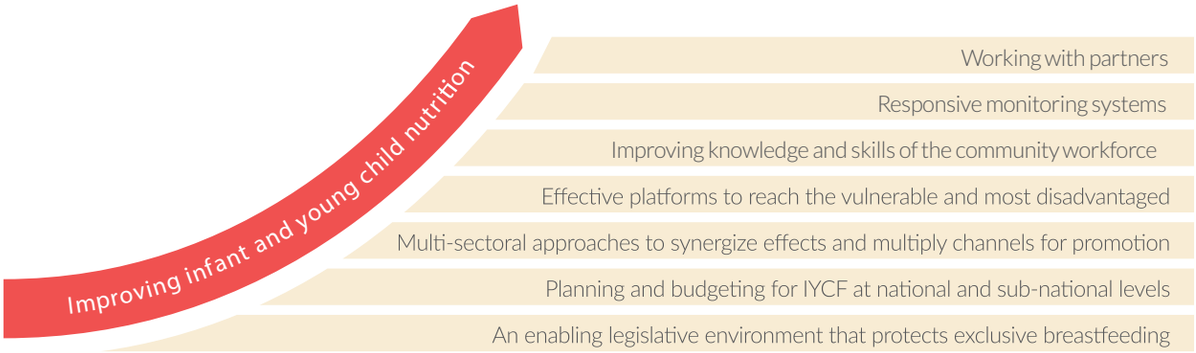
Success factor 4 – Effective platforms to the most vulnerable and disadvantaged households: The most striking results of the programme are evident in reduced stunting and improved IYCF practices in the poorest households. Social protection programmes can help to promote good IYCF practices among the poorest families, yet coverage is currently limited. However, Indonesia's vast network of Posyandu (integrated community health posts) and community health workers (CHWs) provide an excellent mass channel to reach the most vulnerable households with community counselling services on maternal nutrition and IYCF. Many CHWs who have been trained in maternal nutrition and IYCF provide counselling and organize complementary food demonstrations during the monthly Posyandu meetings. Mothers and caregivers from the poorest households are attracted to these meetings by the offer of free and nutritious meals for their children. Other important initiatives to reach the most vulnerable and excluded include Jayawijaya District's maternity waiting homes, where mothers are counselled on IYCF before and after they give birth; Sikka District's 24-hour phone-in centre that provides free round-the-clock counselling on IYCF; and Klaten District's Kafe Baby (Baby Café), which sells affordable nutritious meals for children aged 6-23 months.

Success factor 5 – Improving knowledge and counselling skills of the community workforce: Mothers often seek advice on IYCF from relatives or friends in their communities who may not always be the best informed. In 2011 the Ministry of Health developed a Maternal Nutrition and IYCF Counselling Course to build the capacity of the community health workforce. The course emphasises knowledge building on maternal nutrition and IYCF as well as skills in counselling, problem solving, negotiation and communication. The course was introduced in the districts of Klaten, Sikka and Jayawijaya through a cascade-training model: district master trainers trained facilitators in Puskesmas (community health centres) who were in turn responsible for training all village midwives and at least two CHWs from Posyandu. Strong quality assurance measures were established including follow-on supportive supervision for all trained village midwives and CHWs. This course has since been scaled up to at least 115 districts with support from local government, UN agencies, NGOs and the Millennium Challenge Corporation.

Success factor 6 – Responsive monitoring systems: Data on exclusive breastfeeding among infants under six months is collected from mothers of young infants at every Posyandu visit and is used to monitor trends. Klaten District introduced a data collection process that tracks implementation of district regulations on breastfeeding as well as key indicators across the 1000 days from conception to two years. Real-time monitoring of key nutrition indicators is also in place in Klaten: data entered at community level by village midwives can be immediately accessed by health workers in Puskesmas and at the district level. The availability of good data helps to keep programmes on track and indicates where adjustment is needed.

Success factor 7 – Working with partners: Effective partnerships have the capacity to reach and more rapidly transform the lives of many more children and women. The collaboration of many partners has enabled the scale-up of CHW training in maternal nutrition and IYCF. Religious leaders are ideal partners because they have considerable influence and have much greater capacity than the health sector to reach men and other influential family members with IYCF messages. In Sikka District, making religious leaders aware of nutrition challenges has led some to incorporate relevant messages into sermons and services. Meanwhile, Klaten's association of IYCF counsellors, known as I-KLAN, provides strong support in advocacy, counselling, training and monitoring. Partnerships with businesses such as Bank Central Asia also help to demonstrate how working environments can become breastfeeding-friendly.

Taken together, these success factors represent some of the key determinants that are transforming the nutritional status of children in selected districts of Indonesia.



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INTRODUCTION

Introduction

Every child has the right to good nutrition. Fulfilling that right is an obligation of governments, health providers, employers, educators, community and religious leaders and families – everyone who has the capacity to influence children's access to healthy diets. The rewards of good nutrition in early childhood are immeasurable – delivering lifelong benefits for children, their families, communities and the nation.

Recent global analysis has confirmed the immense importance of good infant and young child feeding (IYCF) practices (Panel 1) in preventing malnutrition and contributing to social and economic development.[3] Breastmilk is virtually cost-free and is therefore a valuable household resource. Early initiation of breastfeeding reduces neonatal deaths and is especially important for infants with low birth weight. It also reduces blood loss in mothers following delivery. Breastfeeding protects infants from diarrhoea and pneumonia and improves their cognitive development and future earning capacity, while among mothers, it reduces the risk of breast and ovarian cancer.[4,5] In Indonesia, improved breastfeeding practices could save over 5,000 child deaths, about USD 256 million (IDR 3 trillion) in health care costs and USD 1.3 billion (IDR 17 trillion) in wages every year[6]. Nutritious complementary foods from six months of age, combined with continued breastfeeding until at least a child's second birthday, ensures that healthy growth and development continues during early life.

In 2013, about 37 per cent of Indonesia's children under five years were stunted, which means they were short for their age, and 12 per cent were wasted, meaning they had a low weight for their height.[7] Progress against malnutrition was slow and disparities in stunting prevalence between the poorest and richest households were widening.[8] This is a national concern because poor nutrition in early childhood has a life-long effect, affecting cognitive development and undermining educational achievement and economic productivity

Poor IYCF practices underlie malnutrition in Indonesia. In 2012, 42 per cent of infants under six months old were exclusively breastfed and 37 per cent of children aged 6-23 months received a 'minimum acceptable diet', meaning it met the minimum requirements in terms of breastmilk or milk content, diversity and meal frequency.[9]

Strong cooperation between the Government of Indonesia, UNICEF and the European Union has delivered many important gains for children. In 2011, Indonesia joined the global Scaling Up Nutrition (SUN) Movement, which aims to combine the collective efforts of government, UN agencies, donors, civil society and the business sector to reduce all forms of malnutrition. In the same year, the Maternal and Young Child Nutrition Security in Asia (MYCNSIA) programme was launched by the Government and UNICEF with support from the European Union and UNICEF (see Panel 2). In accordance with UNICEF's Global Health and Nutrition Strategy (2006-15), the MYCNSIA programme adopted a rights-based approach to maternal, infant and child nutrition that was crucially focused on tackling inequity.

Over the past five years, the MYCNSIA programme has helped the Government and UNICEF to strengthen the enabling environment for nutrition by scaling-up the coverage and quality of high-impact nutrition interventions across the critical 1,000-day window covering pregnancy through the first two years of a child's life. Key achievements include the development of pro-nutrition legislation, policies, strategies and plans across a range of sectors; strengthened information systems and increased use of data to drive decision making on nutrition; increased capacity of service providers; and the scale-up of nutrition interventions for children and women. At the subnational level, the MYCNSIA programme was initiated in the focus districts of Klaten, Sikka and Jayawijaya. The dedication and determination of local government in these districts to improve nutrition played a central role in the remarkable achievements that followed. Within three years, these districts reduced stunting in children under three years by five percentage points (10 percentage points in the

poorest households) and improved exclusive breastfeeding rates by 20 percentage points (30 percentage points in the poorest households). Complementary feeding practices also improved in the poorest households.

Analysis of key factors contributing positive nutrition outcomes in the focus districts highlighted the importance of: (1) an enabling legislative environment that supports IYCF, especially exclusive breastfeeding in the first six months; (2) effective planning and budgeting for IYCF at national and sub-national levels; (3) multisectoral approaches that synergize effects and expand the reach of IYCF messaging and behaviours; (4) effective delivery platforms that reach the most vulnerable and disadvantaged households; (5) improving IYCF counselling skills of service providers, including the community health workforce; (6) responsive monitoring of results to track progress and make adjustments as needed; and (7) working with partners to maximise the reach and to enrich IYCF programming

This report explores these success factors with the aim of encouraging other sub-national administrations, agencies and organizations to adopt or adapt some of these approaches – or to seek and share other processes that deliver the same strong results.

Panel 1: Recommended infant and young child feeding practices from birth to 24 months

Figure 1 illustrates good practices in infant and young child feeding during the first 24 months. The initiation of breastfeeding within one hour of delivery reduces the likelihood of neonatal death, particularly among infants with low birth weight. Exclusive breastfeeding for six months protects against deadly infections, and reduces the costs to the family and health system that may be incurred. Appropriate complementary feeding from six months of age, together with continued breastfeeding until the child is at least two years, ensures that the child receives adequate nutrients for healthy growth and development.

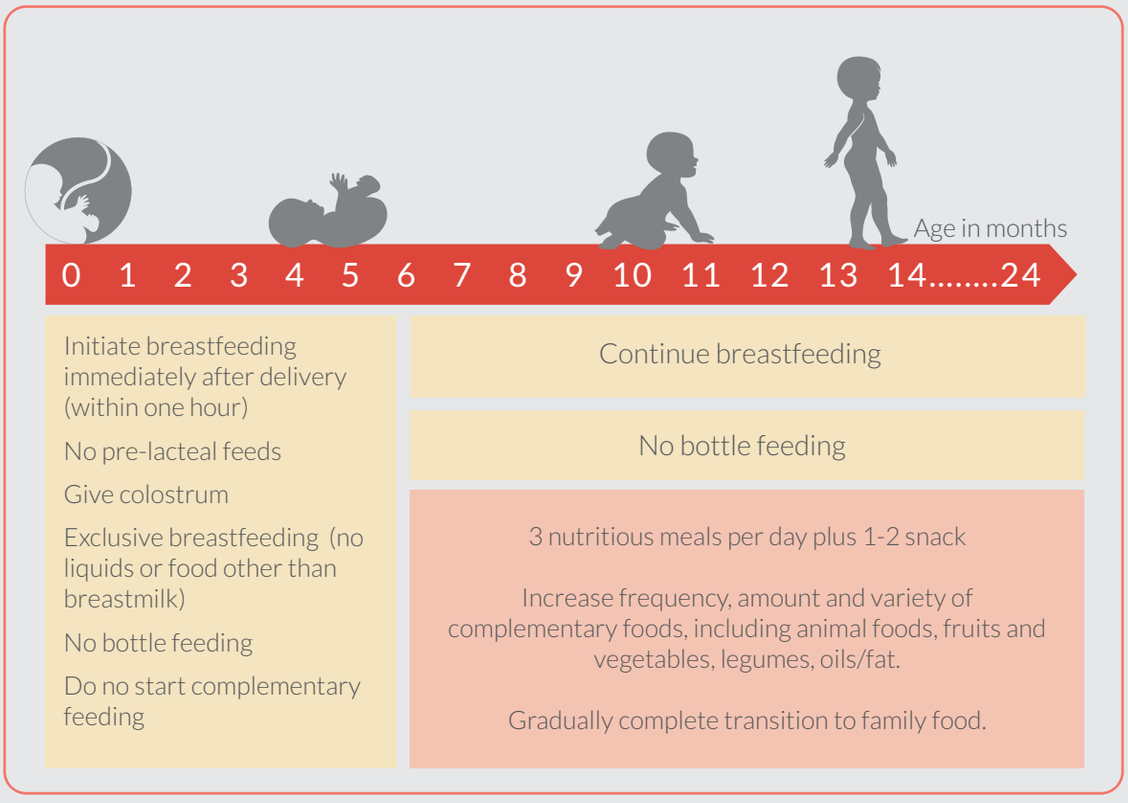

Figure 1: Optimal feeding from birth to 24 months

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INDONESIA'S MALNUTRITION CHALLENGE

Indonesia's Malnutrition Challenge

Key messages

- Nationally, 37 per cent of Indonesia's children under five years were stunted, and 12 per cent were wasted in 2013. Only 42 per cent of infants younger than six months were exclusively breastfed and only 37 per cent of children aged 6-23 months received a minimum acceptable diet in 2012.
- Progress against malnutrition has been slow at national level, and disparities in stunting prevalence between the poorest and richest households have widened.
- Poor nutrition in early childhood affects brain development, limits educational achievement and economic productivity and increases vulnerability to infection.

Malnutrition in Indonesia

In 2013, almost nine million children in Indonesia, or 37 per cent of children under five years, were stunted and almost three million children or 12 per cent were wasted.[10] Progress in addressing these challenges has been slow, and, currently, Indonesia is on track to meet only one of the six World Health Assembly nutrition targets for 2025.[11]

Indonesia has achieved impressive economic growth and emerged as a middle-income country, yet the benefits have not been evenly shared. Disparities in malnutrition are widening. The difference in stunting prevalence among children living in households in the poorest and richest wealth quintiles almost doubled from 10 percentage points in 2007 to 19 percentage points in 2013.[12] Geographic disparities are also striking; in 2013 the prevalence of stunting ranged from 26 per cent in Kepulauan Riau Province to 52 per cent in Nusa Tenggara Timur Province.[13]

Causes and consequences of poor nutrition

Several factors are responsible for malnutrition. Poor nutrition can have origins during the foetal stage if the child's mother is an adolescent and/or malnourished before or during pregnancy. It may also result from insufficient nutritious food intake and diseases, arising from household food insecurity, suboptimal IYCF practices and other caring practices, inadequate access to good quality health services, and an unhealthy environment during the first two years of life. In 2012, only 49 per cent of infants were breastfed immediately after delivery, only 42 per cent of infants under six months were exclusively breastfed and only 37 per cent of infants aged 6-23 months were fed a minimum acceptable diet.[14] As a result, a large proportion of young children were not adequately nourished and had greater vulnerability to infections that can further aggravate malnutrition and weaken immunity.

Children who are stunted or wasted are more likely to suffer serious illnesses and die in childhood. Those who survive often do less well at school because poor nutrition in early life affects brain development. As adults, they tend to earn less and may struggle to lift their families out of poverty. Paradoxically, they are also at greater risk of becoming overweight; the same mechanisms that conditioned their bodies to cope with nutrition deprivations in early life can result in unhealthy weight gain, diabetes and heart disease in adulthood, if they fail to eat a healthy balanced diet and exercise. Poor nutrition consequently has the heaviest impact in the most deprived households and contributes to the inter-generational transmission of poverty.

RAPID PROGRESS IN FOCUS DISTRICTS

Rapid Progress in Focus Districts

Key messages

- Although national progress in stunting reduction has been slow, stunting was cut by five percentage points in only three years in Klaten, Sikka and Jayawijaya districts. The proportion of infants aged less than six months who were exclusively breastfed increased by 20 percentage points during the same period.
- The most notable progress was achieved in the poorest households where stunting declined by 10 percentage points, exclusive breastfeeding improved by 30 percentage points, and complementary feeding practices improved.
- Key success factors include: an enabling legislative environment; effective planning and budgeting at national and sub-national levels; multisectoral approaches; effective delivery platforms that reached the poorest and most vulnerable households; improving the IYCF knowledge and counselling skills of the community workforce; responsive monitoring of results; and working with partners.

Significant change in nutrition and care behaviours

Although national progress in reducing child malnutrition has been slow, surveys show rapid results have been achieved in the districts of Klaten, Sikka and Jayawijaya, with the most impressive results achieved for children in the poorest households (Figure 2). These diverse districts were the focus of the MYCNSIA programme (see Panel 2).

Comparison of the 2011 baseline survey and the 2014 follow-up survey[15] revealed the following results:

Stunting reduction: Between 2011 and 2014, the prevalence of stunting in children under three years in the three districts dropped by more than five percentage points (29.6 to 23.9 per cent) among all children and by 10 percentage points among the poorest children living in households in the lowest wealth quintile. National survey indicates that the prevalence of stunting in children younger than five years remained virtually unchanged between 2007 (36.8 per cent) and 2013 (37.2 per cent).

Improvement in exclusive breastfeeding: The proportion of infants under six months who were exclusively breastfed increased by 20 percentage points (52.2 to 72.3 per cent) among all children between 2011 and 2014. The increase was almost 30 percentage points among the poorest infants, and by 2014 more than 80 per cent of these infants were exclusively breastfed. According to data from the Indonesia Demographic Health Surveys, the percentage of exclusively breastfed infants in Indonesia increased by only 10 percentage points from 32.4 to 41.5 per cent in the five-year period between 2007 and 2012.

Minimum acceptable diet: Although the percentage of children in the poorest households who received a minimum acceptable diet remained low in 2014, at just over 17 per cent, this represented a significant improvement since 2011, when this figure was less than 7 per cent. There was little change in this indicator among all children.

Increased consumption of animal products: In 2011 only a third of children in the poorest households consumed animal products (excluding dairy) in the previous 24 hours, compared with nearly 60 per cent of all children. By 2014, however, children in the poorest households had caught up: 62 per cent of all children and 63 per cent of children in the poorest households had consumed animal products.

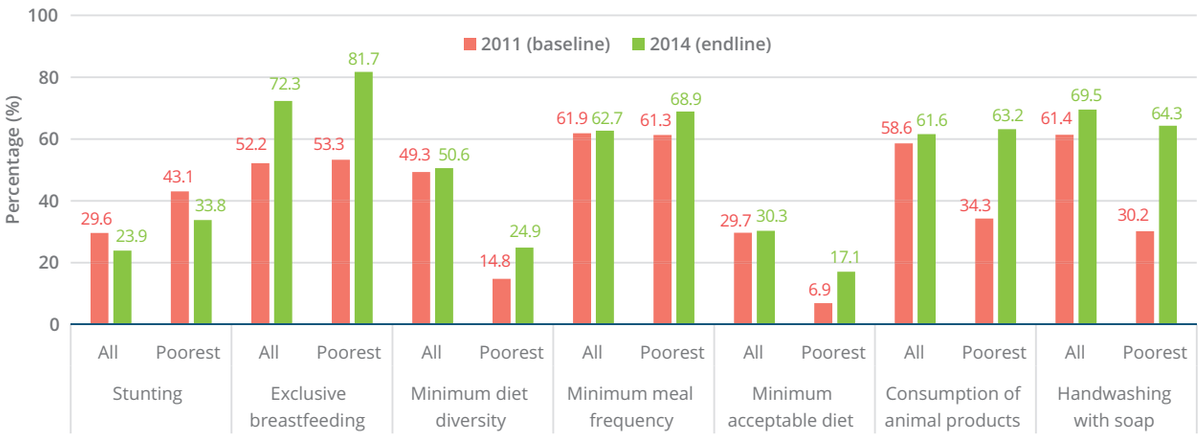

Figure 2: Stunting and IYCF practices among children in MYCNSIA focus districts, 2011 and 2014

Adoption of handwashing with soap: A dramatic improvement was also recorded in the proportion of households that used soap for handwashing. Handwashing with soap increased 8 percentage points among all children, and by 30 percentage points in the poorest households.

The results suggest that children in the poorest households are still at a disadvantage and are more likely to be stunted and less likely to eat nutritious meals than children in wealthier households. Nevertheless, the gap between all children and the poorest children has been reduced for stunting. The gap has also narrowed or been eliminated entirely in many of the IYCF behaviours reflected in Figure 2. The results suggest that the programme successfully addressed inequities.

Success factors in reducing malnutrition and improving IYCF practices

Analysis of the rapid gains against malnutrition and improvement in IYCF practices identified seven success factors that are explored in greater detail in this report. These include:

Success factor 1: An enabling legislative environment: Indonesia's 2009 Health Law paved the way for change that was reinforced by the introduction of the 2012 Government Regulations 33/2012 on exclusive breastfeeding. District-level legislation, notably in Klaten District, added further protections by monitoring compliance with district laws and regulations on exclusive breastfeeding.

Success factor 2: Planning and budgeting at national and sub-national levels: The 2011 National Strategy for Infant and Young Child Feeding was integrated into plans at the national level and replicated in district plans and budgets in Klaten and Sikka Districts. In both districts, funding allocations for IYCF and other nutrition interventions rose sharply. Meanwhile participatory learning helped villages to analyse nutrition problems, define solutions, and translate these into realistic action plans that were implemented with the use of village or district level funds.

Success factor 3: Multisectoral approaches to synergize effects and multiply channels for promotion: Multisectoral approaches are central to all national nutrition strategies because they increase the likelihood that the multiple underlying causes of malnutrition are simultaneously addressed, and expand the reach of services. The Child Friendly Cities initiative mobilized a wide range of sectors, institutions and organizations on children's issues, including stunting and IYCF. The integration of nutrition actions with a conditional cash transfer programme aimed to increase the demand for nutrition services and change IYCF behaviours among vulnerable households, thereby augmenting the impact of cash transfers. Districts have integrated IYCF counselling into family planning, agricultural extension and early childhood development programmes.

Success factor 4: Effective platforms to reach most vulnerable and disadvantaged households: The most striking results of the programme are evident in reduced stunting and improved IYCF practices in the poorest

households. Indonesia's vast network of Posyandu (integrated community health posts) and community health workers (CHWs) provide an excellent channel for reaching parents with information and counselling on maternal nutrition and IYCF. Following training, some Posyandu introduced innovative schemes that have proved especially effective in engaging mothers and caregivers from the poorest households.

Success factor 5: Improving knowledge and counselling skills of the community workforce: In 2011 the Ministry of Health developed a national Maternal Nutrition and IYCF Counselling Course to build the capacity of the community health workforce and their supervisors. This course builds IYCF knowledge and skills in counselling, problem solving, negotiation and communication. The course was initiated in the MYCNSIA districts with a practical cascade-training model and strong quality-assurance mechanisms.

Success factor 6: Responsive monitoring systems: The availability of good programme data helps to keep programmes on track and indicates where adjustment is needed. Data on exclusive breastfeeding among infants under six months is collected during Posyandu visits. Klaten District supplements this with data collection that tracks implementation of district regulations on breastfeeding as well as key indicators across the 1,000 days from conception to two years. Real-time monitoring of key nutrition indicators is also in place in Klaten.

Success factor 7: Working with partners: Effective partnerships can reach and more rapidly transform the lives of many more children and women. The collaboration of many partners has enabled the scale-up of CHW training in maternal nutrition and IYCF. Important partnerships for IYCF at district level include influential religious leaders and Klaten's I-KLAN association of breastfeeding counsellors (see Panels 2 and 8). Businesses that establish working environments that are breastfeeding friendly can also be valuable advocacy partners.

These success factors are the key determinants that are transforming the nutritional status of children in selected districts of Indonesia. The report explores each success factor in greater detail.

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Panel 2: Maternal and Young Child Nutrition Security Initiative in Asia

The Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA) was a European Union and UNICEF supported programme that was launched with the Government of Indonesia in 2011 with the goal of reducing stunting in children under three years by five percentage points by 2015. The MYCNSIA programme has four pillars: (1) strengthening the enabling environment by supporting the development of pro-nutrition polices, plans and strategies; (2) developing capacity; (3) improving information systems and promoting the use of data and evidence to drive decision making; and (4) taking nutrition interventions to scale.

The MYCNSIA focus districts were selected to represent different social and geographic challenges: **Sikka** District is on the coast in a province that has the highest prevalence of stunting in the country; **Klaten** District has relatively lower stunting prevalence but very high number of stunted children due to the large population size; **Jayawijaya** is a unique highland district in a province that lags behind the rest of the country in many health and nutrition indicators. Surveys covering stunting and key IYCF indicators were conducted in these districts in 2011 and again in 2014. Meanwhile, three further districts were added to the programme: **Pemalang** District, where lessons learned from nearby Klaten are being applied; **Brebes** District, to test and improve the nutrition sensitivity of a conditional cash transfer programme; and **Kupang** District due to its high levels of acute malnutrition.

Figure 3: Focus districts of the Maternal and Young Child Nutrition Security Initiative in Asia Programme, Indonesia

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SUCCESS FACTORS

Success factor 1:
An enabling legislative environment

Key messages

- During the 2000s health facilities and health workers frequently promoted infant formula to mothers of young children. Sales of infant formula rose steadily while exclusive breastfeeding declined.
- The 2009 Health Law paved the way for change that was reinforced by 2012 Government Regulation 33/2012 on exclusive breastfeeding.
- District-level legislation, notably in Klaten District, added further protections by monitoring compliance with district laws and regulations on exclusive breastfeeding.

Between 1997 and 2007, exclusive breastfeeding of Indonesian infants under six months declined from 42 to 32 per cent.[16] During this period, sales of infant formula rose steadily facilitated the frequent promotion of infant formula to mothers of young children by health workers and in health facilities. There was also little support or encouragement from employers to help working mothers to continue breastfeeding following maternity leave.

The introduction of the 2009 Health Law requires the government to protect exclusive breastfeeding for infants under six months, which was a significant step forward. It could not be effectively implemented, however, until the release of the corresponding Government Regulation (33/2012) on exclusive breastfeeding in 2012. This regulation specifies the role of health facilities and health workers in promoting, protecting and supporting exclusive breastfeeding. They were no longer permitted to sell, give or promote infant formula in any way to infants under six months old, and formula companies were prohibited from marketing their products in health facilities. The regulation also obliges employers and public facilities, such as government offices and transport hubs, to provide appropriate facilities for mothers to breastfeed their infants.

In the MYCNSIA districts, district health managers and health workers were sensitized to the existence and importance of the new regulations. A booklet explaining the obligations of health managers, health workers and employers under the new regulations was developed. This was used to help transform all health facilities into supportive centres that actively promoted exclusive breastfeeding.

In 2008, Klaten District developed a district law on exclusive breastfeeding. In 2013, the Bupati Regulations (12/2013) were adopted to put the district law into effect. In addition to outlining the obligations of key institutions to protect and promote breastfeeding, the new regulations stipulate rewards for adherence (e.g. public recognition); sanctions for violation (e.g. revocation of licenses of health workers) and the establishment of supervisory and advisory teams to monitor implementation.

Klaten District is arguably the most advanced district in the country in terms of its commitment to protect exclusive breastfeeding. The compliance of Klaten health facilities with laws and regulations is monitored twice yearly by the District Health Office (DHO). In addition, the DHO advises commercial enterprises on how to provide facilities and services to support female employees to breastfeed once they return to work after maternity leave. District regulations give Klaten's DHO the authority to monitor compliance by these commercial enterprises.

In Sikka District, as a result of advocacy from the DHO and other institutions, the local government issued a Bupati Regulation to protect the early initiation of breastfeeding and exclusive breastfeeding for six months.

With these laws and regulations, Indonesia has partially enacted legislation on the provisions of the International Code on the Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions. However, significant gaps remain, particularly in the protection, promotion and support of continued breastfeeding from six months to two years.

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Success factor 2:
Planning and budgeting at national and sub-national level

Key messages

- In 2011, the Ministry of Health launched the National Strategy on Infant and Young Child Feeding.
- Indonesia's strongly decentralized government meant that the strategy needed to be reflected in national and sub-national plans and budgets.
- In Klaten and Sikka, support for IYCF and other nutrition actions was prioritized in the District Plan of Action on Food and Nutrition, and incorporated into annual plans and budgets.
- Both districts dramatically increased budgets for IYCF services using local revenue and Puskesmas funds.
- Participatory learning and action was introduced to help communities analyse nutrition problems, define solutions, and translate these into realistic action plans to be implemented with village or district level funds.

National level

In August 2011, the Ministry of Health launched the National Strategy for Infant and Young Child Feeding. Designed according to the World Health Organization's global strategy, it provided comprehensive guidance on interventions and actions that would protect, promote and support IYCF in Indonesia.

At the national level, IYCF was integrated into the five-year National Medium-Term Development Plan (Rencana Pembangunan Jangka Menengah Nasional or RPJMN), the five-year multisectoral National Plan of Action on Food and Nutrition (Rencana Aksi Nasional - Pangan dan Gizi or RAN-PG) and the multisectoral Policy Framework on SUN. These plans and policies prioritized IYCF and included targets and indicators on exclusive breastfeeding that could be used to assess progress.

Subnational level

With Indonesia's strongly decentralized government, it is vital for national strategies and plans on IYCF to be reflected in corresponding plans at sub-national level. In both Klaten and Sikka, the national strategy was operationalized through the five-year District Plan of Action on Food and Nutrition (RAD-PG). Both districts prioritized IYCF in the RAD-PG and included indicators to track progress. For example, the Sikka RAD-PG included actions to strengthen counselling on maternal nutrition and IYCF, and a specific indicator to track the number of health workers and CHWs who were trained in maternal nutrition and IYCF counselling.

Districts may allocate local revenue funds (Anggaran Pendapatan dan Belanja Daerah or APBD II) for IYCF and other nutrition services. Since 2013, Ministry of Health guidelines have also permitted the use of Puskesmas or BOK funds (Biaya Operational Kesehatan) to strengthen maternal nutrition and IYCF services, including for CHWs and health worker training.

Figures 4 shows the dramatic increase in the allocation of local revenue funds (APBD II) for IYCF and other nutrition actions in Klaten and Sikka between 2011 and 2015. The IYCF budget was allocated to support the training of CHWs on maternal nutrition and IYCF counselling; demonstration complementary feeding at Posyandu; and to monitor IYCF interventions. In addition, BOK funds, which are not reflected in Figure 4, were allocated by several Puskesmas (community health centres) to train health workers and CHWs on maternal nutrition and IYCF counselling.

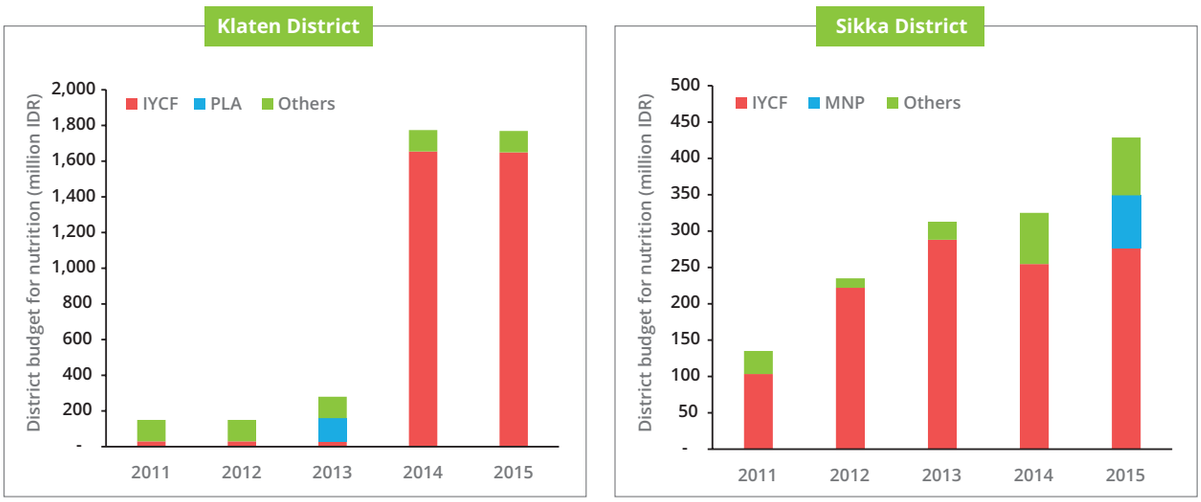

Figure 4: Allocation of local revenue funds (APBD II) for nutrition in Klaten and Sikka districts, 2011-2015

Community level

In Indonesia, an annual bottom-up planning process known as Musrembang enables community members to identify activities that they would like to see incorporated into district plans. However, limited awareness of child nutrition meant that this was rarely identified as a priority. A participatory learning and action (PLA) approach was introduced in the three districts to facilitate community-level planning on nutrition. PLA is a learning process that assists community members in analysing problems, defining solutions, and translating them into realistic actions that they can implement themselves.

The PLA process was facilitated by multisectoral teams comprising government representatives from district and sub-district level from health, food security, fisheries, education, community empowerment, religious affairs and others. The result was the development of community plans of action on nutrition. These plans were funded either from community funds (e.g. the village funds or Alokasi Dana Desa) or district funds obtained through the Musrembang process.

The PLA process was valued by both district and community members, especially because it empowered community members who developed capacity to recognize nutrition problems and identify appropriate solutions. There were also positive funding outcomes. In 2012, for example, nine out 16 communities in Klaten District allocated up to IDR20,000,000 per community from BOK and village funds for activities such as demonstration feeding at Posyandu, CHW training in maternal nutrition and IYCF counselling, and actions to improve sanitation. In the same year in Sikka District, BOK and village funds (between IDR200,000 and IDR3,250,000 per community) were allocated to train CHWs in maternal nutrition and IYCF counselling, home gardening, health promotion for improved sanitation, family planning and bed net use.

Both Klaten and Sikka Districts have allocated their own funds to replicate the PLA approach in additional villages. The process can be applied to inform future planning processes at community level as well, including the use of the newly increased village fund, which will provide IDR1 billion each year to each village in Indonesia to address local development needs. The only drawback experienced by the districts has been the difficulty of establishing an effective mechanism to follow up on the implementation of the community nutrition plans.

Panel 3: Championing the case for nutrition funds

Dr Maria Bernadina Sada Nenu is a tireless advocate for improving the nutritional status of children in Sikka District where she has been head of the District Health Office since 2013. Sikka District is located in Nusa Tenggara Timur province, which has the highest proportion of stunted children in the country. Half of all children in this province were short for their age in 2013.[17]

"Gathering data on nutritional status, exclusive breastfeeding and infant and young child feeding practices in Sikka isn't difficult," says Dr Maria. "The biggest challenge is how to address nutrition problems reflected by those data."

"But I believe in self-empowerment," she adds. "Helping village leaders understand the problem makes them realize that something must be done."

So she asked village heads to provide an update on the infant and young child feeding situation in their communities, and then to sit with the head of their local Puskesmas to look at these problems, and develop concrete solutions.

"I suggested that they allocate 40 per cent of village funds to improve maternal and child nutrition," she says.

Dr Maria also briefed Commission III of the District Parliament, which deals with health issues, on the scale, causes and solutions to malnutrition in Sikka, and did the same with the District Planning Office (Bappeda). As a result, the legislators and the Bappeda agreed to allocate 14 per cent of the district's budget for maternal and child health and nutrition.

The results of Dr Maria's budget advocacy are evident in increased resources for nutrition at district and community level, in the rising proportion of health and community workers who are well informed on IYCF issues, and in the indication of strong improvement in exclusive breastfeeding.

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Success factor 3:
Multi-sectoral approaches to synergize effects and multiply channels for promotion

National and sub-national policy and planning documents in Indonesia all promote multisectoral approaches to address malnutrition. The national and subnational medium term development plans, national and subnational plans of action on food and nutrition, and the Scaling Up Nutrition Policy Framework all reflect the multisectoral strategies.

Although the health sector has primary responsibility for protecting, promoting and supporting actions to strengthen IYCF, other sectors also play vital roles, including agriculture, water and sanitation, social protection, and education, among others. Some of these sectors are especially well placed to influence IYCF issues in the most vulnerable households.

Nutrition and social protection

Several social protection initiatives have been introduced in Indonesia that aim to alleviate poverty. Improving the nutrition sensitivity of these platforms opens up opportunities for reaching children in the poorest and most disadvantaged households who are the most vulnerable to stunting.

The Family Hope Programme (Program Keluarga Harapan or PKH) is a national government-funded conditional cash transfer initiative. Qualifying households need to meet a set of health and education requirements, including the participation of pregnant women and children under five years in routine health services, such as antenatal care and growth monitoring. A 2012 evaluation of PKH found that it encouraged the uptake of health services among pregnant women and children. However, it was unclear whether this benefitted the nutritional status of the most vulnerable household members.

PKH Prestasi is a pilot programme run by the government and UNICEF in Brebes District in Central Java Province that aims to establish whether additional action to increase the coverage and quality of nutrition services results in improved knowledge, behaviour and practices among the PKH beneficiary families. PKH Prestasi adopted three key nutrition strategies: (1) improving coordination between social welfare and nutrition/health stakeholders at all levels; (2) improving the supply of good quality nutrition services; and (3) increasing the demand for nutrition services.

One of the main interventions is to build the capacity of PKH's community facilitators, so that they are better able to create demand among PKH beneficiaries for nutrition services and reinforce health sector's efforts to promote positive maternal nutrition and IYCF

Key messages

- Improving nutrition demands multisectoral approaches involving health, education, agriculture, social protection and water and sanitation, among others.
- At district level, the Child Friendly Cities/Districts programme mobilizes a wide range of sectors, institutions and organizations on children's issues including stunting and IYCF.
- Integration of nutrition actions with a conditional cash transfer programme aimed to increase the demand for nutrition services and change IYCF behaviours among vulnerable households, thereby augmenting the impact of the cash transfers.
- In Klaten, IYCF is integrated into family planning promotion and agricultural extension programmes. The latter is especially valuable since it opens a key channel for engaging fathers on IYCF issues. Pemalang District has incorporated IYCF into a broad early childhood development programme.
- Multisector initiatives increase the likelihood that the multiple underlying causes of malnutrition are simultaneously addressed, and multiply the channels for reaching and engaging households on infant and young child feeding.

behaviours. The trained facilitators motivate pregnant women and mothers of young children to use the PKH cash transfers in ways that support good nutrition, such as the preparation of healthy complementary foods for young children. They organize monthly Family Development Sessions with the beneficiaries to discuss these issues.

Another government-funded social protection initiative, the World Bank supported National Community Empowerment Program (Program Nasional Pemberdayaan Masyarakat or PNPM Generasi), provides block grants to poor communities to finance local development priorities that improve health and education outcomes. PNPM facilitators in eight districts in Nusa Tenggara Barat Province have been trained in nutrition and health, including IYCF, so that they are better able to guide community discussions on ways to use the grants to improve nutrition outcomes. Lessons learned from the process are being used to inform scale-up process across all 64 districts of the government's 'Community-based health and nutrition programme to reduce stunting,' which is supported by the Millennium Challenge Corporation.

Other multisectoral initiatives

Some districts are using the Child Friendly Cities or Districts approach to mobilize institutions and organizations on children's issues, including the improvement of IYCF (see Panel 4). In Klaten District, family planning workers have been trained to promote and support good IYCF practices when they interact with the mothers of young children. Also in Klaten District a specialized training package on IYCF has been developed for agricultural extension workers. This focuses on complementary feeding, including the household production and use of nutritious foods for the preparation of complementary foods. Since most agricultural workers are men, this provides a good opportunity to reach fathers who are often missed in other health promotion efforts. Meanwhile, in Pemalang District, an integrated early childhood development package has been developed for community work that includes components on early stimulation, IYCF, health, water, sanitation and hygiene, and child protection. This package is now being scaled-up with government funds in districts in East and Central Java.

Panel 4: Building Klaten as a Children-Friendly District

While many regions are racing to develop roads, ports and other infrastructure, Klaten District prioritises infant and young child feeding and this is reflected in district budgets as well as the Child Friendly Cities programme. The District Planning Office in Klaten coordinates action across several sectors, bringing together officials from health, food security, women's empowerment, public works and others. Through the Child Friendly City approach, these sectors are galvanized around a common set of priorities for children that include objectives to improve exclusive breastfeeding and reduce stunting.

"We gather the village heads to brief them on what can be done when managing budgets and IYCF activities at community level," Anggoro Budi, Head of Social and Culture Division at the Klaten District Planning Office says. This is especially relevant now that the government has committed to allocate a significant annual budget (around IDR 1 billion) to villages in Indonesia.

According to Budi, "We understand that improving nutrition will help to build human capital and deliver long term economic and social benefits to the communities, the district and beyond."

Panel 5: Kafe Baby - Catering for the nutrition needs of young children

When reviewing nutrition data from her Posyandu in Pandes village, Midwife Budi realized that the growth of most children in her village slowed down after they reached six months. This was happening despite the continuous efforts of local CHWs to counsel parents on IYCF, so she set out to discover the cause.

"We learned that many mothers in the village work long hours in factories," she says. "They leave home at 7 am and only get back at 5 pm. The mothers told us that they don't have enough time to prepare nutritious complementary foods for their children."

In 2013, Midwife Budi and her team of Posyandu CHWs responded by opening a 'Kafe Baby' in Pandes village. The unique cafe sells age-appropriate and affordable complementary breakfast meals for children aged 6-23 months. Guided by Puskesmas nutritionists, each meal has a 'four-star' list of ingredients that meets standards recommended by the Ministry of Health and UNICEF, meaning it contains a protein source (beans or animal protein), vegetables and fruits, as well as carbohydrate (usually rice). The meals are prepared by the CHWs and the menu is varied throughout the week.

The cafe operates at the village's meeting hall from 6.30 to 7.30 am, so caregivers have time to buy breakfast before they depart for work. The demand for the meals is huge and they often sell out. The CHWs working at the cafe also provide counselling on IYCF to customers, for example, on how to prepare healthy meals for the remainder of the day.

Midwife Budi says that they soon noticed the results. Children who regularly had breakfast at the Kafe Baby breakfasts began gaining weight at a healthy rate.

Success factor 4:
Effective platforms to reach the most vulnerable and disadvantaged households

Key messages

- Indonesia's vast network of Posyandu and CHWs provide an excellent mass channel for reaching the poorest and most vulnerable households with counselling services on IYCF.
- Following training in maternal nutrition and IYCF, several Posyandu initiated some highly effective and innovative schemes that responded to local nutrition challenges.
- Complementary feeding demonstrations at the monthly Posyandu meetings attract many mothers and caregivers, especially from poor households, and provide a valuable opportunity for counselling.
- Jayawijaya's maternity waiting homes, Sikka's 24-hour IYCF call-in centre and Klaten's Kafe Baby are all helping to bring IYCF services to the most vulnerable.

With inequities rising in Indonesia, it is particularly important to ensure services reach Indonesia's poorest and most vulnerable households. The most striking reductions in stunting and improvements in IYCF practices in MYCNSIA's focus districts were observed among the poorest households, suggesting that the programme was effective in reducing inequities.

Although social protection programmes offer a platform to reach the very poor (see success factor 3), coverage of these programmes remains low in Indonesia. The PKH programme, for example, currently reaches only 5-7 per cent of households. The MYCNSIA programme therefore sought additional ways to reach Indonesia's poorest and most vulnerable households.

Indonesia's vast and impressive network of Posyandu and CHWs maximise the reach of health services. There are approximately 200,000 Posyandu in the country, each operated by up to five CHWs with assistance from a village midwife. With three or four Posyandu per village, most families live within comfortable reach. The CHWs are volunteers and well-respected members of their communities who have been trained to mobilize communities to attend the monthly Posyandu sessions, conduct growth monitoring and promotion and promote healthy behaviours.

The network of Posyandu and CHWs is clearly a considerable community asset. However, as of 2010 there was no systematic process in place to ensure the CHWs had the necessary knowledge and competencies to deliver counselling services on maternal nutrition and IYCF. One of the major capacity-building focuses of the MYCNSIA programme was to address this gap (see success factor 5).

The introduction of community counselling services on maternal nutrition and IYCF at Posyandu catalysed a number of ingenious local initiatives that have been especially effective in engaging the poorest households.

Many trained CHWs organize regular feeding demonstrations at the monthly Posyandu services: a selection of age-appropriate complementary meals is prepared with local funding and offered to children aged 6-23 months. The nutritious meals attract caregivers and children from the poorest households while the demonstrations help to increase their knowledge of how to prepare inexpensive complementary foods.

Klaten District took this a step further with the 'Kafe Baby' concept that has generated huge demand from local families. Every day, the

cafe sells affordable nutritious breakfasts for children aged 6-23 months using recipes that meet standards set by the Ministry of Health and UNICEF (see Panel 5).

Other initiatives for reaching the poorest include the maternity waiting homes established in Jayawijaya District that provide temporary accommodation close to the Puskesmas for pregnant women from remote rural areas. The mothers-to-be move into maternity waiting homes shortly before their expected date of delivery. Each mother is accompanied by a CHWs from their home community who stays with her throughout. The waiting home provides a perfect opportunity for the CHWs to counsel the mother before and after the birth on IYCF practices (see Panel 6).

Meanwhile in Sikka District, a surge in requests for advice on breastfeeding prompted a Puskesmas to establish a phone-in centre that provides free advice and support to mothers and other caregivers 24 hours a day (see Panel 7).

Panel 6: Reaching mothers in remote highland areas

Late last year Tina Hiluka of the Muliama Village in the Papuan highland district of Jayawijaya moved into a maternity honai, a traditional Papuan home that is made of wood and straw, to await the birth of her baby. Instead of giving birth at home as she had with her first four children, she travelled to the maternity waiting home at the Assologaima Puskesmas so that she could give birth with the help of a trained attendant.

Tina was accompanied by a CHW from her village, who stayed with her at the maternity home until she gave birth to a healthy son. Before the birth, the CHW helped Tina prepare for early initiation of breastfeeding and counselled her on the importance of exclusive breastfeeding for the first six months. Following the birth, the CHW continued to support Tina to exclusively breastfeed. She also taught Tina how to prepare nutritious complementary meals for her baby once he reached six months, and reminded her to continue breastfeeding until at least his second birthday. Tina learned that the best complementary food comes from locally grown vegetables, fruits, nuts, and yams.

Midwife Regina Tabuni says, "The maternity waiting home plays a key role in the battle against poor nutrition in Jayawijaya district. Not only does it enable access to safe birth, it also gives CHWs who have been trained in IYCF a vital opportunity to provide intensive counselling that the mothers are unlikely to forget."

Tabuni has trained about 30 CHWs from 20 Posyandu in the district in maternal nutrition and IYCF counselling. Through the Community Maternal Nutrition and IYCF counselling Course they have learned how to effectively counsel mothers. Back at their Posyandu, the CHWs run monthly information and education sessions on maternal nutrition and IYCF for pregnant and breastfeeding women and conduct home visits to provide one-on-one counselling. Since most people in Jayawijaya District live in the mountains, without access to electricity, telecommunications, running water and transport, these community counselling services are crucial.

As a CHW, Iria Wantik from Kimbim Village makes regular house visits to pregnant women and mothers with infants in her community. She weighs the children at the Posyandu to check that they are gaining adequate weight and counsels the mothers on nutrition and hygiene. She encourages expectant mothers to see the midwife and convinces late-term pregnant women to go to the maternity waiting home.

"At church after the Sunday service, I also give talks to promote healthy nutrition and hygiene," she says. Some of the priests have also participated in maternal nutrition and IYCF training courses and use their sermons to build the awareness of community members on harmful practices.

Wantik says that before the introduction of community counselling services, many mothers used to discard the first milk or colostrum, but now they know it is an important source of antibodies and nutrients. Also, most women only practiced exclusive breastfeeding for one or two months. They used to give very young infants foods like pig's fat which was not good for them. This is also changing, resulting in healthier babies, she says.

Panel 7: Breastfeeding tips are a phone call away

For many people, a mobile phone is a common, everyday communication device, but in Waipare village in Sikka District, mobile phones are important tools that are saving many mothers from arduous trips to the Puskesmas to get information and advice about feeding and caring for their young children.

The head of Waipare Puskesmas, Sofia Tasintha, popularly known as Ibu Opi, opened a counselling unit at the Puskesmas in 2013. Although the unit was known as 'ASI Poi', meaning 'only breastmilk', it provides counselling on both breastfeeding and complementary feeding.

News about the ASI Poi Centre quickly spread among the Posyandu clients and the centre was soon inundated with requests for advice. Some mothers expressed frustration, however, because they were unable to get support outside regular working hours. Ibu Opi responded by transforming the ASI Poi unit into a 24-hour phone-in facility that could help mothers round the clock. Responsibility for manning the 24-hour phone-in unit is rotated among five trained health workers, each of whom carry the ASI Poi mobile phone for one month at a time.

The phone-in facility is especially helpful for women who live far away from the Puskesmas, because it saves them time and money. The cost of the call is not a deterrent since the ASI Poi counsellors can call clients back. Moreover, women throughout the district are able to benefit from this service, not just those who are within the catchment area of the Puskesmas.

Introduced initially with UNICEF support, the call-in facility is now fully funded with BOK funds. Ibu Opi allocates 50,000 rupiah every month to cover the cost of the operation. The number of calls has fallen since the introduction of community counselling services on maternal nutrition and IYCF, because many communities now have access to counsellors in their villages. However, it continues to provide an essential lifeline to mothers who do not live near a counsellor, or for whom some extra advice and reassurance can make all the difference.

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Success factor 5:
Improving knowledge and counselling skills of the community workforce

Most Puskesmas have trained health workers who are able to provide specialized advice to mothers and other caregivers on breastfeeding and complementary feeding. Indonesia adapted the World Health Organization's global 40-hour Breastfeeding Counselling Course and the 40-hour Complementary Feeding Counselling Course to train these health workers.

However, caregivers are unlikely to visit a Puskesmas every time they have a question or concern about IYCF. Many seek advice instead from close relatives and friends who may not be the best informed about appropriate IYCF practices or how to deal with any difficulties.

In 2011 the Ministry of Health developed a national Maternal Nutrition and IYCF Counselling Course with the aim of building the capacity of the community health workforce (see Panel 8). This course is well-suited to CHWs because it uses an interactive adult learning approach. It focuses on developing skills in counselling, problem solving, negotiation and communication, as well as building the knowledge of trainees on recommended breastfeeding and complementary feeding practices. The course also covers the nutrition needs of pregnant and breastfeeding women, the important role of husbands in supporting IYCF practices, handwashing behaviours, growth monitoring and promotion, and linkages with other health services.

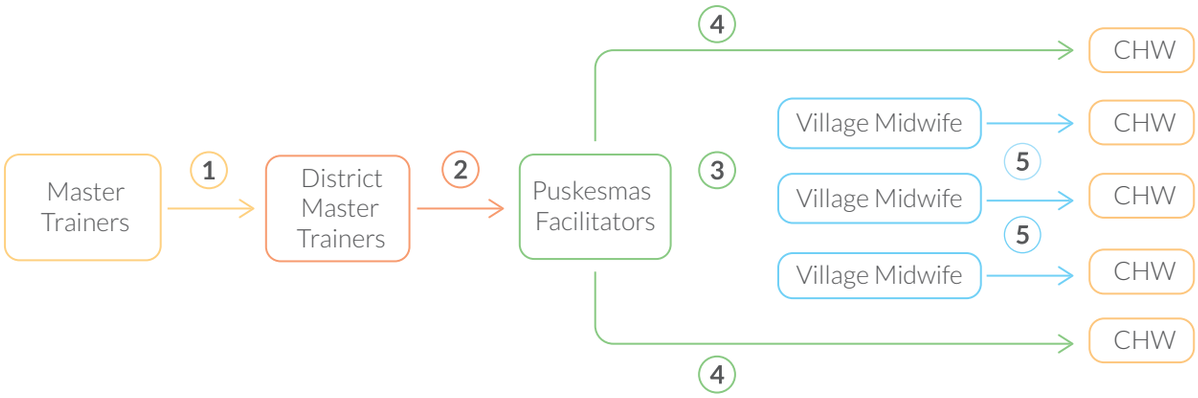
The course was first introduced in the MYCNSIA districts. A cascade training model was developed to facilitate rapid scale-up: each district trained a pool of district master trainers who led the training of facilitators from each Puskesmas. The facilitators then trained village midwives and at least two CHWs from every Posyandu within their Puskesmas' coverage area (Figure 5). A set of quality assurance measures were established to maximize the quality of training and the follow-on support of the trained counsellors (Panel 9). Supportive supervision is used to maintain and improve the quality of community counselling services. Village midwives have primary responsibility for the supportive supervision of CHWs.

The counselling course has now been rolled out to 115 districts with funding from local governments, UN agencies, NGOs and the Millennium Challenge Corporation. Many of these districts have engaged expert trainers from the original MYCNSIA focus districts to develop their own pool of master trainers.

Key messages

- Many mothers rely on family or other community members for advice on infant feeding, although they may not be well informed on these issues.
- In 2011, the Ministry of Health developed a Maternal Nutrition and IYCF Counselling Course to build the capacity of the community health workforce on maternal nutrition and IYCF, as well as skills in counselling, problem solving, negotiation and communication. The scheme ensures that sound advice and counselling on maternal nutrition and IYCF are readily available at community level.
- The training package was initiated in the MYCNSIA districts and a practical cascade-training model was introduced along with strong quality-assurance measures.
- With the aim of ensuring each Posyandu has at least two trained CHWs, the Maternal Nutrition and IYCF Counselling Course has now been scaled up in at least 115 districts in Indonesia with funds from local government, UN agencies, NGOs and the Millennium Challenge Corporation.

Figure 5: Cascade training model to roll-out the Maternal Nutrition and Infant and Young Child Feeding Counselling Course



1. Master trainers from the nationwide pool train the district master trainers
2. District master trainers train the puskesmas facilitators
3. Puskesmas facilitators train the village midwives and provide supportive supervision following training
4. Puskesmas facilitators train the CHW and oversee supportive supervision of CHW following training
5. Village midwives provide supportive supervision to CHW following training

Panel 8: Quality assurance measures for counselling services on maternal nutrition and IYCF

All trainees should express a commitment and motivation to train and or counsel mothers and caregivers on maternal nutrition and IYCF

Criteria for selecting trainee master trainers

Only health workers who have successfully completed the 40-hour Breastfeeding Counselling Course or the 40-hour Complementary Feeding Course are eligible to become district master trainers.

Criteria for selecting Puskesmas facilitators

Facilitators should be maternal and child health staff (nutritionists or midwives) from the Puskesmas staff. Preferably they will have completed the 40-hour Breastfeeding Counselling Course or the 40-hour Complementary Feeding Course.

Quality assurance criteria for trainee master trainers and district facilitators

A report card is used throughout the training process to track the performance of each trainee master trainer and facilitator and assess whether they can (i) progress directly to training others, (ii) require additional coaching in order to address specific capacity gaps; or (iii) lack the basic knowledge, skills or competencies to progress further. All trainee facilitators must conduct two training courses of CHWs under the supervision of an existing master trainer or facilitator before they can train others independently.

Establish supportive supervision of community counsellors

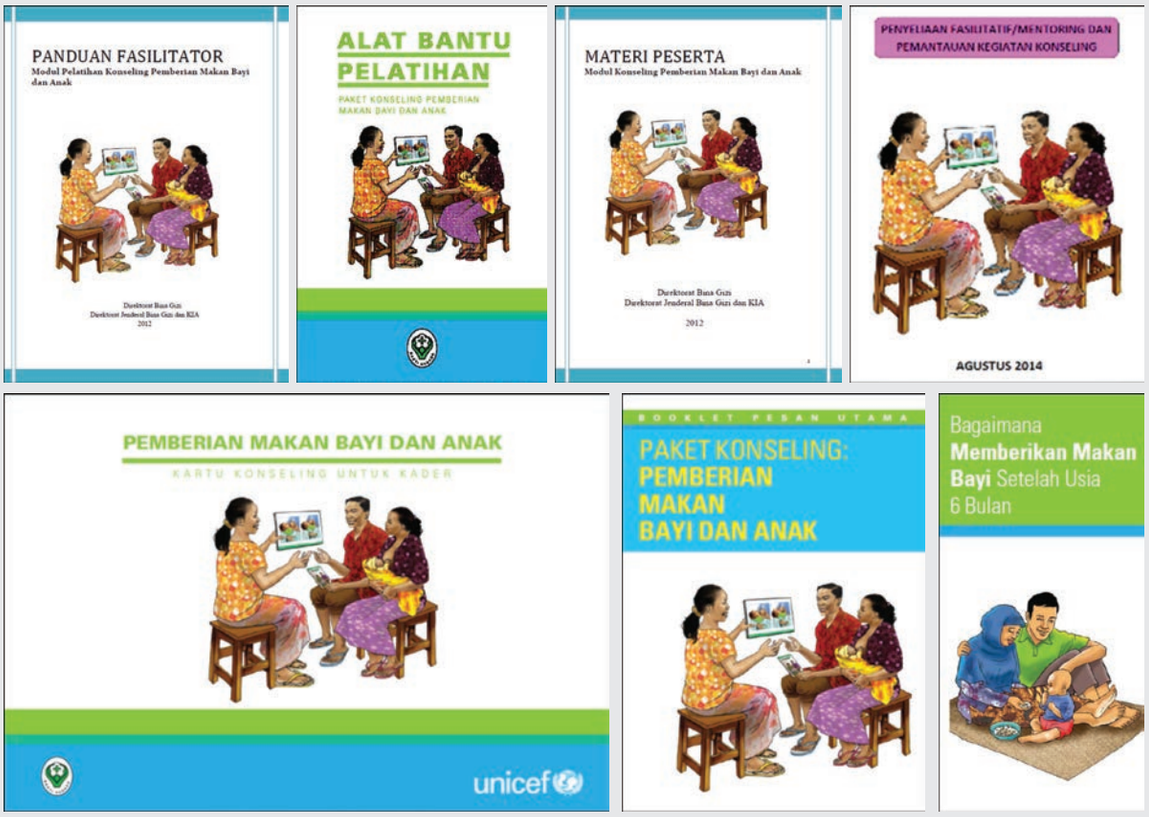
Village midwives provide follow-on supportive supervision to CHWs to maintain and build on their knowledge and competencies, and address any difficulties they face in providing counselling services. Every three months

they observe the CHWs counselling at least one mother or caregiver on maternal nutrition or the care and feeding of infants and young children. A check-list is used by the village midwife to record observations and the results are discussed with the CHWs. The Puskesmas facilitators follow a similar process when providing supportive supervision to village midwives. They may also provide occasional supportive supervision to CHWs as a means of monitoring the quality of supervision that is being provided by village midwives.

Ensure that all village midwives and sufficient CHWs are trained as community counsellors:

The minimum standard is two trained CHWs per Posyandu**.** This ensures that there are sufficient CHWs to effectively counsel pregnant women and caregivers of children under two years.

Panel 9: The Maternal Nutrition and Infant and Young Child Feeding Counselling Course Package



The complete counselling package includes: (1) **Facilitator's guide** and (2)**Training aids** that are used during the training of CHWs and village midwives; (3) **Training in supportive supervision** is used to maintain and improve the quality of counselling services**;** (4) **Participant materials** include counselling cards that are used by CHWs and village midwives during and after training; (5) **Flip-chart** is used by CHWs and village midwives to support counselling sessions with mothers and other caregivers; (6) **Key messages** booklet is used with the flip chart and counselling cards; (7) **Take-home brochures** are given to mothers and other caregivers to take home to remind them about key practices.

Success factor 6:
Responsive monitoring systems

Key messages

- Data on exclusive breastfeeding among infants under six months is collected during every Posyandu visit and used to track trends.
- Klaten District introduced a data collection process that tracks key indicators across the 1,000 days from conception to two years. The system also monitors implementation of Klaten's district-level regulations on breastfeeding.
- Real-time monitoring of key nutrition indicators is also in place in Klaten. Data entered by village midwives can be immediately accessed by health workers at Puskesmas and district level.

Every mother of a baby aged less than six months who attends a monthly Posyandu session is asked if she is exclusively breastfeeding her baby. This data is used to assess the effectiveness of efforts to protect, promote and support exclusive breastfeeding. While an imperfect measure – since mothers may be embarrassed to admit it if they are not following advice on exclusive breastfeeding – most alternative monitoring mechanisms such as household surveys are prohibitively expensive.

Additional monitoring mechanisms have been established in Klaten District. A series of standard operating procedures and data collection instruments help to assess the coverage of interventions across the 1,000 days from conception to two years. The monitoring system also tracks implementation of the Bupati Regulations on exclusive breastfeeding, and generates data on the coverage of essential health and nutrition services.

Klaten District has also developed SIMPUS GizKIA, a software system that enables real-time data collection and analysis on key nutrition indicators such as exclusive breastfeeding, provision of micronutrient supplements and anthropometric data (see Panel 10). Data is entered by village midwives and can be accessed immediately by health workers at Puskesmas and district level. The SIMPUS GizKIA system generates summary tables that allows the performance of Puskesmas to be compared, enabling underperforming Puskesmas to be identified and targeted for remedial action. SIMPUS GizKIA has since been replicated in six districts by two provinces.

Panel 10: Generating real-time data in Klaten District

"SIMPUS GizKIA helps us to generate important statistics on nutrition and access to nutrition services. We can examine indicators for a single health facility, or look at the performance of a specific indicator across all health facilities in the district. Previously, we had to generate these statistics manually. It took a long time to analyse the data and to understand the health and nutritional status of mothers and children. With SIMPUS GizKIA, it takes short time to generate data on any indicator such as the proportion of children who are exclusively breastfed or the nutritional status of children in the catchment area of each Puskesmas. Puskesmas staff can access data as soon as this is entered by village midwives. The system automatically generates summary tables to compare the performance of different health facilities."

Sri Sugiyanti, nutritionist at Puskesmas Juwiring, Klaten District

Panel 11: **Breastfeeding counsellors mobilise to protect, promote and support good infant feeding practices**

The proportion of exclusively breastfed children fell in Klaten District in the aftermath of a strong earthquake that hit Yogyakarta and Central Java in 2006. Infant formula and bottles were in abundance in the aid packages delivered to earthquake-affected areas. The impact on children was serious: research showed that infants who received the donated formula milk were much more likely to suffer from diarrhoea.[18]

Such a situation is unlikely to be repeated today thanks to I-KLAN (Ikatan Konselor Laktasi Klaten), a local association of health professionals who give high priority to the protection, promotion and support of breastfeeding throughout Klaten District.

"I-KLAN was established by a group of lactation consultants and physicians who had received training in breastfeeding counselling following the earthquake," says Dr Rony R. M. Kes, founder of I-KLAN and the former head of the District Health Office. "We wanted to help breastfeeding counsellors discuss ways to improve breastfeeding practices."

The association went on to play a key role in the development of Klaten's 2008 district law on exclusive breastfeeding, which was the first of its kind in Indonesia and has since been translated to a Bupati Regulation.

Dr Agus Widiyarto, the current chairman of I-KLAN who is also the head of the Wedi Puskesmas, says, "We would be ashamed if there was a midwife or health facility [in Klaten] who was still accepting support from companies producing breastmilk substitutes."

Today, I-KLAN members meet regularly, share information via an online chat group and provide assistance to mothers who have difficulties in breastfeeding.

"We monitor and review the performance of midwives, Puskesmas and hospitals in the district," says Dr Ahmad Budoli, a member of I-Klan. "We ensure they are supporting breastfeeding and are not violating breastfeeding regulations."

I-KLAN's breastfeeding facilitators are often requested to conduct training in breastfeeding counselling in other districts. Association members contribute a portion of the fees they receive as training facilitators to support the costs of running their organization.

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Success factor 7:
Working with partners

Key messages

- Effective partnerships have enabled community counselling services on maternal nutrition and IYCF to reach and transform the lives of many more children and women, enabling scale-up to 115 districts to date. The number continues to rise.
- In Sikka District, some religious leaders have incorporated IYCF messages into church sermons and services. Religious leaders are ideal partners because they have considerable influence and have much greater capacity than the health sector to reach men with these messages.
- Klaten's association of IYCF counsellors, I-KLAN, provides strong support in advocacy, counselling, training and monitoring.
- Partnerships with businesses such as Bank Central Asia also help to demonstrate how working environments can become breastfeeding-friendly.

Addressing Indonesia's nutrition challenge is beyond the capacity of any single entity or organization. Working with partners not only expands the capacity for action, it also enriches it. Each nutrition stakeholder – whether central or local government, a UN agency or donor, a civil society or faith-based organization or a commercial operation – contributes a different set of skills, perspectives and resources. Working together, such partnerships have the capacity to reach and more rapidly transform the lives of many more children and women. For example, it is through the collaboration of many agencies, organizations and government that community counselling services on maternal nutrition and IYCF have reached at least 115 districts to date.

The MYCNISIA districts have developed effective local partnerships to expand the impact of programmes on maternal nutrition and IYCF. In Sikka, the DHO has engaged the support of the Catholic Church in promoting optimal practices. Religious leaders can have a strong influence on the adoption of new behaviours if they reinforce messages that mothers have received through the monthly Posyandu meetings. Religious leaders also have the potential to reach and influence husbands, parents, parents-in-law, peers and other community leaders whose support for good maternal nutrition and IYCF practices is often essential for success (see Panel 12).

An independent association of IYCF counsellors in Klaten (Ikatan Konselor Laktasi Klaten or I-KLAN) provides critical support to the District Heath Office across a range of IYCF issues, including the development and monitoring of legislation to protect breastfeeding. Its members also support other districts that are scaling up course on breastfeeding and maternal nutrition and IYCF. I-KLAN is supported by contributions from its members (see Panel 11).

Meanwhile, a partnership with Bank Central Asia (BCA) at the national level is demonstrating the value of supporting breastfeeding employees after they return to work. It is hoped that the BCA experience will encourage other companies to adopt similar practices and meet their obligations under the 2012 government regulations on exclusive breastfeeding (see Panel 13).

Panel 12: Preaching good nutrition

Bloro Parish Church in Nita village of Sikka District is a centre for nutrition advocacy. A Sunday sermon by its priest, Father Antonius Marius Tangi, often includes key messages on the 'golden standards' of infant feeding.

"The church has a responsibility to all its community," says Father Tangi. "Through our services, we would like to improve community's awareness of the best nutrition for young children so that they will have a healthier life in the future."

Almost all Nita villagers are Catholic so the pastor has a powerful influence. Father Tangi is also able to deliver his infant feeding messages to men who are much harder to reach through the health system.

"People always listen to the priest," says Iin, a staff member of the non-government organization Wahana Visi Indonesia. With the support of UNICEF, Wahana Visi Indonesia collaborated with the church to produce a pocket book on the significance of the first 1,000 days of life, the critical period between a child's conception and his or her second birthday. Nutrition deprivation during this period of life can have serious and irreversible consequences on the health, growth and development of a child.

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"Wahana Visi Indonesia helped me understand how important those 1,000 days are for a baby," Father Tangi says. "Now I want to pass this on to everyone in our community. I tell everyone we must support mothers to exclusively breastfeed their infants for six months, and then complement breast milk with nutritious foods from the crops that are grown in their back yards, not with processed foods that are available from the market."

For Father Tangi, improving young child nutrition is a good investment for every family. "I believe that by giving our young children the right nutritious foods, we will create a healthier, smarter and stronger community in the future."

Panel 13: Banking on breastfeeding

The breastfeeding room at Bank Central Asia (BCA) in Jakarta is buzzing. Along with other mothers, Lieka Basuki, who has worked as an assistant to BCA's board of commissioners since 2010, is using an electric pump to ensure a regular supply of breastmilk for her baby. With the blessing of the bank's management, breastfeeding mothers use the room two or three times per day in addition to their lunch breaks.

"I've been using the breastfeeding room since I returned to work when my baby was three months old," Lieke explains. "Because of this facility, I was able to express milk safely and to exclusively breastfeed my baby for the first six months. Now I am continuing to provide breastmilk for my baby as well as complementary foods."

Most mothers give up exclusive breastfeeding after returning to work because of the lack of facilities. Concerned about the difficulties faced by working mothers, the government introduced new regulations in 2012 that require all employers to provide a supportive environment for breastfeeding. The following year, UNICEF and BCA agreed to a partnership that would put the new regulations into practice. A key aim was to use the experience at BCA to encourage other companies in Indonesia to adopt similar approaches.

Houda Mulijanti from BCA's Human Capital Management Division says, "At BCA, we know that breastfeeding makes economic and social sense for the bank, for our staff and their families. Breastfed babies are healthier. Fewer working days are lost to sickness. Breastfeeding reduces costs to families because they don't have to buy any infant formula. The mothers are healthier too and we also have a happier, more stable and more productive working environment because there is less absenteeism. Our breastfeeding programme sends the message that BCA cares about families. This fits with the ethos of the bank."

Houda adds that since more than half the staff of the bank are women, most of them of child-bearing age, finding solutions that support healthier employees and families is a priority.

In addition to the breastfeeding rooms, BCA offers seminars on the importance and advantages of breastfeeding for all staff, including men, so that they may pass on the information to their families. Initially, UNICEF assisted these education sessions with the support of national breastfeeding champion, Dr Utami Roesli. The bank now manages these sessions internally.

The breastfeeding programme has expanded from Jakarta to BCA offices in Bandung, Semarang, Surabaya and Malang. There are plans for expansion to further offices by the end of 2016.

ACRONYMS AND ABBREVIATIONS

Acronyms and abbreviations

APBD	Anggaran Pendapatan dan Belanja Daerah (Subnational Budget Revenue and Expenditure)
BAPPEDA	Badan Perencanaan Pembangunan Daerah (Planning and Development Board)
Bupati	Elected head of a district's government
BOK	Biaya Operasional Kesehatan (Health Operational Funds)
CHW	Community health worker
DHO	District Health Office
I-KLAN	Ikatan-Konselor Laktasi Klaten (Independent Association of IYCF Counsellors in Klaten)
IYCF	Infant and young child feeding
MYCNSIA	Maternal and Young Child Nutrition Security Initiative in Asia
Musrembang	Musyawarah Perencanaan Pembangunan (Bottom up annual planning process)
Posyandu	Pos Pelayanan Terpadu (integrated community health post)
PKH	Program Keluarga Harapan (National cash transfer program and nutrition services)
PNPM	Program Nasional Pemberdayaan Masyarakat (National Program for Community Empowerment Program)
PLA	Participatory learning and action
Puskesmas	Pusat Kesehatan Masyarakat (Community Health Centre)
RAN-PG	Rencana Aksi Nasional - Pangan dan Gizi (National Plan of Action on Food and Nutrition)
RPJMN	Rencana Pembangunan Jangka Menengah Nasional (National Medium Term Development Plan)
SUN	Scaling Up Nutrition
UNICEF	United Nations Children's Fund

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