

SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY: IMPROVING ADOLESCENT NUTRITION IN INDONESIA



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BEHAVIOUR CHANGE
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NUTRITION IN INDONESIA

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ABBREVIATIONS & ACRONYMS

AFHS	Adolescent-Friendly Health Service
BAPPENAS	Ministry of National Development Planning
C4D	Communication for Development
CSO	Civil Society Organization
GAIN	Global Alliance for Improved Nutrition
GPRS	<i>Gerakan Peduli Remaja Sehat</i> or Movement for Healthy Adolescents
IDR	Indonesian Rupiah
IFA	Iron Folic Acid
IPC	Interpersonal Communication
KAMUS	<i>Koalisi Anak Muda</i> Untuk SDG
KAP	Knowledge, Attitudes and Practices
M&E	Monitoring and Evaluation
MA	<i>Madrasah Aliyah</i> , the senior secondary level of <i>Madrasah</i>
MI	<i>Madrasah Ibtidaiyah</i> , the primary level of <i>Madrasah</i>
MT	<i>Madrasah Tsanawiyah</i> , the junior secondary level of <i>Madrasah</i>
NCD	Non-Communicable Disease
OSIS	<i>Organisasi Siswa Intra Sekolah</i> (Internal Student Organization at Junior and Senior Secondary School)
PKPR	<i>Pelayanan Kesehatan Peduli Remaja</i> (adolescent-friendly health services)
<i>Posyandu</i>	<i>Pos pelayanan terpadu</i> (integrated health post)
PTA	Parent-Teacher Association
<i>Puskesmas</i>	<i>Pusat kesehatan masyarakat</i> (community health centre)
Riskesmas	<i>Riset kesehatan dasar</i> (National Basic Health Research)
SBCC	Social and Behaviour Change Communication
SD	<i>Sekolah Dasar</i> (primary school)
SDG	Sustainable Development Goals of the United Nations
SEM	Socio-Ecological Model
SMA	<i>Sekolah Menengah Atas</i> (senior high school)
SMK	<i>Sekolah Menengah Kejuruan</i> (secondary vocational school)
SMP	<i>Sekolah Menengah Pertama</i> (junior high school)
SMS	Short Message Service or text messaging
SUN	Scaling Up Nutrition
UKS	<i>Usaha Kesehatan Sekolah</i> (School Health Programme)

EXECUTIVE SUMMARY

Adolescents in Indonesia – those between the ages of 10 and 19 years – are faced with the triple burden of malnutrition with the coexistence of undernutrition, overnutrition and micronutrient deficiency. Approximately one fourth of adolescents aged 13–18 years are stunted, 9 per cent of adolescents aged 13–15 are thin or have low body mass index, while another 16 per cent of adolescents are overweight or obese. In addition, one fourth of adolescent girls suffer from anaemia.

Malnutrition has serious implications for the health of young people, impacting the well-being of current and future generations, and the economy and health of the country. In particular, the nutritional status of adolescent girls is closely linked to pregnancy outcomes and maternal and child health and survival. Malnutrition is related with gender, with higher prevalence of anaemia among girls and higher prevalence of thinness among boys.

Evidence suggests that adolescence provides a second window of opportunity to influence developmental trajectories (including growth and cognitive development), form future habits and make up for some poor childhood experiences – second only to early childhood (UNICEF, 2018a).

A qualitative-quantitative study on dietary and physical activity commissioned by UNICEF in 2017 revealed that school physical activity was minimal, seldom longer than 90 minutes a week. Furthermore, changes in dietary intake patterns have doubled the consumption of fat and processed foods. The diet diversity of Indonesian adolescents was found to be poor, with only 25 per cent consuming rich sources of iron, folate and other essential micronutrients such as animal-based foods and vegetables.

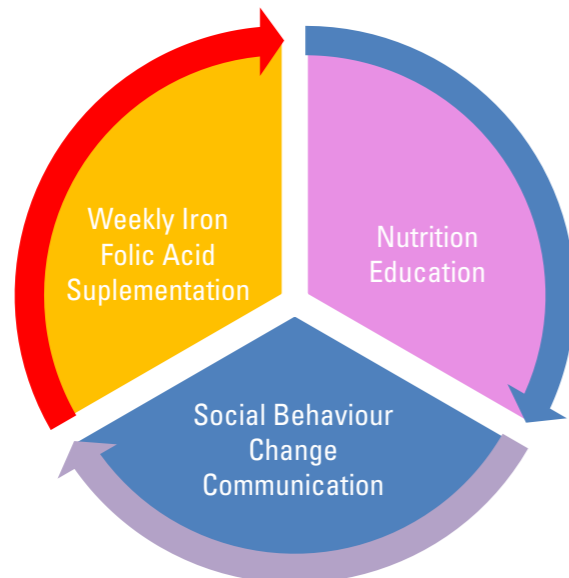
There is growing awareness that adolescent nutrition is an area that requires enhanced attention and investment in Indonesia. Both nutrition-specific and nutrition-sensitive interventions need to be combined into integrated, multisectoral responses to achieve optimal nutritional status of adolescents by mobilizing the support of various line ministries, notably health, education, religious affairs, and social affairs.

UNICEF Indonesia together with the Government of Indonesia has embarked on a pioneering adolescent nutrition programme designed to address the triple burden of malnutrition. The programme applies a life-course framework aimed at breaking the intergenerational cycle of malnutrition. Launched in November 2018, the programme has adopted the catchy brand and tagline '*Aksi bergizi*', translated as 'nutritious action'. Three interdependent nutrition-specific interventions were piloted from 2019 in 110 junior and senior high schools in two districts, namely Klaten in Central Java Province and Lombok Barat in West Nusa Tenggara Province. The *Aksi bergizi* adolescent nutrition package of interventions consists of three components:

1. Weekly iron folic acid supplementation for girls to control and prevent anaemia;
2. An evidence-based, multisectoral Nutrition Learning Module incorporated into the school curriculum. It is designed to improve the knowledge, attitudes and self-efficacy of adolescent girls and boys on healthy eating and physical activity;
3. A comprehensive, gender-responsive social and behaviour change communication (SBCC) strategy that aims to empower adolescent girls and boys to improve dietary practices and physical activity with support from their families, friends and communities.

The SBCC strategy design detailed in this document follows a systematic six-stage process based on well-established SBCC planning models and principles. The strategy builds on evidence and envisions participatory and sustained efforts engaging adolescents, families, community level influentials, teachers and local service providers. This strategy document includes the following sections:

Adolescent Nutrition Programme in Indonesia



Situation Analysis

Gives a brief overview of the nutritional status of adolescent girls and boys in Indonesia, the immediate, underlying and root causes of the problem, the gaps/barriers and opportunities to optimum adolescent nutrition practices, and government and stakeholder responses so far. A look at the communication environment and a channel analysis provide robust evidence to guide strategic approaches, creative interventions and channel/media selection.

Conceptual Framework

Presents proven conceptual tools to guide in planning the strategic approaches and in designing the creative intervention. This communication strategy uses the Socio-Ecological Model (SEM), the Social Cognitive Theory and the Stages of Change Model as framework for understanding the multifaceted and interactive effects of personal and environmental factors that influence an individual's behaviours and a community's collective decision to adopt recommended practices and positive social norms. Reflecting an SEM approach, a Theory of Change is proposed to illustrate the pathways of inputs and activities of each actor or participant group for achieving the intended SBCC outputs, outcomes, change objectives and goals.

Communication Goals and Objectives

Aim to harness the power of communication to contribute to the programme goal of improving the nutritional well-being of adolescents in Indonesia. The overall goal of SBCC is to empower adolescent girls and boys with knowledge, values and skills to adopt healthy dietary practices and physical fitness activities of their choice. This SBCC strategy takes aim at the triple burden of malnutrition, addressing both under nutrition, over nutrition and anaemia, by promoting knowledge of the importance of good nutrition and physical activity as well as building skills and capacities among adolescents to adopt healthier food choices and take up more physical activities.

Strategic Approach

Details the SBCC approaches that are also referred to as intervention modalities to be linked to the implementation plan. Milestones for each modality are listed and prioritized for each phase of the programme.

SBCC intervention modalities for improving adolescent nutrition



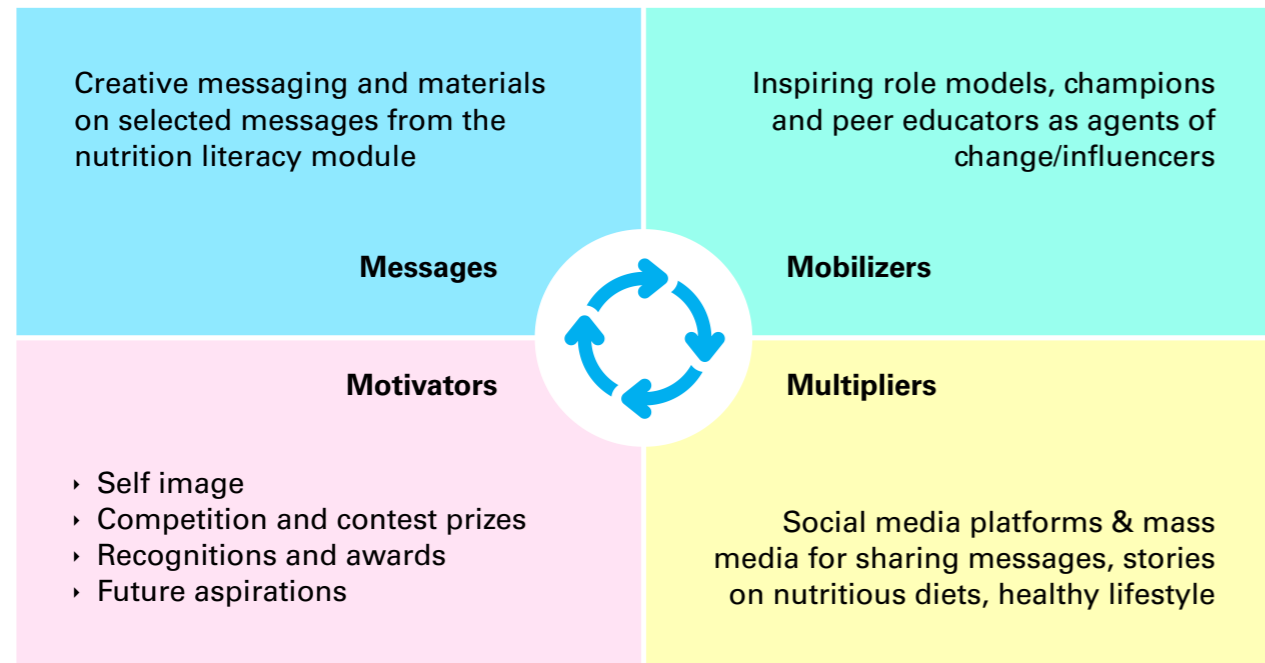
Creative intervention design

Provides an interface between the communication objectives, the adolescents as primary participants, and their involvement in innovative content creation. The design specifies outlines of key messages specific for adolescent girls and boys in the school setting. Their inputs on communication channel selection, creative content, stories, and use of their preferred electronic gadgets and social media platforms are expected to translate into doable activities for the implementation plan.

The idea is to inspire a movement for improving and sustaining adolescent nutritional status in the country through the interconnected and interdependent pillars of the creative strategy, the '4Ms', as illustrated in the figure below.

THE 4MS: INTERCONNECTED PILLARS OF THE CREATIVE STRATEGY			
1. MOBILIZERS	2. MULTIPLIERS	3. MESSAGES	4. MOTIVATORS
Role models, champions and peer counsellors as agents of change	Social media platforms and community media for sharing messages about nutritious diets and healthy movement	Creative messaging, edutainment and design of adolescent-friendly materials aligned with Nutrition Literacy Learning Module lessons and key messages	Positive self-image, intra- and inter-school competitions, recognitions and awards as mobilizers, multipliers and messengers

Suggested creative interventions and fun activities are listed for healthy diets and physical activity, according to the 4Ms. Stakeholders will select and decide which activities are suited and interesting to them given their contextual realities, for inclusion in the implementation plan of each pilot district. Recommendations and implementation guides will be discussed and prepared on the chosen activities and interventions.



The 4Ms – Interconnected pillars of the creative intervention design for SBCC on adolescent nutrition

Key messages for consistency and coherence, the key messages in SBCC activities were selected from the 36 lessons in the Nutrition Education Module. This resource serves as the teacher-facilitator's guide to engaging junior and senior high school students in interactive 30-minute nutrition learning activities.

The key messages are calls to action that address three main themes of anaemia prevention, healthy eating and physical activity:

- Control and prevention of anaemia**
 - › Take iron/IFA supplements
 - › Eat iron-rich and fortified foods
 - › Eat green, leafy vegetables

- Healthy dietary practices**
 - › Eat five servings (five fistfuls) of vegetables and fruits every day
 - › Include a fruit or vegetable with every meal
 - › Eat colourful vegetables and fruits
 - › Choose fresh foods over processed foods
 - › Choose water over sweetened beverages or juices
 - › Reduce intake of packaged foods

- Physical activity**
 - › Get 60 minutes of physical activity every day – walk more, jog, bike, dance, do aerobics, etc.
 - › Engage in active sports that you enjoy.

Creative rallying calls and context-specific message briefs/spiels, scripts and talking points for specific messengers will be developed with participation of adolescents, teachers, parents, influencers, media and other stakeholders focusing on actions that will impact on healthy eating behaviours and physical activity. Culture- and language-specific messages will be designed or refined locally to equip messengers, channels, media and materials, as appropriate, in school and community contexts.

Implementation plan maps the planned milestones or targets and defines concomitant activities (and tasks). The plan also provides guidance on potential resources or support needed, time frame, roles and responsibilities and commitments of various government, non-governmental and private stakeholders in implementing the strategy, and an estimated cost for reaching a given milestone.

Phased approach this SBCC strategy was implemented as a pilot in 2019–2020. The next phase, national scale-up, can be implemented based on evidence, insights and lessons from the pilot.

The pilot was implemented in two districts, Klaten in Central Java Province and Lombok Barat in West Nusa Tenggara, during 2019–2020. This phase focused on supporting behaviour change among school-going adolescents. The pilot was conducted in 110 schools in Klaten and Lombok Barat.

The national phase will be conducted under the National School Health programme. This phase will involve a greater number of schools and communities in all districts of Indonesia.

Monitoring and Evaluation Framework will provide guidance on preparing an M&E plan to track progress of planned activities and measuring intended behaviour change results based on the communication objectives. It also stresses the importance of documenting promising practices and lessons learned, with tips and guides for reporting.

This comprehensive strategy document provides a framework and specific guidance for SBCC efforts aimed to improve adolescent nutrition in Indonesia. Initially planned to be piloted in two districts, the strategic approach, communication activities and key messaging can be scaled up for greater reach. The M&E framework will ensure that changes resulting from the intervention can be tracked and that there is regular monitoring to gauge if activities are going as planned and, importantly, to ensure course corrections. The strategy emphasizes the inherent potential among adolescents to make healthier choices and decisions that can positively impact their lives and health when they have relevant information, skills and self-efficacy and are enabled to develop heightened agency.

This SBCC strategy addressing the triple burden of malnutrition among adolescents in Indonesia should be viewed as a vital contribution to an emerging area of theory and practice. The research, theory, evidence and stakeholder participation that have gone into its design are rigorous and comprehensive. It is hoped that the intervention will emerge as a cutting-edge contribution to the less-than-robust knowledge base of promising and innovative practices to improve adolescent nutrition, and that it will provide significant lessons learned in SBCC programming.

INTRODUCTION

Background and rationale

The Republic of Indonesia has a population of over 260 million, making it the fourth most populous country in the world. Indonesia is known to be the largest archipelagic state, covering over 17,000 islands. In spite of being home to the world's largest Muslim population, Indonesia is a multi-ethnic country with hundreds of distinct ethnic groups speaking a multitude of local dialects. Classified as a lower middle-income country, Indonesia is Southeast Asia's largest economy with a GDP of US\$ 1,015.54 billion and has achieved most of the targets set in the 2015 Millennium Development Goals. Along with economic growth, the country is facing widening inequality, with 28 million people still living below the poverty line and many without access to basic services.^{1,2}

During the United Nations General Assembly in 2015, H.E. President Joko Widodo, along with leaders from 192 countries, made a far-reaching promise to address 17 Sustainable Development Goals (SDGs) by 2030. Through President Widodo's far-reaching vision summarized in his *Nawa Cita* or Nine Programmes, the Government is localizing action plans to adapt the SDGs to the Indonesian context. The Adolescent Nutrition Programme, with a Social and Behaviour Change Communication strategy, is designed to support SDG 2 and SDG 3.³ The adolescent nutrition programme was piloted in two selected districts to create a holistic approach to the malnutrition challenge in Indonesia.

Adolescents are defined by the United Nations as those between the ages of 10 and 19 – amounting to 1.2 billion in the world and comprising 16 per cent of the world's population. A majority of these children live in low or middle-income countries facing multiple socioeconomic challenges. Investing in the rights and development of adolescents contributes to their full participation in a nation's life, a competitive labour force, sustained economic growth, improved governance and vibrant civil societies, accelerating progress towards the SDGs (UNICEF, 2018a). Indonesia's adolescent population is approximately 45 million, amounting to close to a fifth of the total population (18 per cent).⁴ Neither young children nor fully adults, these children are too often overlooked or unreached by development programmes that are not specifically tailored to their distinct needs and vulnerabilities.

Adolescents are increasingly being seen as a window of opportunity with the recognition that investments in the health and well-being of young people are crucial to a country's future and overall development. Evidence suggests that adolescence provides a second window of opportunity to influence developmental trajectories (including growth and cognitive development), form future habits and make up for some poor childhood experiences – second only to early childhood.⁵ Investing in adolescents not only protects the future generation of adults but also consolidates investments in early childhood health, survival and education.

¹ UNDP Indonesia Country Information available at: <http://www.id.undp.org/content/indonesia/en/home/countryinfo.html>

² World Bank Country Profile (2018). World Development Indicators Database.

³ SDG Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture; SDG Goal 3: Ensure healthy lives and promote well-being for all at all ages. (UN General Assembly 2014, A/68/970).

⁴ BPS-Statistics Indonesia, Welfare Statistics, 2016.

⁵ UNICEF (2018), UNICEF Programme Guidance for the Second Decade: Programming with and for adolescents, UNICEF, Programme Division, New York.

Adolescence is a period of rapid growth and development requiring increased nutrients. Adolescents in Indonesia are faced with the triple burden of malnutrition, experiencing both undernutrition and overnutrition and also micronutrient deficiencies. National level data indicate that one fourth of adolescents are stunted, one in seven adolescents are overweight, and one in three adolescents are anaemic. A higher number of boys experience stunting, while more girls suffer from anaemia. Malnutrition – both undernutrition and overnutrition – impacts the economic growth of countries and hampers progress towards achieving development goals. Adolescence is also a time when gender roles can either be consolidated or challenged and transformed. Influencing social and gender norms during adolescence shapes the life trajectories of adolescent girls and boys and the opportunities and vulnerabilities that they may face (UNICEF, 2018a). Girls may be impacted by issues surrounding body image and appearance and the expectation to be thin. Often, girls also face the burden of household work and helping care for younger siblings. Child marriage and early pregnancy could also prevent girls from reaching their full potential. Boys on the other hand, may be impacted by issues surrounding masculinity and the desire to be ‘big and strong,’ combined with the pressure to work outside the home and contribute to the family income. They may also be more at risk of engaging in risky behaviours, which could include smoking and substance abuse.

Malnutrition also has serious implications for the health of young children and adolescents (see data in Chapter 1, Situation Analysis), impacting the well-being of current and future generations as the nutritional status of adolescent girls is closely linked to pregnancy outcomes and maternal and child health and survival (see Figure 1).

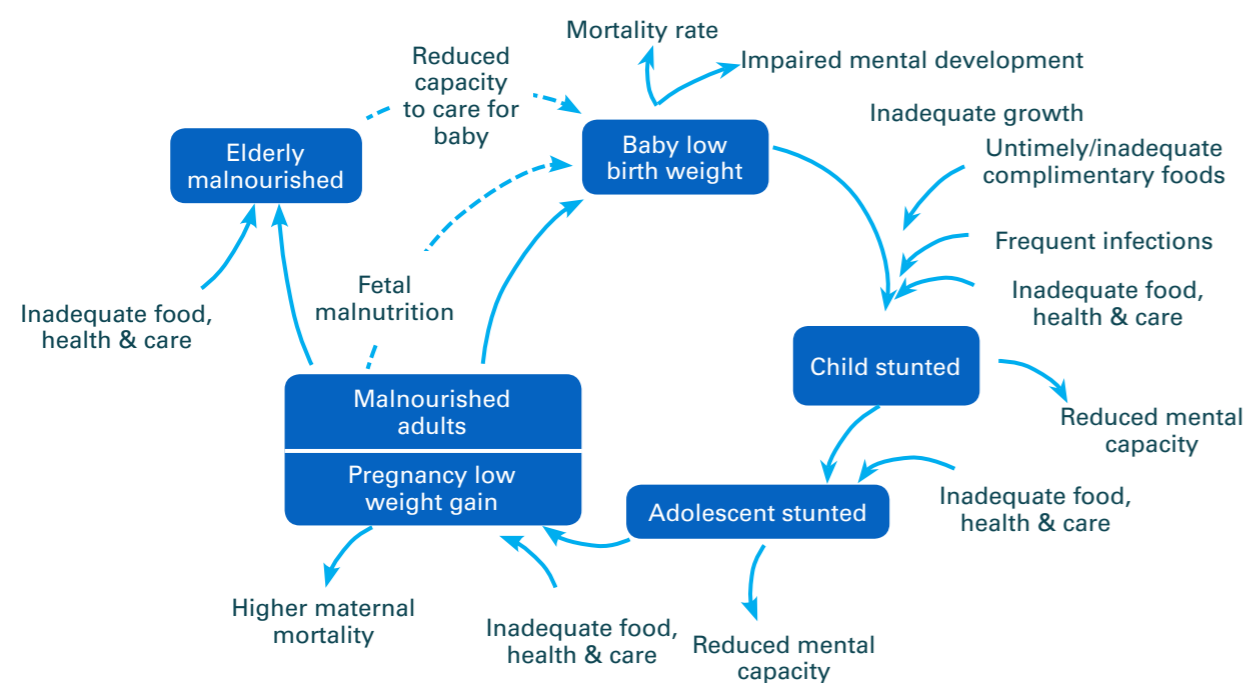


Figure 1. The intergenerational cycle of malnutrition in the life course⁶

⁶ ACC/SCN (2000), Fourth Report on the World Nutrition Situation, ACC/SCN in collaboration with IFPRI, Geneva.

Nutritional interventions targeting adolescents can break the intergenerational cycle of malnutrition and poverty and reap positive benefits to the economy and health of countries. Yet, adolescent nutrition has been neglected or received inadequate attention worldwide.

According to a recent policy review, Indonesia is among the countries with the fewest policies specifically targeting adolescent nutrition. Out of over 100 nutrition-related policies, only 8 were considered nutrition focused, of which only 2 specifically targeted adolescents. Furthermore, there is low awareness regarding adolescent nutrition among policymakers and programme experts, with the exception of the health sector. The most vulnerable groups of teenagers, such as those who are out of school, working, married or pregnant are also generally left out of nutrition policies and programmes in Indonesia.⁷ There is a clear need to invest in adolescent nutrition in order to meet national and international nutrition and development goals. Special efforts are needed to focus on reaching vulnerable girls and in engaging boys and girls to support adolescent health and nutrition.

There is growing awareness that adolescent nutrition is an area that requires enhanced attention and investment in Indonesia. Both nutrition-specific and nutrition-sensitive interventions need to be combined into integrated, multisectoral responses to achieve optimal nutritional status of adolescents by mobilizing the support of various line ministries, notably health, education, agriculture, religious affairs, and social affairs.⁸

Evidence shows that when adolescent girls and boys are supported and encouraged by caring adults, along with policies and services attentive to their needs and capabilities, they have the potential to break long-standing cycles of poverty, discrimination and violence.
www.unicef.org (2018)

⁷ Soekarjo, D.D., Roshita, A., Thow, A., Li, M., & Rah, J. H. (2018), Strengthening Nutrition-Specific Policies for Adolescents in Indonesia: A Qualitative Policy Analysis, Food and Nutrition Bulletin, 39.

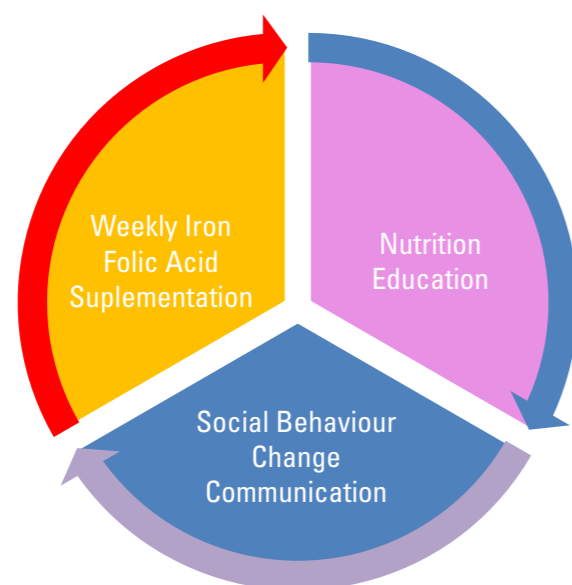
⁸ Rah, J.H., Roshita, A., Sugihantono, A., & Izwardy, D. (2017), New Horizons for the Forgotten Generation. Improving adolescent nutrition in Indonesia, Sight and Life, vol. 31(2).

Adolescent nutrition response in Indonesia

UNICEF Indonesia together with the Government of Indonesia has embarked on a pioneering adolescent nutrition programme designed to address the triple burden of malnutrition. The programme applies a life-course framework aimed at breaking the intergenerational cycle of malnutrition. Launched as a pilot programme in November 2018, the programme has adopted the catchy brand and tagline '*Aksi bergizi*', translated as 'nutritious action'. Three interdependent nutrition-specific interventions were piloted from 2019 in 110 junior and senior high schools including religious schools (*madrasah*) in two districts, namely Klaten in Central Java Province and Lombok Barat in West Nusa Tenggara Province. The *Aksi bergizi* adolescent nutrition package of interventions consists of three components (see Figure 2):

1. Weekly iron folic acid supplementation (WIFS) for adolescent girls to prevent anaemia.
2. An evidence-based, multisectoral Nutrition Education Module implemented at school. It is designed to improve the knowledge, attitudes and self-efficacy of adolescent girls and boys on healthy eating and physical activity.
3. A comprehensive, gender-responsive social and behaviour change communication (SBCC) strategy, designed to empower adolescent girls and boys to improve dietary practices and physical activity with support from their families, friends and communities.

Figure 2. Adolescent Nutrition Aksi bergizi Programme in Indonesia



Social and behaviour change communication for adolescent nutrition

Social and behaviour change communication (SBCC) – also known as Communication for Development (C4D)⁹ – is one of the key strategies for achieving health and development targets. C4D tools have been used to advance socially beneficial goals for decades. Currently the field recognizes the role of communication as going well beyond information

⁹ SBCC/C4D involves understanding people, their beliefs and values, the social and cultural norms that shape their lives. It is a process of engaging communities and listening to adults, adolescents and children, giving them space to amplify their voices as they identify problems, propose solutions and act upon them. C4D is seen as a two-way process for sharing ideas and knowledge by harnessing the power of communication approaches and media that empower individuals and communities to take actions to improve their lives. (UNICEF C4D Section, NYHQ; visit: <https://www.unicef.org/cbsc/>).

transmission; rather as an essential element for people to gain control of their lives and make informed choices. SBCC/C4D approaches combine individual-level behaviour change with broader social change. Central to the change process is communication that builds on evidence and strategic planning and promotes dialogue, participation and engagement of stakeholders. The strategy outlined in this document will build on all four SBCC approaches: advocacy, social mobilization, community engagement for social change, and communication for behaviour (individual) change.

By applying SBCC using a life-course framework (as illustrated in Figure 1) to address the intergenerational cycle of malnutrition, we can create a consciousness among young people on the importance of practising optimal nutrition and physical activities during this period of their development, which for many is the preconception period before their first offspring. Being equipped with adequate nutrition knowledge, attitudes and practices, with support from their families, teachers, healthcare providers and community leaders, can impact not only their decisions and actions to maintain good health, but also, as future parents, in preventing intergenerational malnutrition: child stunting, wasting, micronutrient deficiencies (anaemia, vitamin A deficiency, iodine deficiency) and obesity that can lead to non-communicable diseases (NCDs). Consequently, "improved nutrition across the life course, from pre-conception, pregnancy, infancy, childhood, adolescence, through adulthood, will significantly reduce maternal and child malnutrition, ill health and mortality, improve children's school performance, and result in greater economic productivity for the nation."¹⁰ Girls and boys both face specific nutrition challenges throughout their life. Girls have higher nutritional needs for iron due to menstruation and are more likely to be anaemic than boys (UNICEF, 2017). Ensuring the nutritional well-being of adolescent girls becomes even more crucial in Indonesia, where 11 per cent marry before they reach 18 years and become mothers (SUSENAS 2018).¹¹ Adolescent boys have increased need for calories and higher levels of physical activities, compared with girls, which may be putting them at increased risk of thinness in Indonesia (UNICEF, 2017).

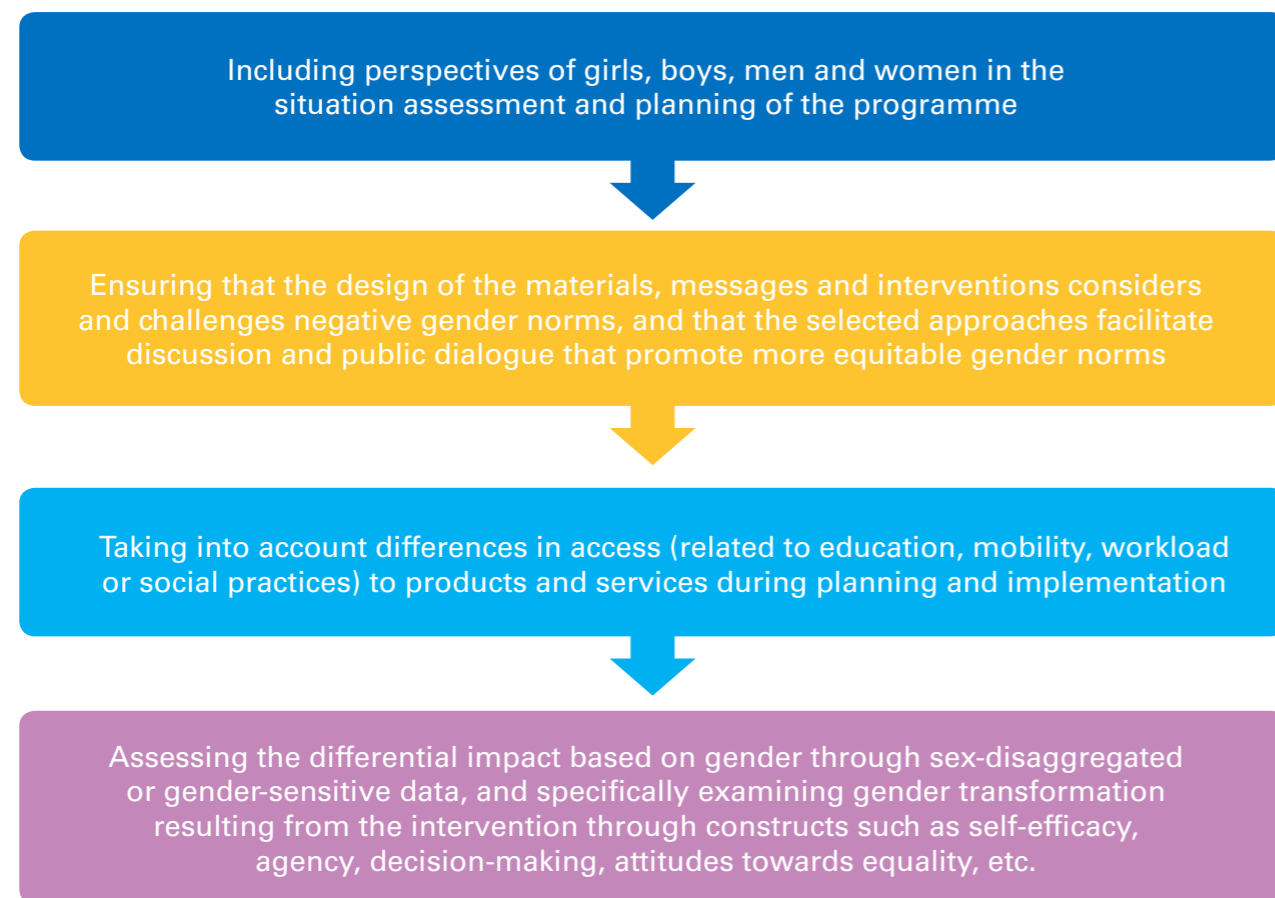
Gender and nutrition are closely linked by social norms and cultural traditions. Data from Indonesia reveal important gender differences. Thinness rates are higher among boys and anaemia is more prevalent among girls. Girls aged 16–18 also are more likely to be overweight compared with boys, and boys are more likely to be stunted (The National Health Research and Development Agency, 2018). Gender norms that restrict girls' mobility and household demands also impact their ability to engage in more physical activity, especially outside the house or school. Likewise, traditional beliefs and food restrictions on girls during menstruation, pregnancy and lactation may further hamper nutritional well-being. Boys spend more time outside the house and are more likely to be expending more energy and consuming higher amounts of convenience or fast foods. Smoking is also more prevalent among boys. This strategy will take into consideration the gender-specific needs of girls and boys in Indonesia and promote the goal of achieving gender-equitable health care and nutrition for all children – girls and boys – as put forth in UNICEF's current Gender Action Plan (UNICEF 2018c).

¹⁰ Indonesia Nutrition Profile (2014)

¹¹ National Statistics Bureau/BPS (2018), Indonesia Socio-Economic Survey or *SUSENAS*, 2018

Integrating gender in SBCC efforts requires gender-specific considerations to guide the overall planning process, as illustrated in Figure 3.

Figure 3. Gender Responsive Communication¹²



Scope of the strategy

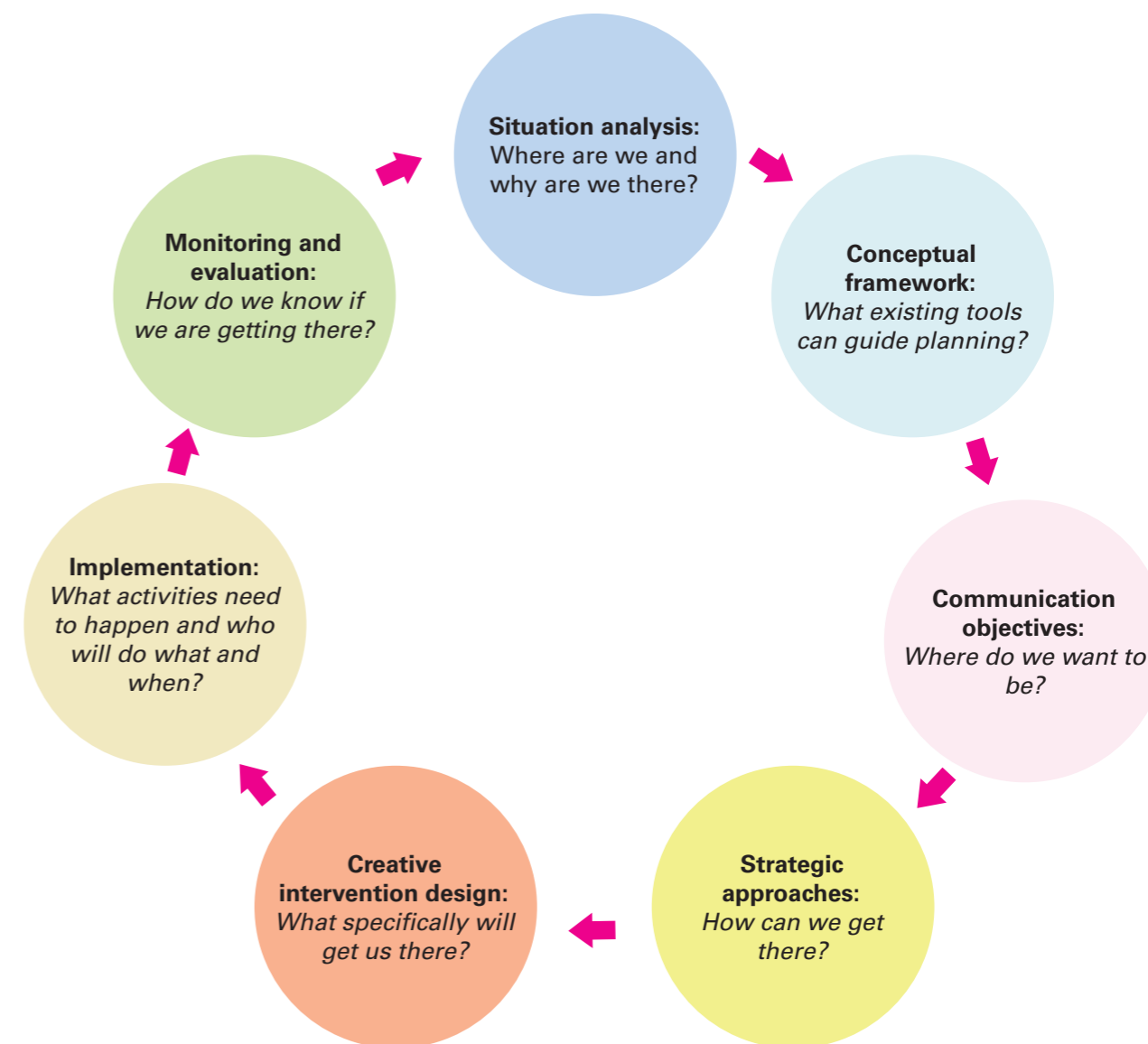
The SBCC strategy set forth here provides a guiding framework for a range of communication activities – both mediated and interpersonal. The strategy was piloted in two districts – Klaten in Central Java and Lombok Barat in West Nusa Tenggara – with the social media and mass media components being both district level and national in scope. The strategy covers school-going adolescents and builds on available evidence and a theory of change. It includes a detailed implementation plan and monitoring and evaluation (M&E) framework to ensure that the changes are tracked, measured and reported.

Promoting dialogue among and between adolescents, teachers and parents is an essential feature of the proposed SBCC strategy. Adolescents and their parents will be engaged through ongoing dialogue that increases demand for better health and nutrition using messages and channels that are best suited to young people. This will include using their

¹² Gender responsive communication for development: Guidance, tools and resources. Dikembangkan oleh Ami Sengupta untuk UNICEF ROSA (2018).

preferred social media platforms and interpersonal communication with their social networks that can inspire, motivate and sustain adoption of recommended nutrition practices. Improving adolescent nutrition will require combining service delivery with nutrition education. Nutrition-specific interventions such as iron-folic acid supplementation will be reinforced by improved knowledge of nutrition through multiple communication platforms such as interpersonal outreach, school-based initiatives, youth engagement, peer education and social and mass media. Parents, teachers, school officials, health workers and other influencers will be engaged to support adolescent nutrition as well as physical activity.

Figure 4. Six stages in the C4D/SBCC planning cycle and guiding questions



Design of the SBCC strategy

Strategy development follows a systematic process based on well-established SBCC planning models and principles. The process builds on a thorough understanding of the situation to inform the strategic design, implementation, monitoring and evaluation of the strategy. Figure 4 illustrates this process. Each stage corresponds to the chapters in this document.

Stages in the development of this SBCC strategy

Stage/Chapter 1 – Situation Analysis: This stage corresponds to Chapter 1, which provides a brief overview of the nutritional status of adolescent girls and boys in Indonesia, the immediate, underlying and root causes of the problem, the gaps/barriers and opportunities to optimum adolescent nutrition practices, and government and stakeholder responses so far. A look at the communication environment and a channel analysis are also presented to inform strategy development.

Stage/Chapter 2 – Conceptual Framework: This chapter provides a rationale and proven conceptual tools to guide planning the strategic approaches and designing the creative intervention (Socio-Ecological Model or SEM, Social Cognitive Theory and Stages of Change Theory) toward improving adolescents' nutritional status, starting in two pilot districts..

Stage/Chapter 3 – Objectives: This section details the priority behaviours that need to be addressed. Behaviour and social change objectives are defined and linked to strategic approaches of advocacy, social and community mobilization, and social and behaviour change communication. This chapter presents a Theory of Change for achieving the desired SBCC outputs, outcomes, change objectives and goals reflecting an SEM approach that encompasses other relevant theories of change in the conceptual framework.

Stage/Chapter 4 – Strategic Approach: The strategic approach section details the four SBCC strategies and maps participant audience groups by strategic approach according to the SEM model. The section also provides an analysis of current behaviours, revisits challenges and opportunities and the implications for creative interventions in Chapter 4.

Stage/Chapter 5 – Creative Intervention Design: This section outlines key messages for specific primary, secondary and tertiary participant audience groups. Local inputs on communication channel selection and creative content and media are expected to lead to recommendations to be translated into activities for the implementation plan in Chapter 5.

Stage/Chapter 6 – Implementation: This section provides guidance on potential roles and responsibilities and commitments of various government, non-governmental and private stakeholders in implementing the strategy. It also provides guidance on sequencing and geographical prioritization of initiatives.

Stage/Chapter 7 – Monitoring and Evaluation Framework: This section provides guidance on preparing an M&E plan to track progress of planned activities and measuring intended behaviour change results based on the communication objectives. It also stresses the importance of documenting promising practices and lessons learned, with tips and guides for reporting.

CHAPTER 1. SITUATION ANALYSIS OF ADOLESCENT NUTRITION IN INDONESIA

The triple burden of malnutrition among adolescent girls and boys

The SBCC strategy offered here has been designed to address recent evidence regarding the nature and causes of nutrition problems among adolescents in Indonesia. The triple burden of malnutrition is characterized by the coexistence of undernutrition along with overweight and obesity and micronutrient deficiencies, within individuals, households and populations, and across the life course. At the individual level, more than one type of malnutrition can occur simultaneously; for example, obesity with anaemia or a vitamin deficiency. More than one type of malnutrition can also occur at the household level when one family member may be underweight or have a nutritional deficiency and another member may be overweight or obese; for example, an anaemic mother and an overweight grandparent. The triple-burden household is more common in middle-income countries undergoing rapid nutrition transition. The triple burden exists at the population level when both undernutrition and overweight, obesity or NCDs and micronutrient deficiencies are prevalent in the same community, region or nation. Undernutrition and overweight, obesity or NCDs now coexist in many countries, with women disproportionately affected at the population level (WHO, 2017).¹³

The National Basic Health Research Survey (2018) indicated that the burden of undernutrition in Indonesia was considerable, with over a fourth of the adolescent population aged 13–15 years stunted (approximately 26 per cent) and 9 per cent underweight (thin). Among adolescents aged 16–18 years, 27 per cent were stunted and 8 per cent were thin, and the prevalence of anaemia among adolescents aged 13–18 years was 12.4 per cent for boys and 22.7 per cent for girls (see Table 1).

Table 1. Nutritional status of Indonesian adolescents¹⁴

Age/gender	Thinness	Stunting	Overweight	Anaemia ¹⁵
	Prevalence (%)			
13–15 years	8.7	25.7	16	-
▸ Boys	11.7	26.5	16	12.4
▸ Girls	5.4	24.9	16	22.7
16–18 years	8.1	26.9	13.5	-
▸ Boys	11.8	28.8	11.3	-
▸ Girls	4.3	25	15.9	-

¹³ World Health Organization (2017), The double burden of malnutrition, Policy brief, WHO, Geneva.

¹⁴ Source: Riskesdas, 2013.

¹⁵ Anaemia prevalence is for 13–18 year olds.

Although undernutrition persists, Indonesia is a country rapidly undergoing its nutrition transition. The nutrition transition is often defined by characteristic changes in diet and physical activity patterns that occur as a result of changes in economic development, globalization and urbanization. As countries undergo their nutrition transition, the prevalence of overweight tends to increase following changes in diet and physical activity. National data suggest that the consumption of processed and energy-dense foods is common, as is an increasingly sedentary lifestyle. These changes are associated with increases in overweight and obesity. Data from 2018 indicated that the prevalence of overweight among adolescents was higher than thinness. In order to expand the evidence base on adolescent nutrition in the country, UNICEF Indonesia conducted a baseline survey in 2017. Adolescents were surveyed regarding their anthropometrics, dietary intake, physical activity and other social determinants of health.

Data from the 2017 Survey¹⁶ highlighted that the dual burden of malnutrition continues to persist among the adolescents in Indonesia, as indicated by the coexistence of thinness (6.4 per cent) as well as overweight (8.9 per cent) and obesity (4.0 per cent). The burden of obesity was not evenly distributed across the sample. More adolescents in Klaten were obese than in Lombok Barat (5.2 per cent vs. 1.7 per cent) and there was also a significant difference in obesity prevalence by sex, such that boys (4.3 per cent) were more likely to be obese than girls (3.7 per cent). The prevalence of obesity in the wealthiest households was significantly higher than obesity prevalence in the poorest households (7.1 per cent vs. 1.2 per cent). There were also differences in the prevalence of thinness by sex, as thinness was higher among adolescent boys (9.1 per cent) than girls (3.6 per cent). Approximately one in five adolescents were stunted. A higher prevalence of stunting was observed among adolescents living in Lombok Barat (22.9 per cent) than in Klaten (16.0 per cent). Older adolescents (15–18 years) were more likely to be stunted than adolescents aged 12–14 years (21.5 per cent vs. 14.6 per cent). There was also heterogeneity in stunting prevalence by wealth: adolescents in the poorest wealth quintile (25.8 per cent) were more likely to be stunted than those in the wealthiest quintile (11.6 per cent). Table 2 provides an overview of the nutritional status of adolescents.

Table 2. Adolescent nutritional status in Klaten and Lombok Barat districts

Background characteristic	Thinness	Stunting	Overweight	Obese	Anaemia (mild & moderate)
	Prevalence (%)				
By district					
▸ Klaten	5.9	16	9.5	5.2	11
▸ Lombok Barat	7.4	22.9	7.6	1.7	12.5
By sex					
▸ Boys	9.1	16.7	10	4.3	4.7
▸ Girls	3.6	20.2	7.6	3.7	18.8
By age group					
▸ 12–14	14.6	6.7	8.7	4.5	10.1
▸ 15–18	21.5	6.3	9.1	3.5	12.6
By location					
▸ Urban	5.8	17.9	8.3	4.7	10.3
▸ Rural	7.1	18.9	9.5	3.2	12.8
Total	6.4	21.1	8.9	4	11.5

¹⁶ Baseline Survey of Adolescent Nutritional Status in Klaten and Lombok Barat Districts, Indonesia 2017.

Approximately 11.5 per cent of adolescents aged 12–18 years were anaemic: 7.7 per cent had mild anaemia and 3.7 per cent had moderate anaemia. There was a much higher prevalence of anaemia among girls (18.8 per cent) than boys (4.7 per cent). But the prevalence of anaemia among adolescent boys and girls aged 12–14 years (10.1 per cent) in the survey areas was lower than anaemia trends among a similar age group sampled in the most recent (2014) Indonesia Family Life Survey (15.8 per cent). Overall, adolescents reported a diet high in carbohydrates, and low in animal-source protein (e.g., only 23.9 per cent consumed meat/poultry/fish at least once per day). Adolescents in Klaten were less likely than their peers to eat vitamin and mineral-rich foods, such as fruit and vegetables. On average, adolescents were fairly sedentary and commonly consumed sweetened beverages and snack foods (e.g., 65.5 per cent usually consumed factory-made snacks), which are highly processed and tend to be energy dense.

Causal analysis of malnutrition among adolescent girls and boys

This section looks into the immediate, underlying and basic causes of the triple burden of malnutrition among adolescents in Indonesia. Among the drivers and risks factors for nutrition in Indonesia, data support that socioeconomic status is a key factor for stunting, with higher odds of stunting among adolescents living in less urbanized/developed areas, poorer households and those responsible for looking after siblings. For example, adolescents in Klaten had significantly lower odds of stunting compared with those in Lombok Barat. Likewise, adolescents in the wealthiest households had 55 per cent lower odds of stunting compared with adolescents in the poorest households and watching one's siblings one or more times in the past 7 days was associated with 33 per cent higher odds of stunting among the adolescents surveyed. In addition, the odds of stunting were 60 per cent higher among adolescents aged 15–18 years, compared with adolescents aged 12–14 years, and girls had marginally higher odds of stunting than boys.



Adolescents are doing exercise at school

Key risk factors for overweight among adolescents included physical activity levels and age. Adolescents who regularly engaged in physical activities requiring exertion, such as pumping water, had lower odds of being overweight compared with those who were less active and spent considerable time watching TV and consequently had higher chances of being overweight. Adolescent gender and indicators of socio-economic position were risk factors for thinness in this sample. Girls had significantly lower odds of being thin compared with boys. Adolescents living in a food insecure household had 81 per cent higher odds of being thin, compared with those living in a food secure household.

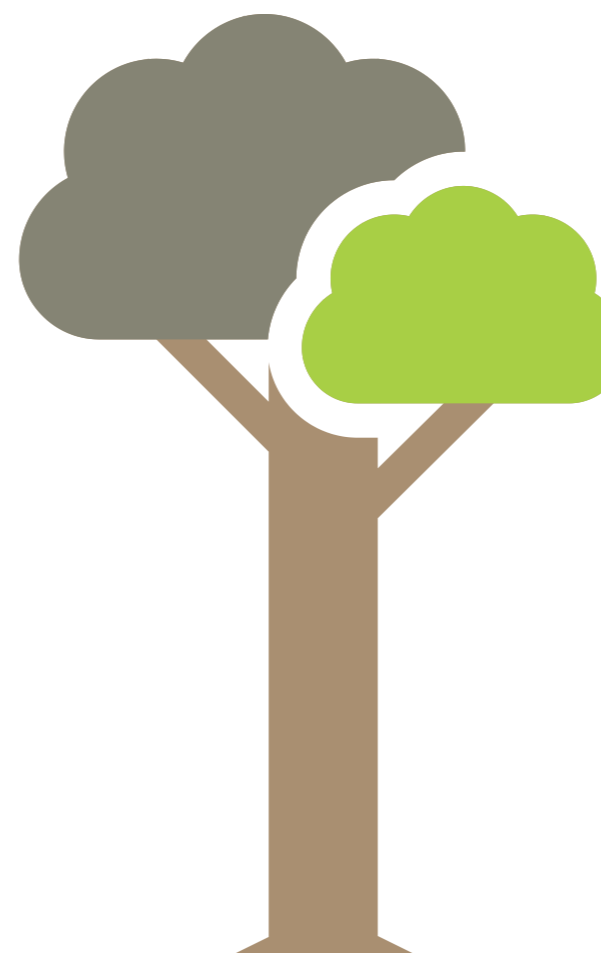
Compared with adolescents whose fathers lacked formal education, adolescents whose fathers had some primary education had lower odds of thinness. Spending more time walking to school or playing was noted as a protective factor against anaemia. Gender was the strongest predictor of anaemia, with girls being at almost five times higher odds of being anaemic than boys.¹⁷ Fieldwork revealed additional gender-related insights. In the two districts, food discrimination based on gender and differential access to household food resources were not reported. Girls appeared to be more aware of which foods were nutritious and routinely listed fruits and vegetables in their diet. Boys reported more physical activity and time spent outside the house. Girls spent more time at home and on their devices. Local officials shared that parents are generally aware of the additional nutritional requirements for girls due to menstruation but were not always aware of the nutritional needs of boys.

Body image appears to be another factor that affects the food consumption and physical activity of adolescents, thereby impacting their nutritional status. Focus group discussions conducted by the team with girls and boys highlighted that few of them felt their body was ideal. Boys wanted to be taller and gain weight and muscle, while girls wanted to be thinner. Teachers also expressed that at times girls restrict food intake and skip meals to be thinner. These findings are also supported by previous qualitative research, which highlights body image issues among adolescents. Boys tend to aspire to have film star like muscles and the motivation for working out in the gym was to get a 'good body' and a 'sis pek' (six pack). Girls, likewise, desired a proportional body and did not want to be too fat or chubby.¹⁸

A problem tree model on a causal analysis of the triple burden of malnutrition among adolescents was pictured using UNICEF's Conceptual Framework. Malnutrition among adolescents defines three levels of causes as **basic or root causes**, **underlying or indirect causes** and **immediate or direct causes** (see Figure 5). The basic causes include the social, economic and political context around the structure and dynamics of society. Underlying causes include those emanating from the demand side; i.e., individual knowledge, attitudes and practices, social norms associated with body image, and influences from households and communities that may lead to poor dietary practices and sedentary lifestyle.

At the same time, underlying causes may stem from the supply side; i.e., lack of adolescent-friendly and gender-responsive programmes, poor facilities and services in schools (e.g., school canteens), in health delivery systems and in communities. Immediate causes operate at an individual level, which may include low quantity and quality of food intake; or high intake of unhealthy diets and lack of physical activity. These immediate causes can lead to undesirable effects such as anaemia and stunting, as well as obesity and predisposition to non-communicable diseases in adult life.

Figure 5. The problem tree: a causal analysis of the triple burden of malnutrition among adolescents in Indonesia



Core problem: Triple burden of malnutrition among adolescent girls and boys in Indonesia.

Manifestation/effects: Thinness and obesity higher among boys; anaemia and stunting higher among girls.

Immediate causes: Low quantity of food intake; poor quality of diet; lack of physical activity.

Underlying causes (Demand Side): Low awareness, self-efficacy & motivation; poor food choices, eating habits & hygiene practices; harmful social norms including body image; low access to food sources, nutrition & AFHS services; lack of physical activity; low participation in school nutrition by parents and community.

Underlying causes (Supply Side): Lack of nutrition education in schools and community; lack of adolescent-friendly & gender-responsive physical fitness, health and WASH services; weak linkage among schools, community, service facilities and households.

Basic/root causes: Poverty; lack of adolescent development policy and school nutrition programme infrastructure for adolescents; low capacity of teachers & service delivery system; poor coordination; lack of supportive environment.

Media and communication landscape in Indonesia

This SBCC strategy also builds on research and data regarding the media in Indonesia and the range of communication channels available to adolescents and their families, implying the importance of using a multichannel approach.

The media landscape in Indonesia has expanded vastly post 1998 and the end of the Soeharto regime. By 2017, the Dewan Pers (Press Council) estimated that the number of media in Indonesia reached 47,000 outlets. Of these, an estimated 2,000 are printed media, 1,166 radio stations, 674 television stations and 43,300 online media. The current media environment is marked by increased press freedom and the emergence of media conglomeration, with about a dozen major media groups controlling most of the media channels. The largest media groups are Global Mediacomm (MNC), Jawa Pos Group, and Kompas Gramedia Group (KKG). MNC Group has 20 television channels, 20 radio stations, 7 print media and 1 online media. The Jawa Pos Group has 20 television channels, 171 print and 1 online media. KKG, for its part, has 10 television channels, 12 radio stations, 88 print media and 2 online media.

According to data from the Ministry of Communications and Information (2015), as many as 87 per cent of households have a television set. The same data also show that close to 90 per cent of Indonesians regularly watch television for entertainment or information. Although the internet has changed the media environment, television is still estimated to be the main medium and is likely to remain so for several years. Another traditional

¹⁷ Baseline Survey of Adolescent Nutritional Status in Klaten and Lombok Barat Districts, Indonesia 2017.

¹⁸ RCA+ and UNICEF (2016), Perspectives and Experiences of Adolescents on Eating, Drinking and Physical Activity.

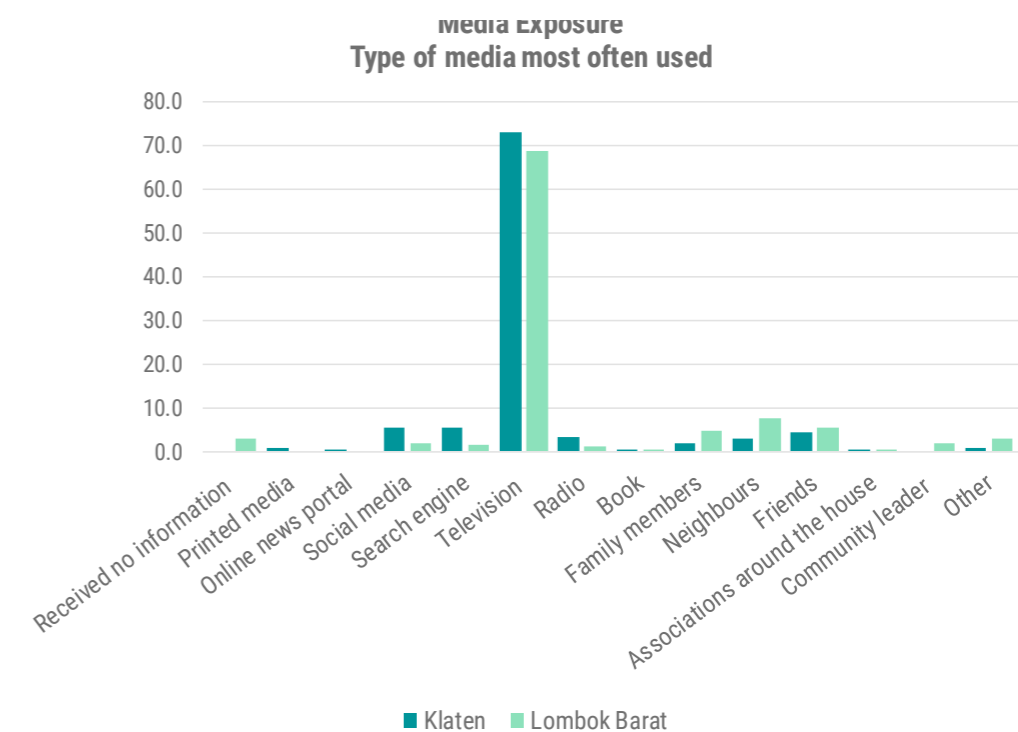
medium that remains popular is radio. Radio is relatively cheaper to produce than television and printed media and is easier to adapt to the presence of the internet. Most disrupted by the advent of the internet was the print press – over the last five years, tens of printed media stopped publishing. The reason was high printing costs and sharp drop in subscriptions. As more printed media stopped publishing, online media sharply increased in numbers.¹⁹

The UNICEF adolescent nutrition baseline study also provides useful information on media access and use. According to the survey, most adolescents (88 per cent) have used the internet, with the number being higher in Klaten (95 per cent) than in Lombok Barat (75 per cent). Differences were also based on age, residence and wealth, with older adolescents, those living in urban areas and belonging to higher wealth quintiles reporting greater use. Adolescents aged 15–18 reported higher use (95 per cent) compared with those aged 12–14 (80 per cent); those in urban areas using internet was 90 per cent compared with 85 per cent living in rural areas; almost all adolescents belonging to wealthier quintiles (98 per cent) reported use of the internet compared with only 68 per cent of adolescents living in poorer households. In terms of frequency of use, less than half of all adolescents surveyed (43 per cent) used the internet every day in the past month, 16 per cent used it often, 34.5 per cent used it rarely, and 6.5 per cent did not use it at all in the past month.

The respondents also reported high access to smartphones and other mobile devices. Most adolescents surveyed owned or had access to a smartphone (82 per cent), 66 per cent had a mobile phone without internet access, 24.1 per cent had a mobile phone with access to social media, 51 per cent had a laptop, and 19 per cent had a tablet. Variation was noted based on district, age and wealth. Adolescent mobile-phone ownership was higher in Klaten (84 per cent) than in Lombok Barat (77 per cent). Similarly, ownership of a computer/laptop was higher in Klaten (58 per cent versus 37 per cent), while ownership of mobile phones with access to social media (34 per cent versus 19 per cent) or a tablet (23 per cent versus 17 per cent) was higher in Lombok Barat. Older-aged adolescents, compared with younger teenagers, were more likely to own various mobile devices (mobile phone with social media access, smartphone, computer/laptop). The percentage having a smartphone, tablet or computer also increased with increasing wealth quintile. Smartphones were mostly used to access social media (46 per cent), with few adolescents using it for online or offline games or to watch videos (approximately 8 per cent). Roughly a fifth of the respondents used their smartphones for school or work.

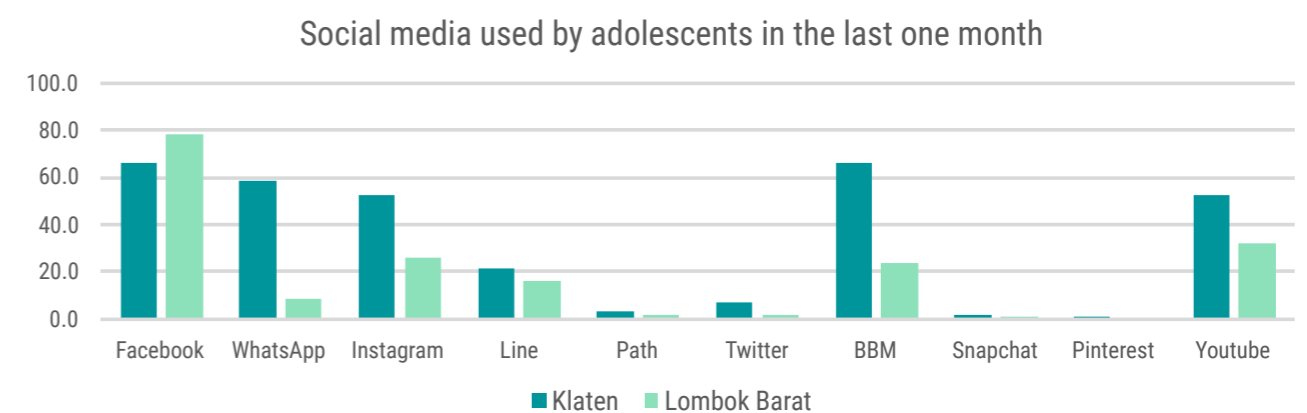
Finally, only one fifth of adolescents' parents/guardians (19 per cent) had used the internet. In addition, parents/guardians in Lombok Barat were less likely to have used the internet than those in Klaten. Respondents most often had media exposure via television (71.5 per cent). However, about 4 per cent reported using social media and search engines. A majority of respondents reported media exposure on a daily basis (70.1 per cent). When designing intervention approaches aimed at the whole household, it will be important to also consider using more traditional media approaches (e.g., television), given that a large majority (80 per cent) of parents/guardians, particularly in Lombok Barat, do not yet use the internet. Figure 6 presents the household media exposure in the two districts.

Figure 6. Household media exposure in two pilot districts: Klaten and Lombok Barat



The most preferred type of social media among adolescents was Facebook (56 per cent). Half of adolescents also reported using BBM²⁰ (53.6 per cent), YouTube (46.3 per cent), Instagram (44.5 per cent), and WhatsApp (44.0 per cent). In Klaten, several social media sites/apps (i.e., Facebook, WhatsApp, Instagram, BBM) were used simultaneously by more than half of adolescents, but those in Lombok Barat predominantly used Facebook (78.3 per cent). There were some differences in the type of social media app preferred by sex and age group. For example, girls were less likely than their male peers to use Facebook and YouTube, whereas boys were less likely than girls to use Line and Snapchat. Older-aged adolescents (aged 15–18 years versus 12–15-year-olds) were more likely to use all apps except BBM. The use of Facebook was equal across the five wealth quintiles, but access to other social media platforms tended to increase with higher wealth quintile (see Figures 7 and 8).

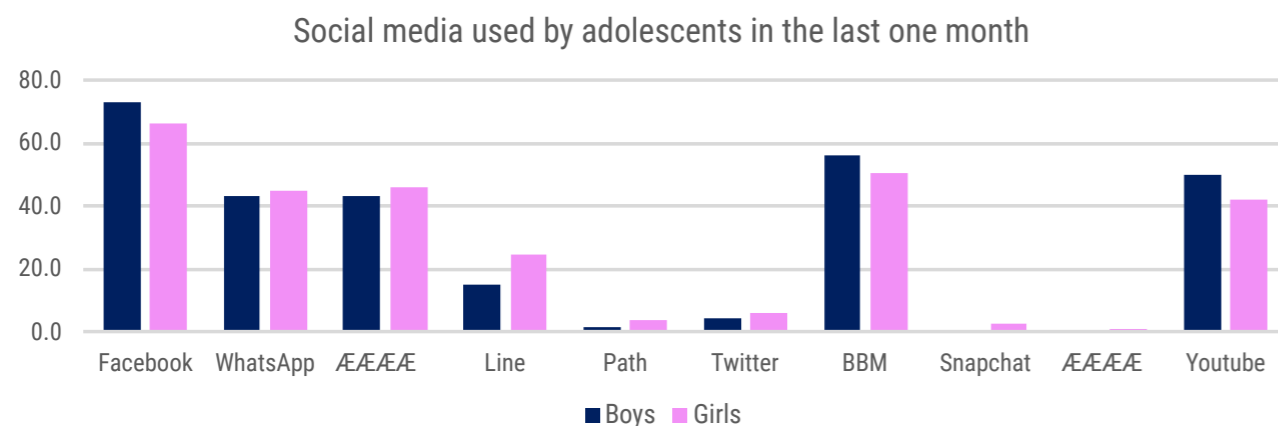
Figure 7. Differences in social media use by districts



¹⁹ Indonesia Media Landscape, available from: <https://medialandscapes.org/country/indonesia>

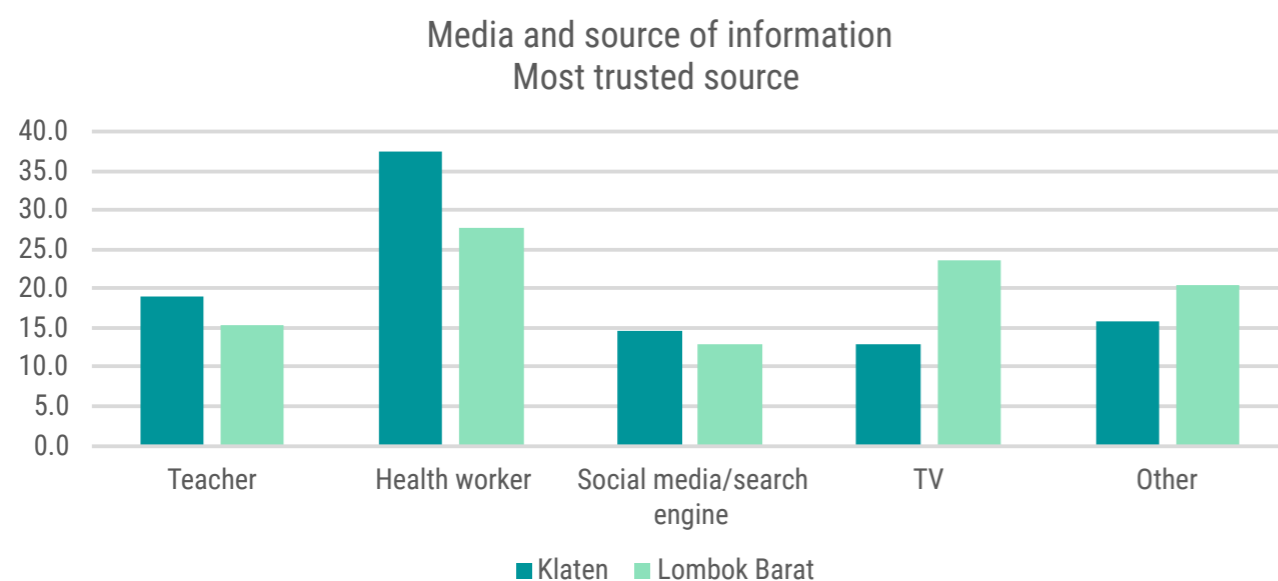
²⁰ During the period of strategy development, Blackberry Messenger/BBM still operated in Indonesia.

Figure 8. Differences in social media use by sex



In line with national findings on media use, the adolescent survey reported that television was the most used media source (32 per cent), followed by search engines (26 per cent) and social media (22 per cent). Interpersonal channels and trusted information sources for health and nutrition for adolescents included health workers (35 per cent), whereas teachers, social media, search engines and television were considered to be a less trusted source of information (<20 per cent). Adolescents in Klaten were more likely to report health workers as a trusted source of information, while those in Lombok Barat were more likely to report television or others (parents, family members, printed media) as trusted sources of information. With increasing wealth quintile, the preference for television as a trusted source of information decreased, while the recognition of social media/search engines as a trusted source of information increased (see Figure 9).

Figure 9. Most trusted sources of information in the two pilot districts



Barriers and opportunities to healthy eating and physical activity

The proposed SBCC strategy takes into account barriers and opportunities coming from both the supply side and the demand side of the development equation. Supply side barriers and opportunities pertain to factors related to accessibility, availability and quality of services, presence and quality of structures, resources, policies, laws and governance. Demand side barriers and motivators relate to behavioural, social, cultural, economic and physical factors that prevent or predispose individuals and families deciding to practise desired behaviours and seeking information, agency and services. The SBCC strategy addresses demand side barriers first and foremost, while flagging advocacy opportunities to reduce some supply side bottlenecks. The primary contribution of SBCC or C4D is in addressing demand side barriers.

Available evidence from previous studies, expert interviews and field assessments suggests multiple barriers and challenges to optimal eating and exercise behaviours among adolescent girls and boys in Indonesia. While geographic, socioeconomic and cultural variations are plentiful, most of the observations made are likely to hold their validity across other parts of the country with similar context.

See Annex 1 for the key findings²¹ on communication-related barriers and opportunities that were extracted based on current gaps and challenges persisting in Indonesia and grouped according to levels of the Socio-Ecological Model (SEM) (see Chapter 2).

The proposed SBCC strategy addresses demand side barriers and challenges using strategic approaches. But for SBCC to proceed and succeed, supply side factors – policies, programmes, structures, resources, services, capacities – need to be in place. SBCC supports the programme in addressing supply side bottlenecks through policy, programme and media advocacy.

Table 3 summarizes the confluence of supply and demand side challenges and potential solutions. This SBCC strategy attempts to address the social and behavioural challenges and build on some of the opportunities listed above. Drawing on extensive research and stakeholder recommendations, the strategy spotlights potential solutions through engagement of influencers at each level of the socio-ecological system (see Chapter 2: Conceptual Framework with the Socio-Ecological Model and levels of SBCC intervention). These are further discussed in Chapters 3 and 4.

²¹ Derived from Preliminary Draft: Sources: Expert interviews; field-based focus group discussions, RCA & UNICEF, 2016; Agustina & Prafiantini, 2016; GAIN 2016; GAIN 2014; Bait 2017; RISKESDAS 2013; SUSENAS 2016; BAPPENAS & UNICEF 2017, Soekarjo et al, 2018.

Table 3. SBCC challenges and potential solutions to address the triple burden of adolescent malnutrition in Indonesia

Adolescent nutrition imperative	Main barriers/challenges	Potential solutions addressed by programme (SUPPLY)	Potential solutions addressed through SBCC (DEMAND) – intervention modalities
Reduce prevalence of anaemia among adolescent girls	<ul style="list-style-type: none"> Few national policies on adolescent development that includes adolescent nutrition and physical activity for optimal adolescent health Ad-hoc programme on nutrition education and physical activity in SMP, SMA and SMK schools and in their communities Low KAP on adolescent nutrition and physical activity across SEM levels 	<p>Adolescent nutrition policy and programme mainstreamed in national and district Food and Nutrition Action Plan</p> <ul style="list-style-type: none"> Develop comprehensive nutrition policy and Food and Nutrition Action Plan that equally address nutrition of adolescents and other age groups in the life course. Ensure that district equivalent of Food and Nutrition Action Plan includes adolescent nutrition. Advocate for intensified multisectoral coordination of adolescent nutrition programme stakeholders at district/national level along with nutrition efforts across the life course. Advocate for district leaders to issue circular establishing all schools as platforms to promote and practise healthy eating habits, physical exercise, and healthy, responsible behaviour. In-school girls (SMP, SMA, SMK) receive nutrition counselling and weekly doses of iron and folic acid (IFA) supplementation in schools UKS health units. Out-of-school adolescent girls receive weekly doses of IFA in AF health posts/ <i>Posyandu</i>, <i>Puskesmas</i>. Mainstream nutrition education in school curriculum at all levels using Nutrition Module with 36 lessons and key messages. Strengthen capacity of teachers in nutrition education. Strengthen capacity of health providers in health and nutrition service delivery in <i>Puskesmas</i> and <i>Posyandu</i>. Issue and implement guidelines on healthy school canteen to operators and vendors. 	<ul style="list-style-type: none"> Advocacy – policy, programme, public and media advocacy Social mobilization in schools and communities Family and community engagement Capacity building in IPC and counselling skills, messaging and SBCC processes Social media and mass media engagement Edutainment and creative learning, messaging and materials SBCC research, monitoring and evaluation, and documentation <p><i>(See Chapter 4 and Chapter 5 for strategic approaches and suggested creative interventions for each of the above modalities)</i></p>

Adolescent nutrition imperative	Main barriers/challenges	Potential solutions addressed by programme (SUPPLY)	Potential solutions addressed through SBCC (DEMAND) – intervention modalities
Reduce thinness in adolescent boys and girls		<p>Adequate supply and access to diverse and nutritious food in community and school:</p> <ul style="list-style-type: none"> Engage students, volunteer parents/PTA, partners and allies in food production project/competition/challenge (e.g., school and home gardens), food provision, selection and cooking demonstration/preparation of nutritious meals with rewards. Establish school meal programme and link to school vegetable gardens with student–parent involvement. Mount contests around best school vegetable plots, kitchen and community vegetable gardens, food preparation and sharing of nutritious recipes posted via Instagram, other social media platforms. Compile recipes and share via social media, blogs and print 	
Reduce obesity with increased physical activity and active, healthy lifestyle to mitigate NCDs later in life		<p>National/district policies on the following:</p> <ul style="list-style-type: none"> Physical fitness programme and facilities in all schools with provision of appropriate facilities for girls and boys. Guidelines for school canteens to regulate sale of packaged/processed foods and sugary beverages. Support and funding for school and community activities, events and competitions around good nutrition and physical activities. 	

CHAPTER 2. CONCEPTUAL FRAMEWORK

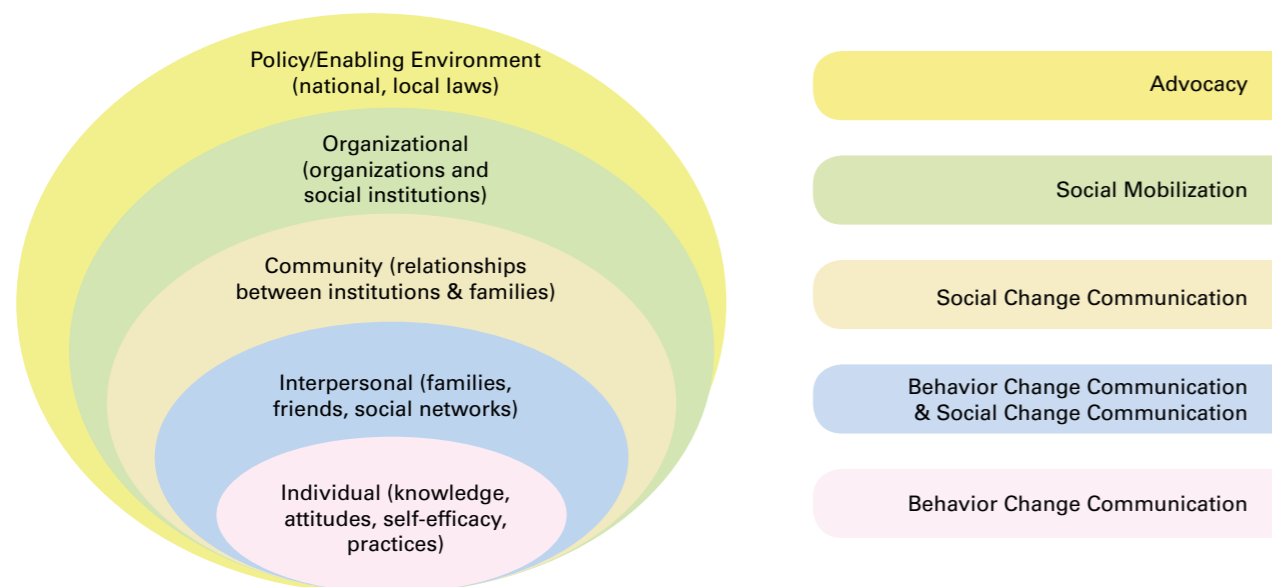
The Socio-Ecological Model and levels of intervention

This communication strategy uses the Socio-Ecological Model (SEM), a theory-based framework²² for understanding the multifaceted and interactive effects of personal and environmental factors that influence an individual's behaviours and a community's collective decision to adopt recommended practices and positive social norms. The framework recognizes the dynamic and complex sphere of influence at each level of society.

To develop a sustainable and effective framework that delivers results, the SBCC strategy is designed to operate at multiple levels of influence. Therefore, it not only seeks to engage individual adolescent girls and boys and their parents, families and friends, but also their teachers and school administrators, and health care workers in schools and in health facilities. It also encompasses other development agents, community and religious leaders and other influencers, school administrators, health system programme managers, policymakers and decisionmakers at district, provincial and national levels, including the media. As such, it offers a holistic and synergistic approach to social and individual change.

Figure 10 illustrates the orbits of influence in the SEM and corresponding SBCC approaches of advocacy, social mobilization, social change communication, and behaviour change communication.²³

Figure 10. The Socio-Ecological Model (SEM) and SBCC approaches



²² UNICEF, Communication for Development Programme Guidance (Draft of March 2018), UNICEF, C4D Section, New York.

²³ Adapted from UNICEF (2016), Communication for Development Strategy Guide for Maternal, Newborn and Child Health and Nutrition (MNCHN), UNICEF, C4D Section, New York. Visit: https://www.unicef.org/cbsc/index_43099.html

In using the SEM, the SBCC strategy takes into account that the barriers and challenges identified through research and stakeholder engagement cannot be addressed through a single level of analysis. Rather, they require a more comprehensive social-ecological approach that considers influences from the psychological, sociological, cultural, community, organizational, policy and regulatory perspectives.²⁴ The role of interpersonal communication and the media – mass media, social media and mobile technology, and creative materials – cuts across all levels.

- 1. Individual level** – includes an adolescent girl or boy's current behaviours, knowledge and attitudes (including internalized values, gendered norms, motivations and aspirations) that predispose actions around consuming (or not) a healthy diet and engaging (or not) in physical activity. These actions are influenced by the individual's immediate environment, family and social networks and depends on each person's self-confidence and efficacy to positively change behaviour.
- 2. Interpersonal – family and social network level** corresponds to social, cultural and economic influences around the individual adolescent girl or boy. While we look at the individual in terms of her/his current knowledge, predispositions and actions, this individual does not live in a vacuum. Rather, she/he is under the constant influence of prevailing social and gender norms, beliefs and expectations of close family members and peers and others who are trusted and respected. The pressure to fit in and follow gendered scripts of what it means to be feminine or masculine may impact individual level behaviours and decisions. However, depending on the level of one's own self-confidence or conviction on an issue, and each person's assessment of the costs associated with adopting a behaviour different from the norm, outside influences may or may not hold sway.
- 3. Community/supportive environment level** – These are relationships coming from the extended community and social groups; e.g., the extended family, religious congregation, peer group, teachers and health care providers that the adolescent girl/boy interacts with. Families and individuals are impacted by practices, beliefs, expectations and gender norms that prevail in the community. Community level actors can be pivotal in either influencing or impeding change. The community should aim to provide a supportive environment (adolescent-friendly and gender-responsive structures, facilities, services, materials and tools) that cultivates gender equality, self-efficacy and empowerment among adolescents. Self-efficacy in turn can lead to positive behaviour change on recommended nutrition practices and other healthy actions, not only during adolescence but also at all stages of the life course. To the extent that communities embrace and promote healthy lifestyles and empowerment among adolescents, demand for improved policies and services can fuel positive change for all.
- 4. Institutional/organizational or service delivery level** – Institutional entry points for adolescent nutrition at the district and community level are the schools and the health service delivery system. This level is linked to community efforts to improve and sustain the quality of nutrition education and physical education programmes in schools and to build and sustain quality, adolescent-friendly health and gender-responsive services within schools and in community health and recreational facilities.

²⁴ Stokols, D (1996), Translating Socio-ecological theory into guidelines for community health promotion, American Journal of Health Promotion, 10, 4, 282–298.

This level also involves social mobilization activities with implementing partners, allies and other stakeholders, including the media and business community, to support the SBCC objectives. Specifically, social mobilization of multisectoral stakeholders will help facilitate coordinated and mutually reinforcing implementation of district level nutrition-specific and nutrition-sensitive programmes using evidence-based, creative and appropriate channels and messages.

5. **System/societal/policy level** refers to the policies, programmes, structures and funds made available at national and operational levels that ensure an enabling environment for positive change. If these elements are lacking or weak, advocacy efforts by concerned stakeholders will need to be mounted that can result – in the context of this project – in new or improved nutrition policies, programmes and funds that incorporate gender-responsive, adolescent-focused, nutrition-specific and nutrition-sensitive programmes in schools and communities. Advocacy engages a broad range of actors by raising awareness and creating demand among policymakers and decision makers for better policies, programmes, services and accountability.

The SEM provides a meta-model framework to understand and plan how different social and behaviour change theories operate. At each level of the framework, different theories or theoretical constructs may be drawn upon. If the focus is on individual level change, behaviour change theories such as the Health Belief Model or Theory of Planned Behaviour can be useful. Likewise, if the focus is on interpersonal change, the Social Cognitive Theory or Social Network Theory can inform the strategy. Theories provide us with a set of conceptual tools to plan social and behaviour change strategies. They allow us to build on an existing knowledge base of why a situation exists and what may likely aid in changing it. Drawing on social and behaviour change theories helps us to plan, implement and evaluate more robust interventions. There is a wide repertoire of social and behaviour change theories that planners can use. Communication efforts aiming to promote health and nutrition related changes are more likely to succeed if based on a thorough understanding of factors influencing food choices and grounded on established theory and research on changing health behaviour (Glanz & Rimer, 1997).²⁵ The section below details some of the major theories the strategy will draw on.

²⁵ Glanz, K. & Rimer, B.K. (1997), Theory at a Glance: A Guide for Health Promotion Practice. US Dept. of Health and Human Services Public Health Service, National Institutes of Health, Washington, DC.

Social Cognitive Theory

Social Cognitive Theory (SCT) describes a dynamic, ongoing process in which personal factors, environmental factors and human behaviour interact and exert influence upon each other. According to SCT, three main factors affect the likelihood that a person will be motivated to change a behaviour: (1) self-efficacy, (2) goals, and (3) outcome expectancies. Self-efficacy, in the case of improving adolescent nutrition and physical activity, refers to an individual's belief, based on knowledge of benefits and presence of a supportive system, that he or she is capable of deciding to a) consume a healthier diet and b) engage in physical activities available in school and in the community.

Communication programmers tend to consider self-efficacy a cornerstone of most communication activities because of the many studies demonstrating the link between an individual's self-confidence that they can achieve a behaviour and feeling empowered to actually practise the behaviour (for examples, see Bandura, 1977, 1997, 2001, 2004; Glanz, Rimer, & Su, 2005). If individuals have a sense of personal agency or self-efficacy, they can change behaviours even when faced with obstacles. If they do not feel that they can exercise control over their behaviour, they are not motivated to act, or to persist through challenges.

A key component of SCT is the presence of role models and peer mentors who provide guidance to the individual for the appropriate behaviour through their own behaviour. This is a reason SCT is used extensively in edutainment programmes, in which characters in the story adopt particular behaviours as either positive role models or as negative examples. The application of SCT also suggests that individual behaviour and environmental factors influence one another dynamically. This implies that small changes in individuals within communities, such as those adolescents who decide to eat healthier diets, engage in regular exercise or delay marriage, can lead to significant environmental changes, which in turn can influence changes in others' behaviour that can lead to social (norms) change.

Social Cognitive Theory when applied to gender provides an understanding of how gender conceptions or roles, identity and relationships are constructed and maintained through the life course. Gendered scripts are a product of a broad range of social influences and motivation operating interdependently within the social system. Several constructs of SCT apply to gender roles and norms. For example, how girls and boys behave or what is considered acceptable behaviour is largely learned through modelling. Adolescents learn observationally from how their peers, parents, families, teachers and others around them. They also model behaviours based on what they see on media. Ideas about body image where boys need to be muscular and girls should be slim are good examples of observationally learned values. Alternatively, when boys role model cooking and eating healthy meals or girls role model physical exercise, new scripts are created. Gender norms are maintained by social sanction or judgement are also closely linked to behavioural outcome expectations. Actions that may bring on negative sanctions may be harder to adopt, such as motivation can also serve as cue to change behaviour or to follow behavioural expectations. If a child receives positive reinforcement when they behave in a certain way, they are likely to continue that behaviour. Likewise, if they receive negative reinforcement they are likely to stop that behaviour. This has implications on how adolescent girls and boys practise the recommended behaviours. Girls may not be encouraged to exercise, and boys may not be encouraged to eat meals with the family or spend more time at home.²⁶

²⁶ Bussay, K. & Bandura, A. (1999), Social cognitive theory of gender development and differentiation, Psychological Review, 106, 4, 676–713.

Stages of Change Theory or Transtheoretical Model

The Stages of Change Theory, also known as the Transtheoretical Model, suggests that behaviour change occurs when individuals move through a series of stages of varying levels of readiness to alter their behaviour. The model is comprised of five stages that represent incremental increases in preparedness to change: (i) precontemplation – the individual is unaware of the consequences of their behaviour and resistant to change; (ii) contemplation – the individual is aware of the consequences of their behaviour and open to change; (iii) preparation – the individual shows anticipation and willingness to change within the next six months; (iv) action – the individual is in the process of changing their behaviour and shows enthusiasm and momentum; and (v) maintenance – the individual has sustained the new behaviour for more than six months and shows perseverance in maintaining the change (see Prochaska and DiClemente, 1983; Prochaska and Velicer, 1997; and Glanz, Rimer, Viswanath, 2008).^{27,28,29}

According to this model, change occurs as an ongoing process as people move closer to adopting the desired practice. People are at different stages of change and interventions or messages need to be tailored to where people are in the process. Some people may not go through all the steps in a sequential process, and could skip some steps, others may relapse but do not necessarily need to start all over again. The Transtheoretical Model has been applied to a range of health and nutrition behaviours.

²⁷ Glanz, K., Rimer, B. K., Viswanath, K. (2008), Health Behaviour and Health Education: Theory, Research and Practice (4th Edition), Jossey-Bass, San Francisco.

²⁸ Prochaska, J. and DiClemente, C. (1983), Stages and processes of self-change in smoking: toward an integrative model of change, *Journal of Consulting and Clinical Psychology*, 5, 390–395.

²⁹ Prochaska, J. and Velicer, W. (1997), The transtheoretical model of health behaviour change, *American Journal of Health Promotion*, 12, 38–48.

CHAPTER 3. SBCC THEORY OF CHANGE, GOAL AND OBJECTIVES

SBCC Theory of Change for improving adolescent nutrition and physical activity

The Theory of Change was developed using an SEM lens to illustrate how SBCC interventions will contribute to achieving impact, programme and communication goals and objectives.³⁰ In the context of adolescent nutrition goals and objectives, SBCC interventions can help achieve the most impact when adolescent girls and boys are engaged and empowered as individuals, as family, as students, as community members, as media consumers and as beneficiaries of adolescent-focused nutrition policies, programmes and services. Using this theoretical construct will guide planning, implementation and monitoring towards the intended behaviour change results/goals linked to intermediate outcomes, emanating from outputs, interventions and inputs (see Figure 11).

SBCC goal

Every C4D/SBCC strategy requires a clear, overarching goal. This SBCC strategy aims to harness the power of communication to contribute to improving the nutritional well-being and physical fitness of adolescents in Indonesia. The strategy takes aim at the triple burden of malnutrition, addressing both under and over nutrition and preventing anaemia, by promoting knowledge of the importance of good nutrition and physical activity as well as building skills, capacities and self-efficacy among adolescents to adopt healthier food choices and take up more physical activities.

The SBCC Theory of Change states the goal as to **“Empower adolescents, girls and boys, with knowledge, values, self-confidence and skills to adopt healthy dietary practices and physical fitness activities of their choice.”** The strategy is also designed to engage families, community level influentials, local service providers such as teachers and health workers, and policymakers to support positive health and nutrition among adolescents. The communication goal will be achieved through the following outcomes:

- Adolescents practise healthy eating habits and physical exercise;
- Parents encourage healthy eating and physical fitness exercise for adolescents;
- Influentials support healthy eating and physical exercise among adolescent boys and girls;
- Providers promote adolescent-friendly and gender-responsive nutrition and health education and counselling;
- Policymakers endorse adolescent nutrition policies and programmes.³¹

³⁰ The design of this SBCC Theory of Change on Improving Adolescent Nutrition (see Figure 11) was adapted from the draft C4D Theory of Change for the 2018–2021 UNICEF Strategic Plan shared by C4D Section, UNICEF NYHQ, October 2016.

³¹ Outcome 5 focusing on policy level changes (in blue in Figure 10) will be ongoing as policy changes take time and are likely to go beyond the strategy timeline.

SBCC objectives for adolescent nutrition and physical activity

Breaking down the overarching goal into specific communication objectives, the strategy proposed here details the desired changes in knowledge, attitudes and practices expected among the various participant groups. These objectives need to take into account barriers and motivators that can hinder or enable the adoption of desired behaviours. Typically, communication objectives are categorized by a) what people 'know' (cognitive changes); b) what people 'feel' (affective changes); and c) what people 'do' (behavioural changes). In the case of adolescent nutrition, it is well known that poor knowledge of good nutrition as well as lack of motivation to opt for more nutritious food choices are barriers to practising healthy eating. So people need to 'know' about healthy foods, they need to 'feel' it is important or beneficial to consume these foods, and ultimately they need to act on the knowledge and consume these foods (the 'do' aspect).

The communication objectives articulated in this strategy inform the choice of activities, key messages and training content that will be implemented. Communication objectives are also important for the M&E of the strategy, as they form the basis of measurable indicators. Based on an analysis of the barriers to adolescent nutrition and fitness provided in Chapter 1, Table 4 presents the communication objectives (which translate to the outputs in the Theory of Change). These objectives will be formulated into measurable indicators in Chapter 7, Monitoring and Evaluation Plan.

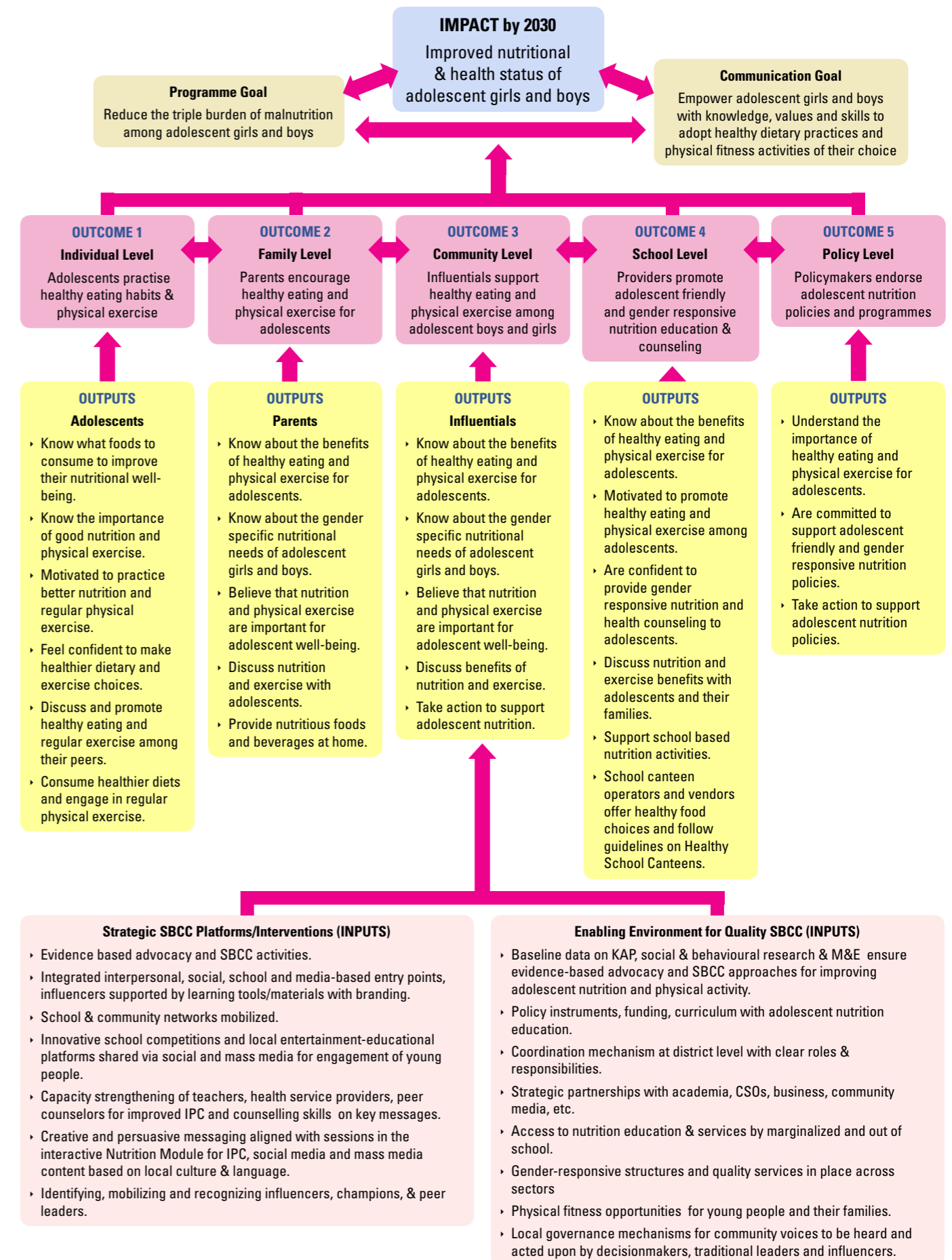
Table 4. Communication barriers and behaviour change objectives

Barriers	Behaviour change objectives/outputs
Individual level	
<ul style="list-style-type: none"> ▸ Limited knowledge of nutritious foods, including misperceptions and myths of certain foods. ▸ Consumption of a high carbohydrate diet and lower intake of proteins, vegetables and fruits. ▸ Sedentary lifestyle, more so in the case of girls. ▸ Preference for packaged snack, highly processed foods and sugary beverages. ▸ Influence of peer preferences and perception of fast foods as 'cooler.' ▸ Lack of motivation to adopt healthier food and lifestyle choices. ▸ Attitudes towards physical exercise. ▸ Smoking among boys. ▸ Body image issues that motivate boys to be big and strong and girls to be skinny. 	<ul style="list-style-type: none"> ▸ Adolescents know what foods to consume to improve their nutritional well-being. ▸ Adolescents know the importance of good nutrition and physical exercise. ▸ Adolescents are motivated to practise better nutrition and physical exercise. ▸ Adolescents feel confident to make healthier dietary and exercise choices. ▸ Adolescents discuss and promote healthy eating and exercise among their peers. ▸ Adolescents consume healthier diets and engage in regular physical exercise.

Barriers	Behaviour change objectives/outputs
Family level	
<ul style="list-style-type: none"> ▸ Limited knowledge of nutritious foods, including misperceptions and myths of certain foods. ▸ Adolescents lack support from family and friends to adopt healthy eating and physical exercise. ▸ Fewer home based or family shared meals, more so in the case of boys. ▸ Gender norms that restrict girls' mobility and free time. ▸ Traditional beliefs that restrict foods for girls and women during menstruation and pregnancy. 	<ul style="list-style-type: none"> ▸ Parents know about the benefits of healthy eating and physical exercise for adolescents. ▸ Parents know about the gender-specific nutritional needs of adolescent girls and boys. ▸ Parents believe that nutrition and physical exercise is important for adolescent well-being. ▸ Parents discuss nutrition and exercise with adolescents. ▸ Parents provide nutritious foods and beverages at home.
Community level	
<ul style="list-style-type: none"> ▸ Limited knowledge among the general public on nutrition in general and adolescent nutrition in particular. ▸ Gender norms that restrict girls' mobility and free time. ▸ Gender norms that accept boys working and spending time away from the home. ▸ Limited engagement of community influentials to support optimum nutrition and physical activity. 	<ul style="list-style-type: none"> ▸ Community influentials know about the benefits of healthy eating and physical exercise for adolescents. ▸ Community influentials know about the gender specific nutritional needs of adolescent girls and boys. ▸ Community influentials believe that nutrition and physical exercise are important for adolescent well-being. ▸ Community influentials discuss benefits of nutrition and exercise. ▸ Community influentials take action to support adolescent nutrition.

Barriers	Behaviour change objectives/outputs
School level	
<ul style="list-style-type: none"> › Limited knowledge about adolescent nutrition. › Limited availability of healthy food options in/ around school. › Lack of adolescent-friendly and gender-responsive health and nutrition counselling. › Lack of healthy food choices in school canteens and around schools. 	<ul style="list-style-type: none"> › Know about the benefits of healthy eating and physical exercise for adolescents. › Are motivated to promote healthy eating and physical exercise among adolescents. › Are confident to provide gender-responsive nutrition and health counselling to adolescents. › Discuss nutrition and exercise benefits with adolescents and their families. › Support school-based nutrition activities. › School canteen operators and vendors offer healthy food choices and follow guidelines on Healthy School Canteens.
Policy level	
<ul style="list-style-type: none"> › Low awareness of or interest in nutrition in general and adolescent nutrition in particular among decisionmakers. › Absence of adolescent nutrition education in school curriculum. 	<ul style="list-style-type: none"> › Understand the importance of healthy eating and physical exercise for adolescents. › Are committed to support adolescent friendly and gender responsive nutrition policies. › Take action to support adolescent nutrition policies.

Figure 11. A Theory of Change on SBCC for improving nutritional status of adolescent girls and boys in Indonesia



Participant audience groups for improving adolescent nutrition

Identifying and prioritizing the population groups to be reached and empowered is crucial to any SBCC strategy. Three broad categories of participant audience groups – primary, secondary and tertiary – were identified for the SBCC strategy and are aligned with the SEM model. Calling them primary, secondary and tertiary is a matter of convenience and does not reflect a hierarchy of importance, as these groupings are of equal and vital importance. They are groupings that allow us to focus strategic SBCC approaches, specific interventions and to formulate appropriate messages to obtain the greatest impact (see Figure 12).

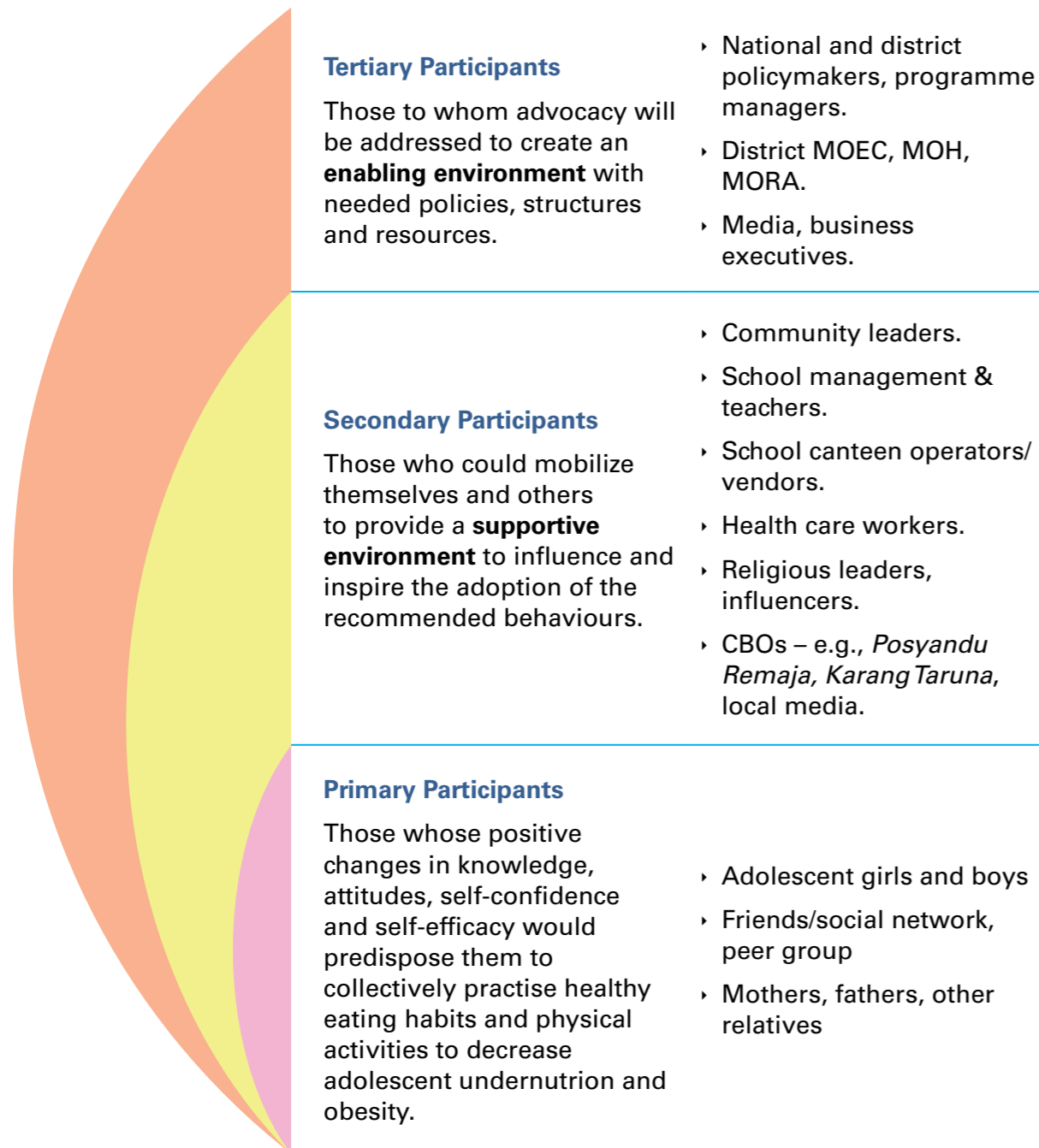
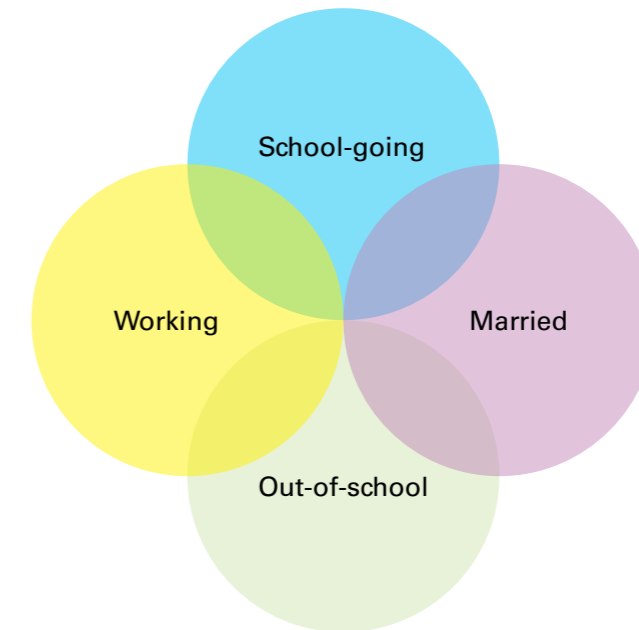


Figure 12. Three categories of participant groups for the SBCC strategy

Adolescents: Primary participant audience group

Adolescents in the two pilot districts were the primary participant group for SBCC interventions. They were grouped further according to these categories: school-going, out-of-school, married/pregnant, and employed. Figure 13 illustrates the overlap of these categories of adolescents; i.e., some school-going adolescents may be married and working, and likewise for out-of-school adolescents.

Figure 13. Categories of adolescents for nutrition-specific and nutrition-sensitive SBCC interventions



For engagement in SBCC activities, these adolescents may be further categorized in terms of age group and school level, sex, language, ability/disability, socioeconomic status, religious and ethnic background, and whether they live in rural, peri-urban or urban areas. These factors may signal whether they have high or low access to education, information and media resources, health and nutrition facilities and services and opportunities for livelihood, social and economic upliftment. Types of schools – public, private, religious, etc. – should also be taken into account to get the most traction for the variety of interventions envisaged with school-going adolescents.

For this programme, parents and immediate family members are considered among the key secondary participant or audience group. Their support and engagement are crucial to ensuring improved nutrition among adolescents. Parents will need to enhance their knowledge of the importance of optimum nutrition and exercise for adolescents in order to be able to model and encourage healthy eating and physical activity. They will also need to be sensitized on the differences between the nutritional requirements of girls and boys and how to overcome gendered beliefs or practices that might hamper children's nutritional well-being.

Secondary participant audience group

Secondary participants include school management, teachers and health service providers, school canteen operators and peer counsellors. As part of the school-based initiatives, teachers trained in facilitating the *Aksi bergizi* Nutrition Education Module will need to be mobilized to become allies for adolescent nutrition. Likewise, school canteen operators need to be reoriented on the available Healthy School Canteen Guidelines. Trained peer counsellors and teacher-health care providers assigned in the school health unit or UKS as well as those in subdistrict or *puskesmas* and community health posts or *posyandu* will be critical in ensuring consistent and quality nutrition education and counselling. They will all be major players in mainstreaming adolescent nutrition into the Food and Nutrition Action Plan, the Adolescent Health Policy and overall, the government's Health and Nutrition Programme.

Tertiary participant audience group

A conducive policy environment is essential for enabling improved nutrition among adolescents. Advocacy efforts will be required to gain the support and buy-in of policymakers and programme managers.

CHAPTER 4. STRATEGIC APPROACHES

Building blocks of the SBCC strategy on adolescent nutrition

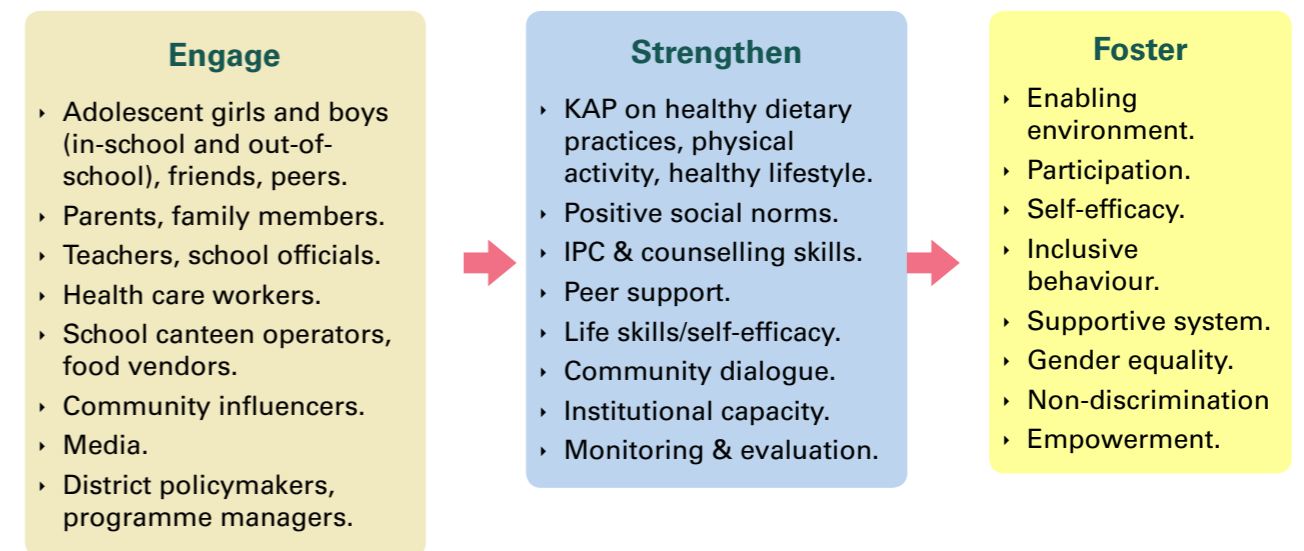
Specifically, SBCC on adolescent nutrition aims to influence social and behaviour change among adolescents to improve their eating habits and increase physical activity. Social and behaviour change interventions will involve engaging with adolescents, their families and other key stakeholders in schools and communities; strengthening capacities and confidence; and fostering an enabling environment; i.e., one that promotes participation, inclusion, meaningful dialogue and positive actions towards self-efficacy and empowerment.

Figure 14 illustrates the building blocks of the SBCC strategy. SBCC will specifically engage adolescent girls and boys, their parents, other family members, their social networks, teachers and school officials, food vendors and canteen operators, health care workers in health facilities, community and religious leaders, and communities at large to promote, be role models of and champions for adolescent nutrition and health.

SBCC offers strategic approaches designed to strengthen capacities such as knowledge, positive attitudes and actions towards maintaining healthy diets and physical activity. Beyond diet and fitness, the strategy also aims to strengthen interpersonal communication and decision-making skills of adolescents, teachers, health workers and community level influencers.

Ultimately, the engagement and enhanced capacities would foster an enabling environment for participation in nutrition-specific and sensitive activities, leading to self-efficacy, inclusive behaviour that promotes a supportive system with peers, that is gender responsive and non-discriminatory, leading toward sustained actions to improving adolescents' nutritional status, i.e., healthy eating habits, regular physical activities and responsible behaviours that would impact intergenerational well-being.

Figure 14. Building blocks of the SBCC strategy



Establishment of the district task force on adolescent nutrition as programme implementer

The SBCC strategy requires programme implementers and supervisors at the district level. A district task force on adolescent nutrition can be formed to act as the programme implementer and supervisor, consisting of members of the district school health programme (Usaha Kesehatan *Sekolah* or UKS) committee and other related institutions such as health workers at the *puskesmas* who are responsible for adolescent nutrition and health programmes. The district task force can be led by the health or education sector and include nutrition-sensitive sectors such as social welfare, religious affairs, domestic affairs and agriculture, as well as representatives from the media and academia, etc.

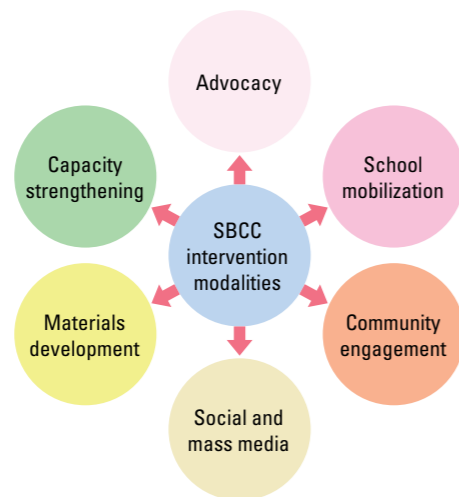
The aim of establishing the District Task Force is to improve coordination at the district level and multisector cooperation. Multisector coordination and regular meetings need to be carried out by the Task Force in order to carry out related policy advocacy, including planning and budgeting, formulating priority SBCC activities in districts, carrying out activities in schools and communities, as well as conducting facilitative supervision, monitoring and reporting of activities.

SBCC activities can be part of UKS activities in districts, both at the community and school level, by dividing the roles and responsibilities of the UKS committee and other stakeholders at the district, subdistrict or health centre and education unit levels. At the school level, teachers and students can form a school committee for *Aksi bergizi* or a school committee for adolescent nutrition to be able to carry out activities at the school level.

Strategic SBCC approaches to engage, strengthen and foster

The proposed SBCC strategy will address the triple burden of malnutrition among adolescent girls and boys by using multiple mutually reinforcing approaches. The strategic approaches will target different levels of the SEM: advocacy to address the policy level, social mobilization to address organizational and community level change (in schools and with service providers), and social and behaviour change for individual and interpersonal and community level change. The social and behaviour change component has been further broken down into school and community engagement, materials development, and social and mass media. For the purpose of this initiative, we refer to these approaches as intervention modalities (see Figure 15). These intervention modalities correspond to the components of the implementation plan (see Chapter 6).

Figure 15. SBCC intervention modalities for improving adolescent nutrition



SBCC intervention modalities and milestones

Six SBCC intervention modalities are proposed with suggested indicative milestones (in blue). Each modality includes several interventions that address some of the barriers and challenges that impede adolescents from practising optimum nutrition and adequate physical activity and build on opportunities that can be addressed through SBCC. These milestones/interventions will be further detailed as activities in the implementation plan (see Chapter 6). Activities will then be vetted for their acceptability and feasibility in different district and school contexts.

The proposed list of interventions is offered as a smorgasbord of ideas or a menu of choices that participating schools and communities may choose from. Implementation of selected activities for a one-year period will be part of the follow-up action plans of the teachers and students who have received the training of trainers on the Nutrition Learning Module or *Aksi bergizi* Module. Under the oversight of the District Task Force, the respective student councils and *Aksi bergizi* teachers will determine what activities would resonate with the students; i.e., which mix of interventions are achievable in the given time frame, according to their respective contexts.

Advocacy



Signing of commitment to implement *Aksi Bergizi* programme in Lombok Barat district

Advocacy can be undertaken by the UKS Advisory Team or the district task force. Advocacy efforts will aim to influence district level policymakers, officials and media to garner commitment for adolescent nutrition. Advocacy with local media and social media users will also promote public attention towards the issues preventing adolescents from practising optimum nutrition and exercise by creating a media buzz. Advocacy is important for initiating school policy changes (e.g., improvement of school canteen offerings and creating relevant guidelines).

C4D or SBCC is pivotal in bringing the voices and perspectives of students, teachers, school management and community stakeholders to the policy dialogue. For this strategy the advocacy component will include the following:

- Advocacy tools developed.
- *Aksi bergizi* Brand Ambassadors selected based on established criteria.
- Media sensitization conducted.
- *Aksi bergizi* public awareness campaign implemented.
- District level task force formed.

Advocacy tools for policymakers: Advocacy tools developed for national and subnational policymakers, school management, media and private sector to raise awareness about the triple burden of adolescent malnutrition. These tools will include facts as well as adolescent perspectives and be presented at the highest level – President, parliamentarians, BAPPENAS – (policy briefs, infographics, multimedia packages on, for example, rationale for urgency to address adolescent nutrition, data profiles, economic cost). The tools will highlight the need for gender responsive national guidelines on adolescent nutrition including updating healthy canteen guidelines.

Aksi bergizi Brand Ambassadors: Aksi bergizi Ambassadors selected based on suggestions from adolescents and endorsement by partners. These may include popular icons in music or theatre, sports personalities as well as local level celebrities. For instance, the students in a junior high school in Klaten identified fellow students who compete nationally in swimming, table tennis and karate, respectively. These ambassadors or champions will promote adolescent nutrition and fitness and provide high level endorsement to the efforts. Suggestions for national and local celebrities who are popular with adolescents will be elicited from students and teachers. Male and female role models should be selected, including those who may be able to promote alternative gender roles; for example, female sports personalities or male chefs.

Media sensitization and training of journalists/broadcasters: Sensitization and training of media practitioners conducted through media events, lunch forums and roundtables to orient the media on issues related to adolescent nutrition. In addition, adolescent leaders may be invited to meet and brief telecoms and media executives, producers, journalists, broadcasters, bloggers and applications developers to generate support and together develop innovative ideas to promote nutrition and physical exercise. Gender sensitization should also be conducted for media professionals to promote gender transformative materials and avoid reinforcing negative gender stereotypes.

Public awareness campaign: Aksi bergizi public awareness campaign implemented to trigger public attention, promote the key messages on adolescent nutrition and create buzz. The Aksi bergizi brand can be promoted through a catchy jingle across different media platforms. Public service announcements (PSAs), spots and plugs may be developed for radio and television and also shared through the internet and social media. The audiovisual component can be reinforced with Aksi bergizi branded print and outdoor media such as posters, billboards, banners, standees. The campaign should highlight the gender differences in adolescent nutrition including the barriers that may prevent girls and boys from adopting healthier choices.



The launching of Aksi Bergizi programme in Klaten district

School mobilization

The primary focus of mobilization for this strategy will be in schools, with support from the UKS committee or District Task Force. The school mobilization component will be intrinsically linked to the existing school-based initiatives; i.e., IFA supplementation and the Aksi bergizi nutrition education module. Teachers, particularly those overseeing the UKS programme, physical education and science, along with school management will be responsible for ensuring that these school-based activities are organized and sustained.

Once again, several options for activities are provided, as a menu for schools and adolescents to choose from. Students in different schools may decide to engage in different activities following a common framework which includes awareness-raising, participation, discussion and sharing with a friend. Every school running the Aksi bergizi nutrition learning module could be required to conduct a minimum of 2–3 school-based activities. The schools can also become a place where students, their families, local leaders and community-based groups come together for a common cause. The school mobilization will include the following:

- School competitions held
- Cooking demonstrations organized
- School garden programmes initiated
- Tell a friend initiative modelled
- Recognitions and rewards instituted
- Physical activity organized.

School competitions: Various school competitions organized to promote better nutrition and increased physical activity among adolescents. These could include essays, quizzes, drama, photography, arts, dance, aerobics and theatre. It is important that students are encouraged to choose which competitions they wish to be engaged in rather than enforce a prescriptive list of contests. These competitions can start off as intra-school activities and expand to become inter-school competitions. Options can include quizzes, essay writing, poetry or jingle compositions among junior and senior high school students. Teachers can facilitate and orient students in writing essays on given themes; e.g., around their dreams for the future and how nutrition and physical activity can help achieve their goals. Winners will be featured in the local media to create additional buzz. Both girls and boys should participate, and they should be encouraged to consider the gender differences or barriers to better nutrition or more physical activity and how these can be overcome. Partnerships can also be established with local businesses and the food industry to sponsor prizes or recognition schemes. Likewise, photography/videos, posters, mural-painting competitions can be organized. The visuals may be further disseminated through mass and social media (e.g., YouTube or Instagram). Students can be engaged in fun activities such as schoolyard theatre, dance or aerobics and parents or community members may also be invited to join. Local theatre and visual/performing arts groups can be engaged to draw out artistic potential among adolescents through content creation; e.g., in crafting drama scripts, traditional art forms and artistic presentations that incorporate key nutrition-specific and nutrition-sensitive messages.

Cooking demonstrations: Cooking demonstrations/contests organized in schools as part of annual celebrations (e.g., school anniversary or national nutrition day). Cooking demonstrations by students, parents, canteen operators and local food providers or chefs should showcase nutritious recipes – drawn from national, local or international culinary traditions – made from locally available food ingredients. At the end of the year, students could compile the recipes into a booklet to be shared with their families. Boys and fathers should also be encouraged to participate, not just the girls. Additionally, partnerships could be established with local media such as TV



Adolescent girls and boys are joining cooking competition at school

channels to include youth segments in popular on-air cooking shows or highlight celebrity chefs as champions of adolescent nutrition. Another possible partnership to be considered is linking with the youth movement known as Masak Akhir Pekan, or 'Cooking on the Weekend', which aims to engage young people and raise awareness of agriculture, food production and preparation, while also celebrating the diversity of Indonesian cuisine.

Physical activity: Physical activities at school can be in the form of aerobics, dance challenges such as Dance4Life³² and TikTok, Zumba, hip-hop, etc., which are recognized and preferred by adolescents. OSIS together with physical education teachers can raise funds and organize these initiatives in schools and can invite coaches to train students in dancing, Zumba and other physical activities through extracurricular funds at school.

School gardens: School gardens initiated and student gardeners oriented and recognized for their extracurricular participation. Schools that were visited in both pilot districts had ample space and some were already initiating a small-scale vegetable garden. These incipient efforts can be scaled up and organized to further engage students and their families. Sponsors from local business groups could support this kind of school project. A school event could be organized to share the produce from the school garden and use the venue to promote key nutrition and physical exercise messages. This component can benefit from partnering with the Ministry of Agriculture and their pilot school-garden initiative and, if possible, inviting agricultural extension workers to talk and teach programmes in schools.

Tell a friend: Tell a friend programme modelled in schools. Each student who has attended the nutrition learning module sessions will be encouraged to share the information they have learned with a friend (or friends), family or community member either in person or through social media platforms. The tell a friend initiative will encourage organized diffusion of key messages through existing social networks.

Recognitions and rewards: Recognition and reward schemes instituted in schools for student participation and excellence in Aksi bergizi school-based activities. Awards may be given to student winners, champions, role models and peer mentors during annual school functions or district or community celebrations and festivals. Stories of winners, champions and innovators can be further shared through local and social media.

Community engagement

Engaging communities and fostering participation is a critical part of any SBCC initiative. Satgas Remaja engages stakeholders at the community level to organize themselves, voice their perspectives and make decisions that are locally suited and contextualized, and is both empowering and sustainable. Community engagement builds on the strength of social networks and interpersonal communication channels. Agents of change can further trigger community engagement and influence local level support for adolescent nutrition. The community engagement component will include the following:

- Posyandu Remaja dan Karang Taruna.
- Mengadakan sesi untuk meningkatkan pengetahuan dan kesadaran masyarakat
- Menyelenggarakan acara-acara di masyarakat.

³² Dance4Life by RutgersWPF Indonesia: <https://www.rutgers.id/program/dance4life> and the video on YouTube: <https://www.youtube.com/watch?v=vOLGE9CdkZs>

Posyandu Remaja: Youth volunteers at village health posts and members of Karang Taruna oriented to promote Aksi bergizi messages and physical activities. Orientation will also contain a component on interpersonal communication and counselling and gender equality. Adolescents supported by the head of village, Karang Taruna (youth groups) organization and Community Health Volunteer of Posyandu Remaja may invite local sponsor and private donation to provide tools, logistics, healthy snacks as an incentive for adolescents attending Posyandu Remaja. The head of village may invite a mentor to provide adolescents with physical activity trainings.

Awareness raising sessions: Schools will conduct awareness-raising sessions for parents, local leaders and food vendors. For out-of-school adolescents, Posyandu Remaja will conduct sessions and generate discussion among parents and local stakeholders. These sessions can also be a platform to identify, mobilize and recognize family and community influencers, champions and role models for adolescent nutrition. The challenges and opportunities for better nutrition and increased physical activity for girls and boys should be highlighted in the sessions.

Community events: Community events organized to promote adolescent nutrition and celebrate nutrition-specific and nutrition-sensitive annual observances in schools and communities. These events will create a buzz at the local level and highlight the role of families and communities in supporting adolescent nutrition. The challenges and opportunities for better nutrition and increased physical activity for girls and boys should be highlighted during the events. The Kepala Desa (village head) and the Karang Taruna can be mobilized to organize these events and join hands with other community influencers. Some form of recognition ceremony or certificates to recognize role models or change agents can be included.

Some suggested observances are:

National:

- National Nutrition Day on 25 January.
- Independence Day on 17 August.
- Indonesia Scout Day on 14 August.³³
- Youth Pledge Day on 28 October.
- National Health Day on 12 November, led by MOH.

International:

- World Health Day on 7 April.
- International Youth Day on 12 August.
- World Food Day on 16 October.



A school parade to promote nutrition messages

³³ August is a special month for Indonesians. It is also the second month after the new school year starts. The students have opportunities to celebrate events in school as they are not yet busy with exams or assignments.

Capacity strengthening

Capacity strengthening efforts will focus on building interpersonal communication (IPC) and nutrition counselling skills among adolescents as nutrition peer counsellors, local health service providers and influentials. Orientation sessions will be held for specific groups who in turn will serve as change agents and promote nutrition messages to their peers and community networks both individually on an as needed basis and through organized group sessions. The orientation module will include information on key messages as well interpersonal communication, especially communicating with adolescents and counselling suggestions to ensure inclusive and gender responsive outreach. For this strategy, the capacity strengthening component will be geared towards the following:

- › Peer Counsellors trained.
- › Health *kaders* trained.
- › Religious leaders oriented.
- › School canteen operators sensitized.



A training of adolescent peer support groups for Aksi Bergizi programme

Peer Counsellors: Peer counsellors trained and engaged in adolescent nutrition and interpersonal communication. Invite SMP and SMA student council members and volunteers to train as nutrition peer counsellors from junior and senior secondary level under the teacher who leads lessons on the *Aksi bergizi* nutrition learning module. They should also be oriented on gender and should understand the differences faced by girls and boys to adopt better nutrition and physical exercise. According to their availability, engage nutrition peer counsellors in UKS/school health unit and in their respective *Posyandu Remaja*, *Karang Taruna* or *Forum Anak*, as the case may be. These peer counsellors can

also play a decision-making and organizing role for school-based activities and serve as intermediaries for both school- and community-based nutrition promotion and physical activities. They should be encouraged to challenge prevalent gender norms that impact adolescent nutrition and well-being. In addition, they can liaise with the local media and promote stories of champions and role models as well as translate key messages into creative, catchy content on anaemia prevention, healthy dietary practices and physical activity suited to their local context.

Health workers and health volunteers or *kaders*: Health workers and health cadres/volunteers trained on adolescent nutrition and conducting outreach efforts. The training should include content on the gendered aspects of nutrition and physical exercise that may influence adolescent girls and boys. These trained health volunteers conduct monthly maternal and child health and nutrition monitoring, promotion and counselling in their village health post or *posyandu*. Community Health Volunteers or *Kaders* will be engaged and given orientation to promote *Aksi bergizi* messages to extend their health and nutrition

promotion to the marginalized and vulnerable adolescents in their villages, particularly those who are out of school, already married or are working.

Religious leaders: Religious leaders oriented on adolescent nutrition and incorporating *Aksi bergizi* messages in their teaching. The training should include content on the gendered aspects of nutrition and physical exercise that may influence adolescent girls and boys. As faith leaders, they play an important role in offering counsel and promoting health and nutrition to worshippers. They can reinforce what is taught in schools and promoted in health care facilities and encourage demand for services provided in the *posyandu* and *puskesmas*. Religious leaders will be encouraged to promote *Aksi bergizi* to their congregation through orientation and a booklet of key messages that are linked to the scriptures.

School canteen operators: School canteen operators sensitized and mobilized to support adolescent nutrition. The training is conducted by teachers or health workers who are part of the District Task Force. The training should include content on the gendered aspects of nutrition and physical exercise that may influence adolescent girls and boys. To nudge students to make more healthy food choices and to develop healthy eating habits, it is important that the school food environment is healthy. Students and teachers will play an active role in ensuring healthy and nutritious foods are available in their school canteens and school premises (food vendors) and promoting recommended *Aksi bergizi* actions based on key messages.

Social and mass media

Social and mass media will serve as an important vehicle to promote key messages as well as adolescent participation. The proliferation of digital technology in Indonesia and the popularity of social media among adolescents makes it a suitable platform for both dissemination of messages and dialogue generation. Gender differences should be considered and accounted for when social and mass media interventions and messages are developed. Evidence suggests that behaviour change interventions that use digital platforms in conjunction with non-digital platforms such as health education, goal-setting, self-monitoring and parent involvement can produce significant improvements in the dietary and physical activity behaviours of adolescents (Rose et al., 2017). The social and mass media component will include the following:

- › Media training for adolescents conducted.
- › Social media messaging (Instagram, WhatsApp, Line, YouTube, Facebook) utilized.
- › Nutrition portal/apps for adolescents developed.
- › Local champions for nutrition promoted through media.

Media training: Media training for adolescents conducted. Potential mentors from media and creative arts groups will be invited to offer short trainings for interested students in the following: scriptwriting, short video production, visual arts, performing arts, theatre arts, etc.

Social media messaging: Social media messaging utilized through channels such as Instagram, WhatsApp, Line, YouTube and Facebook. Adolescent students could take part in social media-based networking (Instagram, Twitter, Facebook, etc.) and two-way chatting



Lomba Aksi Bergizi di sekolah di Kabupaten Klaten

(WhatsApp, Messenger, etc.); e.g., by posting a group physical activity they participate in, or showing their 'colourful plate' and by inviting their friends to join. They will post their physical activities, share photo-stories with schoolmates and invite participation to create a snowball effect.

Social media could also be used to showcase adolescents' stories of change in digital audio and short video formats using their smartphones. Train students in scriptwriting, photography, short video production and editing through OneMinutesJr.³⁴ workshops to produce short films on their stories of learning, sharing and change. Another option is to engage students in crowd-sourcing in which they contribute to the continuation of a story initiated by a peer counsellor, student leader or Brand Ambassador via social media, through tutorial vlog challenges³⁵ on nutritious recipes, innovative storytelling that contain elements of romance, drama and comedy, group physical activities, or motivational quotes on nutrition and physical activity.

UKS/M or School Health Programme or adolescent nutrition portal/apps: [A UKS/M or School Health programme or adolescent nutrition website or application developed, accessed and used by students and teachers, UKS/M advisory team, partners, media and other relevant stakeholders.](#) This will provide one stop access to relevant adolescent-friendly and gender responsive information on UKS programme, health, nutrition and fitness and will also include an interactive component allowing for sharing, discussion and updates. The interactive digital infrastructure – website and/or application – dedicated to adolescent nutrition information can also be used to share creative content, stories, images, videos, texts, promising practices.

Local champions: [Local champions for nutrition promoted through media – social and mass.](#) Role model adolescents, their parents/families and teachers featured via social media, broadcast and print media programmes that showcase their innovative ideas, stories of change and proposals to improve quality of school snacks and meals, in food production, preparation, sale and intake of diverse, locally available nutritious foods, and sharing fun activities that boost physical fitness among their peers. Advocate with popular sports shows to promote physical activity among adolescents. Sports stars can be identified as healthy adolescent lifestyle role models and champions. Male and female role models should be selected, including those who may be able to promote alternative gender roles; for example, girls or women who are leading local exercise or Zumba groups or boys and men who are helping prepare healthy meals.

³⁴ OneMinutesJr. is a video initiative that highlights and celebrates the diversity among youth around the world. Workshop participants produce videos of 60 seconds that are positive and powerful examples of the way visual arts works as a communication tool across cultural, geographic and national borders. See: https://www.unicef.org/videoaudio/video_42432.html

³⁵ Human Centered Design for Digital Adolescent Health (2018), Co-ideation, prototyping and concept testing results, Final report and Powerpoint presentation to UNICEF Indonesia, November 22, 2018.

Materials development

Communication materials aimed at specific participant groups will be required to reinforce the nutrition modules and provide content for the mass and social media components. These materials need to tailor the nutrition messages and technical content into a user-friendly format. It is important to solicit inputs and feedback from the users themselves to ensure the content is clear, relevant, credible and useful. The format and content should be pretested with both girls and boys as well as women and men. The materials, messages and products should not reinforce negative gender stereotypes and where possible should challenge negative gender norms related to nutrition. For example, girls could be portrayed as engaging in physical activities outside the house and boys could be shown helping to prepare healthier meals at home. Fathers could be shown shopping for healthier foods.

Materials development will include the following:

- ▶ Photo novellas by and for adolescents developed
- ▶ Guides for religious leaders and other community influentials created
- ▶ Information booklet for parents developed.

Photo novellas for adolescents: [Photo novellas by and for adolescents developed and disseminated.](#) Information on the key messages can be incorporated in a youth friendly and engaging format such as photo novellas. Adolescents tend to prefer visuals over text-heavy materials and comics are popular among the age group. Design of the storyline and illustrations can be led by adolescents, capturing their realities and potential solutions for better nutrition. Professional writers and illustrators or photographers can train adolescents in creative writing and illustration and facilitate the material development process.



Adolescents are having discussion on their daily food choices

Guides for religious leaders and community influentials: [Guides for religious leaders and community influentials created and used as tools for interpersonal outreach and counselling.](#) Local level influentials and religious leaders will require a concise and simple guide to facilitate discussion. Religious leaders in Lombok Barat have already been mobilized to promote health messages that are adapted and contextualized to the Quran or Bible and are offered in a pocketbook format. A similar approach can be used for adolescent nutrition and physical exercise as well.

Information booklets for parents: [Information booklets for parents and caregivers developed and disseminated.](#) Booklets will provide home-based support and reinforcement for the key messages on nutrition and physical activity. These booklets should inform parents on the importance of good nutrition and exercise for both boys and girls, detailing the distinct needs for each sex. The booklet can also contain tips for healthier options, recipes and other useful resources. Adolescents at schools and *Posyandu Remaja* are encouraged to develop information booklets for parents.

CHAPTER 5. CREATIVE INTERVENTION DESIGN

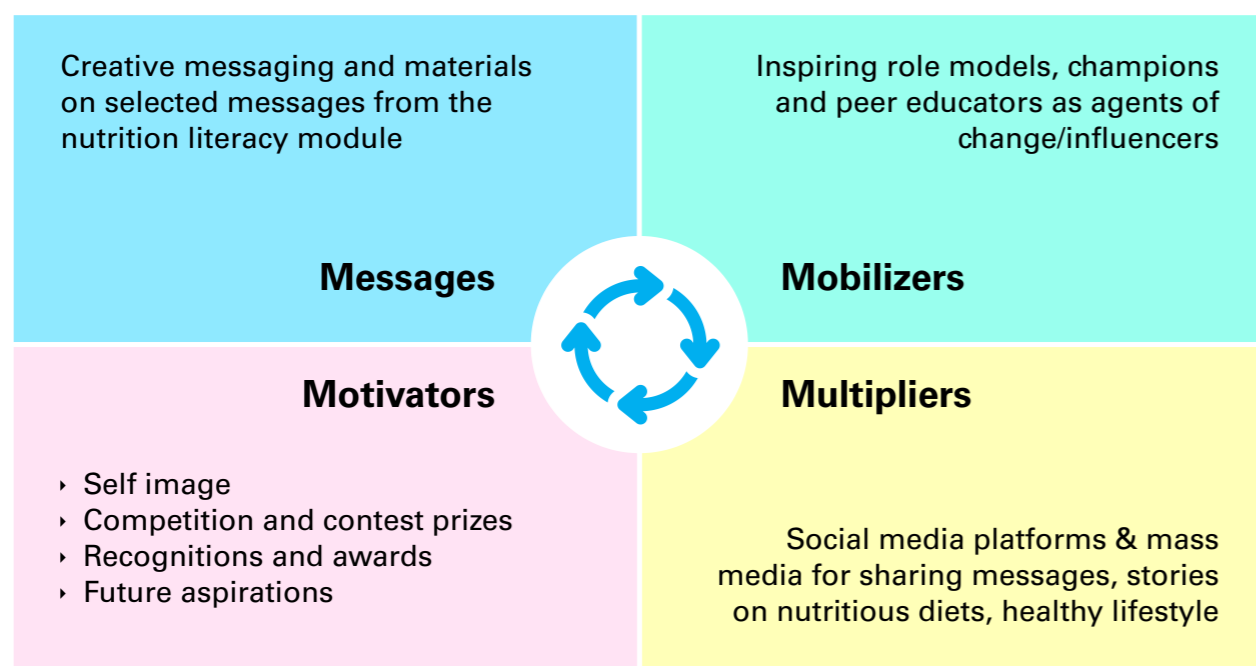
Creative intervention design offers a way of bringing to life the foundation principles and provides an interface between the communication objectives defined in Chapter 3, the adolescents as primary participants, and their involvement in innovative content creation. The idea is to create a ripple effect that would inspire a movement for improving and sustaining adolescent nutritional status initially in school, in the community, in the district, and eventually throughout the country.

The 4Ms: Interconnected pillars of the creative strategy

The milestones in each strategic approach proposed in Chapter 4 can be identified with one or more of these four interconnected pillars, the 4Ms of the creative strategy (see Figure 17):

Mobilizers	Inspiring role models, champions and peer counsellors as agents of change.
Multipliers	Social media platforms, mass and community media for sharing messages about nutritious diets and healthy lifestyle.
Messages	Creative messaging and design of adolescent-friendly materials aligned with Nutrition Literacy Learning Module lessons and key messages; edutainment.
Motivators	Self-image; intra- and inter-school competitions, contests, recognitions, awards, prizes and future aspirations.

Figure 16. The 4Ms – interconnected pillars of the creative intervention design for SBCC on adolescent nutrition



Key influencers, entry points and delivery mechanisms

Focus Group Discussions (FGDs) with stakeholders from Klaten and Lombok Barat (in August 2017 and October 2018) provided insights and recommendations on the most adolescent-appropriate entry points and delivery mechanisms for nutrition-specific and nutrition-sensitive interventions (see Annexes 3 and 4).

Table 5 provides an overview of potential entry points and platforms for school and community engagement, social mobilization and advocacy to improve nutritional practices and physical activity among adolescents.³⁶

These entry points may be structures or individuals who could be engaged, oriented and equipped with appropriate key messages, materials and guides for activities that they could carry out as part of the SBCC intervention in schools, and linked to their homes and communities. For example, they could use a combination of social media platforms as well as mass media and entertainment education shows that appeal to adolescents, reinforced with communication materials, training and orientation, outreach and counselling to maximize school or community initiatives.

Table 5. Overview of potential entry points, key influencers and channels for school and community mobilization for SBCC messaging and mobilization

Family/ friends	Schools	Community	District	Digital/ social media	Digital/mass media
Parents	Teachers	Community/ religious leader/ influencer	District Health Office	WhatsApp	TV
Grandparents	School administrator	PKPR AFHS <i>posyandu</i> health worker	District Education Office/Board	Instagram	Radio
Married siblings	UKS/ school health unit provider	<i>Puskesmas</i> nutritionist/ AFHS counsellor	District Health Promotion	Twitter	Newspapers
Aunts and uncles	PE teacher	Youth centre leader	Nutrition Task Force	Facebook	Magazines
Friends	PTA	Sports and recreation coach	Sports and Youth Office	KAMUS blogs, other youth websites	Others to be suggested by adolescents
Social media networks	OSIS or Student Council/ peer counsellors	Theatre and other art forms	Media managers	Snapchat	
Others to be suggested by adolescents	School club	Food producers	Others to be suggested	Youtube	
	School canteen	Street-food vendors		SMS	
	Food vendors	Canteens, kiosks		Viber, Messenger	
	Others to be suggested by adolescents	Others to be suggested by adolescents		Others to be suggested by adolescents	

³⁶ Based on FGDs with adolescents in two pilot districts.

Figure 17 presents some of the main entry points and influencers for engaging school-going adolescents. For out-of-school adolescents, Figure 18 shows the potential entry points and influencers for reaching and engaging them. Entry points for adults and caregivers are illustrated in Figure 19.

Figure 17. Key influencers for school-going adolescents

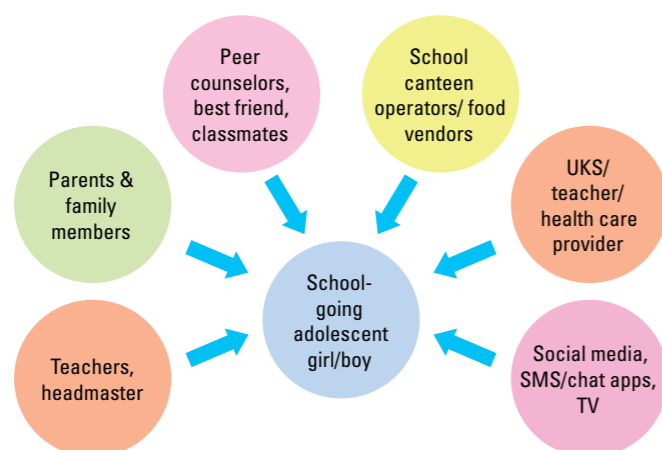


Figure 18. Key influencers for out-of-school adolescents

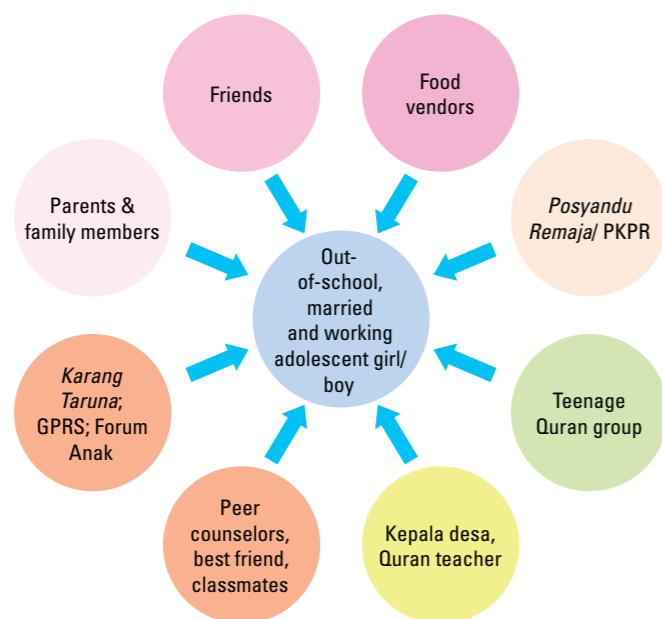
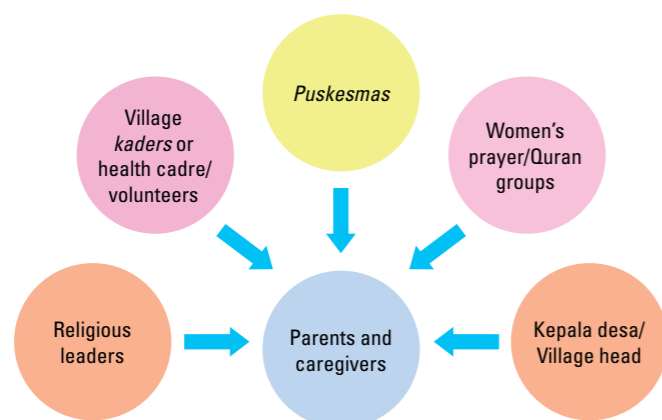


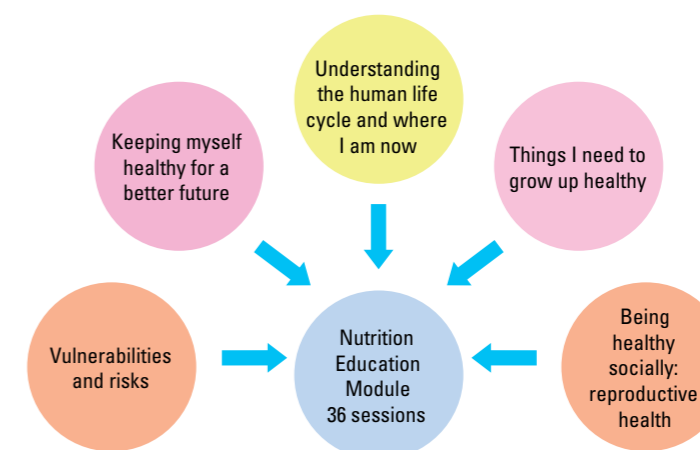
Figure 19. Key entry points/influencers for parents and caregivers



Nutrition Education Module: resource for key messages

The *Aksi bergizi* Nutrition Education Module (see Figure 20) serves as the teacher-facilitator's guide for engaging junior and senior high school students in interactive nutrition learning activities. Each session is of 30-minute duration. Teachers received training to be able to serve as Nutrition Education Facilitators at schools. Teachers' training was conducted by the District UKS committee or other trained teachers.

Figure 20. Main topics in the Nutrition Learning Module



Key messages for SBCC strategy

This SBCC strategy will not deal with every message covered in the Nutrition Education Module; rather, it will focus on the most strategic messages that have the most impact on the intended behaviour changes as defined in the communication objectives and the Theory of Change.

The **key messages** for this SBCC strategy are listed in red in Figure 21. The messages and material development phase should also take into consideration the gender norms and barriers that may prevent girls and boys from adopting the recommended practices. For instance, issues surrounding body image impact the nutritional choices of both girls and boys. Likewise, girls may not be encouraged to exercise or participate in sports and boys may not be encouraged to eat iron-rich foods. These key messages focus on the three main areas for addressing adolescent nutrition:

Control and prevention of anaemia

- › Take iron/IFA supplements
- › Eat iron-rich and fortified foods
- › Eat green, leafy vegetables

Healthy dietary practices

- › Eat five servings (five fistfuls³⁷) of vegetables and fruits everyday
- › Include a fruit or vegetable with every meal
- › Eat colourful vegetables and fruits
- › Choose fresh foods over processed food

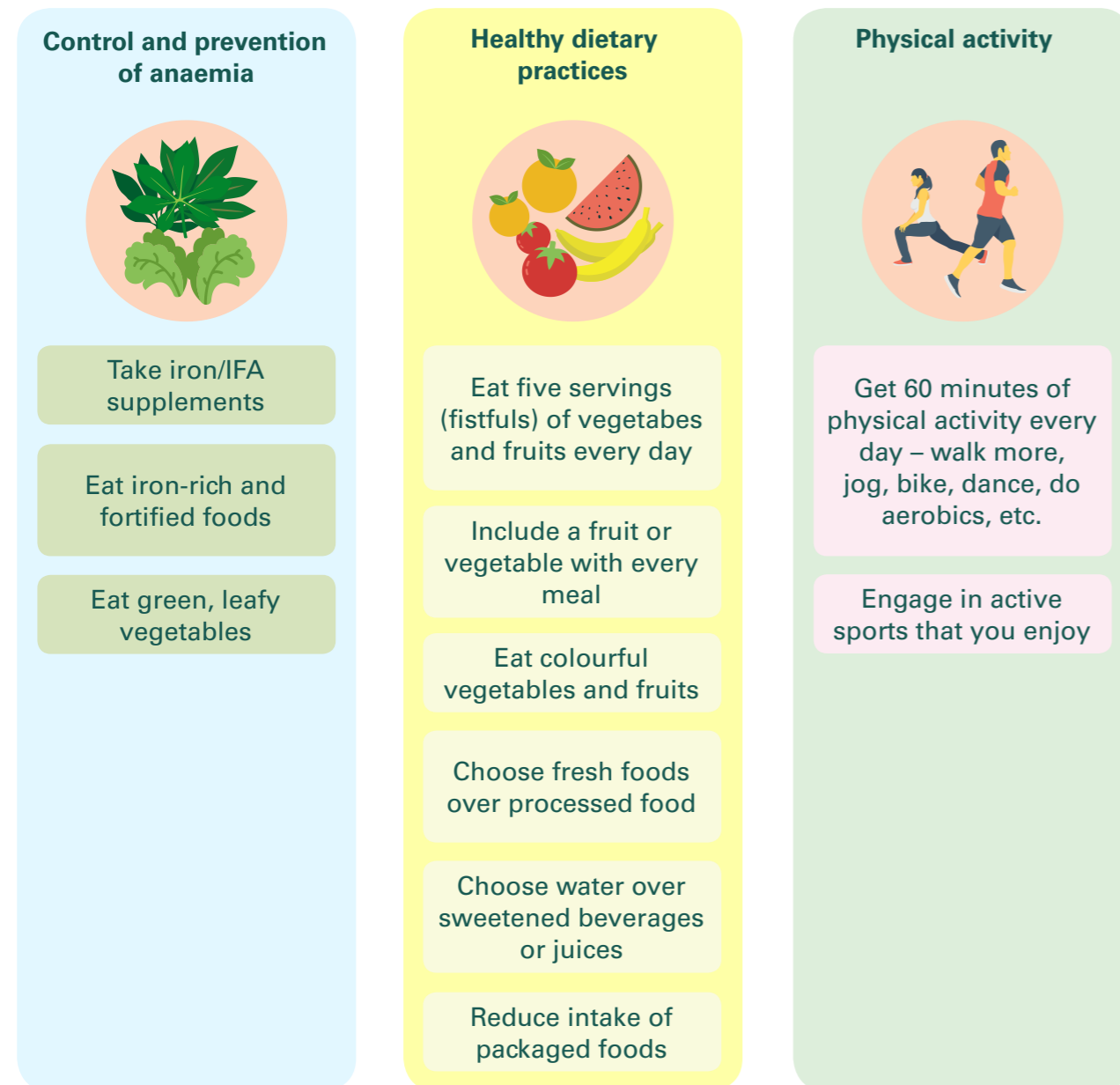
³⁷ Denotes amount, equivalent to an individual's closed fist.

- › Choose water over sweetened beverages or juices
- › Reduce intake of packaged foods

Physical activity

- › Get 60 minutes of physical activity every day – walk more, jog, bike, dance, do aerobics, etc.
- › Engage in active sports that you enjoy.

Figure 21. Categories of recommended practices in the Nutrition Education Module that highlight key messages (in red) for this SBCC strategy



The key messages will be referred to as '**Aksi bergizi** messages'.

Suggested rallying messages

Empowering, motivational messages that can inspire adolescents and families to eat better and adopt a healthier lifestyle can also be developed. The messages should convey the importance of children/adolescents shaping their own lives, shaping themselves and the country's future.

Possibly develop a creative spin on: **"Healthier kids, healthier families, healthier futures."**

Or something like: **"Nourished adolescents for a well-nourished Indonesia."**

The SBCC strategy may incorporate the following acronyms in Indonesian as part of campaign identity and branding:³⁸

A - Anak (child/children)

K - Kuat (strong)

S - Sehat (healthy)

I - Indonesia

Which translates as:

"Strong and healthy Indonesian children (have) plenty of energy, (eat a) variety of nutritious (food), and (become) today's inspiration."

B - Banyak (plenty of)

E - Energi (energy)

R - Ragam (variety of)

G - Gizi (nutrition)

I - Inspirasi (inspiration)

Z - Zaman (era/period)

I - Ini (now)



Adolescents are showing posters of nutrition messages at school

³⁸ Credits to Vida Parady and her daughter for coining terms for this acronym.

Recommendations for creative design

Based on evidence and experience in the creative design and message development across various child rights and well-being sectors, below are some pointers on message development. Additional details may be included in the creative brief for specific materials.

- Consistent messaging – it is important to keep the messages consistent, clear and concise. Competing messages or confusing wording can impact the campaign negatively, and once stakeholders begin to doubt or lose interest/faith in messages it is very hard to regain their trust and attention.
- Brand identity – the strategy and all its components should be associated with an attractive and catchy brand image, which again should be used consistently across all material.
- Positive – in most cases, encouraging people what to do is more effective than telling them what not to do. Except in cases where you need to emphasize abstinence or reduction of certain foods or lifestyle choices, try to frame messages in the positive; e.g., instead of saying do not eat certain foods, suggest the healthier alternatives.
- Select messages with specific, doable actions – having a clear call to action is central to behaviour change efforts. People need to understand what they should do. For instance, ‘eat healthy’ could mean different things to different people and they may not be clear on what they should or should not eat. A clearer message would be ‘eat green leafy vegetables’ or ‘drink at least eight glasses of water a day’.
- Aspirational messages – messages that are aspirational and that promote future possibilities can be motivational. This is particularly relevant for adolescents who need to understand the link between their current behaviours and the long-term benefits of adopting healthier lifestyles. The hook should be that good nutrition and adequate physical activity can help adolescents grow, thrive and succeed in the future.
- Promote choices among local foods – messages and activities should promote choices among local foods. Having choices and making healthier selections is empowering for youth. Messages should also celebrate and highlight the variety of local fruits and vegetables and the diversity in Indonesian cuisine, framing better nutrition as something local and part of Indonesian culture, rather than information directed from outside.
- Reinforce through multiple channels/influencers – repetition and reinforcement are key. Evidence strongly suggests that drawing on multiple channels to reinforce key messages increases the likelihood for change and programme impact.

CHAPTER 6. IMPLEMENTATION PLAN

Core principles that guide SBCC implementation and work in communities

UNICEF’s core C4D/SBCC principles guide how we plan implementation and work with children, adolescents, families and communities, development partners and programme staff. These principles are rooted in the human rights based and gender-responsive approach to programming, particularly the rights to information, communication and participation as enshrined in the Convention on the Rights of the Child (Articles 12, 13 and 17). A gender-responsive communication checklist is included to guide the strategy implementation and roll-out and to ensure that gender aspects are considered to the extent possible (*see Annex 5*). From formative research and planning to implementing and monitoring this SBCC strategy, we adhere to these principles that we believe encourage ownership, sustainability and replicability of activities that resonate with stakeholders. They include:

- Involving adolescents both as primary audience and as agents of change.
- Offering visibility and voice for the most marginalized and vulnerable groups.
- Facilitating intergenerational listening, dialogue and debate.
- Linking community perspectives and voices with subnational and national policy dialogue.
- Addressing the child/adolescent holistically across all stages of the life course.
- Building trust, social cohesion and ownership.
- Ensuring gender-specific and culturally appropriate content and approach.
- Seamless, interdependent application of SBCC actions between development and humanitarian contexts.

The SBCC strategy has been implemented in two pilot districts, namely Klaten and Lombok Barat, by UNICEF, the Ministry of Health and other partners in 2018–2020. SBCC activities were carried out in the two selected districts together with the government at the provincial and district levels including the Health Office, Education Office, Religious Affairs Office, Social Affairs Office, BAPPEDA, and various partners including the Child Forum and Child Protection institutions. Activities were carried out in 110 junior high schools, senior high schools and equivalent, as well as *Madrasah* in both districts (48 schools in Lombok Barat and 62 schools in Klaten).

Preparing school level implementation plans

The *Aksi bergizi* School Committee assigned for each school will select from the menu or list of suggested implementation milestones and activities proposed in Table 6. Through a consultation with representatives of students, the Committee will decide on the most feasible and practical activities that could be implemented within the agreed time frame. The district level implementation activities will be planned by the District Task Force, which will aim to support achievement of school-based activities.

Implementation plan format

The proposed Implementation Plan format is structured around the six intervention modalities presented in Chapter 4, Strategic approaches (see Figure 15). However, the plan also includes **monitoring and evaluation and coordination and operations management**. This strategy is structured as an ongoing process, whereby after the implementation of activities, the district task force and the school committee can evaluate and determine which approaches and activities are 'sticky' or resonate the most with adolescents, their families, schools and communities. Hence, eight modalities are featured in the implementation planning format (see Table 6).



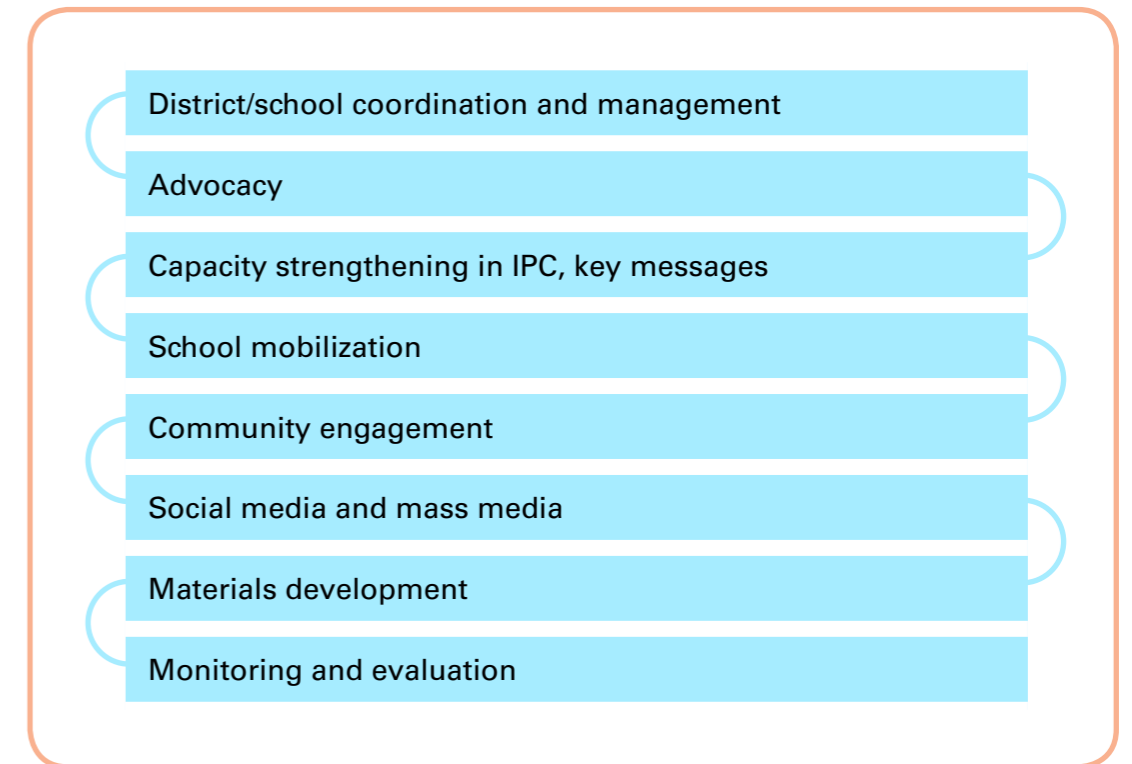
A training and meeting to monitor weekly iron folic acid supplementation and Aksi Bergizi programme in Klaten district.

Preparation and validation of the implementation plan involves a consultative, iterative process with the partners and stakeholders, who will have specific roles in implementing the SBCC initiative. Terms of reference (ToR) of district implementing partners (e.g., media, private sector and civil society organization) and their role in the coordination, oversight and management mechanism will need to be defined and agreed. Adherence to the ToR will be instrumental in effectively carrying out the activities and in achieving the communication objectives in the short and medium term.

Implementation modalities

Figure 22 presents the different intervention modalities arranged across the horizontal plane of the implementation planning table:

Figure 22. Implementation modalities of Aksi bergizi SBCC strategy



On the vertical plane of the matrices, the following entries appear as column headings:

- Milestones or targets.
- Suggested activities.
- Implementing partners or responsible agency.
- Time frame.
- Needed support/communication materials/resources.
- Estimated cost by milestone.

Table 6. Proposed Implementation Plan for Aksi bergizi SBCC Strategy on Improving Adolescent Nutrition and Physical Activity (A menu of suggested implementation activities for one year duration)

IMPLEMENTATION MODALITY/ Milestone or target	Suggested activities	Implementing partner/agency ³⁹	Needed support/ communication materials	Time frame	Estimated cost (US\$) by milestone TBC ⁴⁰
1. DISTRICT AND SCHOOL COORDINATION AND MANAGEMENT – District health and education officials and pilot schools					
establish system for coordination, oversight and monitoring					
Milestone or target: 1.1 District Task Force (DTF) for Aksi bergizi activated	<p>PREPARATORY</p> <ul style="list-style-type: none"> Advocate with district officials to include Aksi bergizi in regular agenda of high-level district coordination meetings Establish Aksi bergizi district coordination mechanism, through AB District Task Force (comprising of UKS Advisory Team, district government representatives, health workers and teachers or school representatives) Appoint DTF chair and co-chair Establish partnership with other district ministry officials, media, telecoms, business sector, academia, local artists groups, etc. to obtain support for Aksi bergizi school activities Agree on terms of reference, including dates of regular meetings Complete TOT of teachers, health workers in pilot schools and puskesmas on Nutrition Education Module <p>IMPLEMENTATION</p> <ul style="list-style-type: none"> Include Aksi bergizi in regular agenda of periodic high-level District Coordination Meetings, inviting implementing partners for reporting on progress Establish regular District Task Force monitoring meetings with school committee representatives (one planned meeting a quarter, plus some ad hoc meetings, as required) Endorse Aksi bergizi inter-school events and competitions with prizes and recognition awards Establish system for monitoring and evaluation, and documenting and reporting milestones and promising practices on Aksi bergizi (IFA, Nutrition Literacy and SBCC) Promote and ensure compliance of school canteens to the available National Guidelines for Healthy School Canteens 		<ul style="list-style-type: none"> Advocacy package, including National Guidelines for Healthy School Canteens Brief description of Aksi bergizi pilot programme The situation analysis Policy brief on Aksi bergizi SBCC – Why, Who, What we hope to achieve, etc. 	Quarter (Q)1 to Q4	Estimated based on scale of activities and local context
1.2 Aksi bergizi School Committee activated	<p>PREPARATORY</p> <ul style="list-style-type: none"> Establish MOU/ commitment from school management of each school to take part in Aksi bergizi programme Participating schools establish Aksi bergizi School Committees TOT of teachers and students in Nutrition Education Module and school mobilization activities Each school appoints representatives to District Task Force <p>IMPLEMENTATION</p> <ul style="list-style-type: none"> Aksi bergizi School Committee selects and plans Aksi bergizi school activities for the year from list of suggested activities School Committee plans categories for year-end recognitions and awards Giving district and school recognitions and awards School Committee meets regularly on Aksi bergizi implementation and monitoring 		<ul style="list-style-type: none"> Respective plans of Aksi bergizi School Committees Guidelines for Aksi bergizi peer counsellors (developed and agreed with inputs from teachers and students) Categories and criteria for recognitions and awards 	Q1	Estimated based on scale of school activities

³⁹ To be determined during District Coordination Meeting.

⁴⁰ To be costed.

IMPLEMENTATION MODALITY/ Milestone or target	Suggested activities	Implementing partner/agency ³⁹	Needed support/ communication materials	Time frame	Estimated cost (US\$) by milestone TBC ⁴⁰
2. ADVOCACY – District officials, media and private sector commit support to <i>Aksi bergizi</i>					
2.1 Commitment obtained from district officials, school management, <i>puskesmas</i> health workers (HW) in TOT, media, private sector to support <i>Aksi bergizi</i> 2.1 Commitment obtained from district officials, school management, <i>puskesmas</i> health workers (HW) in TOT, media, private sector to support <i>Aksi bergizi</i>	<ul style="list-style-type: none"> Invite officials/executives/HW for one-on-one orientation meeting or to a DTF coordination meeting (one planned meeting a quarter, plus some ad hoc meetings, as required) Produce advocacy briefs, infographics, visuals on situation/data and about the <i>Aksi bergizi</i> programme 		<ul style="list-style-type: none"> Advocacy package: advocacy brief, infographic, graphs showing statistics 	Q1	
2.2 <i>Aksi bergizi</i> Brand Ambassadors appointed for district	<ul style="list-style-type: none"> Schools nominate <i>Aksi bergizi</i> Brand Ambassadors (local celebrities, sports figures, artists, high profile figures, etc.) 		<ul style="list-style-type: none"> MoU and TOR for Brand Ambassadors 	Q2	
2.3 Media sensitization roundtable on adolescent nutrition issues and key messages	<ul style="list-style-type: none"> Conduct media events to create awareness and garner support for <i>Aksi bergizi</i> programme Engage Brand Ambassadors (influencers) 	Media	<ul style="list-style-type: none"> Media kit with <i>Aksi bergizi</i> advocacy tools; media release; fact sheets Standard Operating Procedure (SOP) on communication materials' approval 	Q2	
2.4 Public awareness campaign to create buzz on <i>Aksi bergizi</i>	<ul style="list-style-type: none"> Engage local media and telecom partners Engage media and creative designers to produce PSAs, spots and plugs, posters, billboards, banners, standees, etc. for advocacy events Feature school activities and students' stories Engage peer counsellors, students and their social networks in promoting <i>Aksi bergizi</i> key messages in social media Organize school contests on <i>Aksi bergizi</i> poster design, video-making, crafting slogans and jingles and partner with media or local artists/creative designers Giving <i>Aksi bergizi</i> district recognitions and awards 	Media	<ul style="list-style-type: none"> Media kit with <i>Aksi bergizi</i> advocacy tools; media release; fact sheets Creative brief for PSAs and other promotional materials Booklet on key messages for social media campaign Criteria for contests/competitions 	Q2-Q4	Production, design, and airing cost.
3. CAPACITY STRENGTHENING - Training in IPC and counselling skills around <i>Aksi bergizi</i> key messages					
3.1 Peer counsellors, UKS <i>kaders</i> trained	<p>PREPARATORY</p> <ul style="list-style-type: none"> Write TOR and contract for IPC Training Specialist Develop module and interactive session plans on IPC and counselling using <i>Aksi bergizi</i> key messages Develop training tools and exercises <p>IMPLEMENTATION</p> <ul style="list-style-type: none"> Conduct training on IPC and counselling, using key messages and role playing 	Peer counsellor and support groups	<ul style="list-style-type: none"> IPC and counselling module 	Q1 – Q2	
3.2 <i>Puskesmas</i> health workers, <i>Posyandu Remaja</i> and health <i>kaders</i> trained in <i>Aksi bergizi</i>	<ul style="list-style-type: none"> Conduct training on IPC and counselling using key messages and role playing 	<i>Puskesmas</i> health workers, <i>Posyandu</i> volunteers, peer support groups	<ul style="list-style-type: none"> IPC and counselling module 	Q1 – Q2	

IMPLEMENTATION MODALITY/ Milestone or target	Suggested activities	Implementing partner/agency ³⁹	Needed support/ communication materials	Time frame	Estimated cost (US\$) by milestone TBC ⁴⁰
3.3 School canteen operators and food vendors sensitized	<ul style="list-style-type: none"> › District to issue and ensure compliance to National Guidelines on Healthy School Canteens › Conduct orientation on <i>Aksi bergizi</i> key messages and Guidelines among school canteen operators and food vendors 	School canteen operators and food vendors	› National Healthy School Canteen Guidelines	Q1 – Q2	
3.4 Religious leaders oriented	<ul style="list-style-type: none"> › Insert <i>Aksi bergizi</i> key messages/ talking points in guide or references for sermons › Conduct orientation on <i>Aksi bergizi</i> key messages 	Religious leaders	› Booklet on key campaign messages linked to religious scripture	Q1 – Q2	
3.5 Media and artistic training for adolescents	<ul style="list-style-type: none"> › Identify and train students interested in developing skills on the following in connection with planned school competitions and activities: <ul style="list-style-type: none"> • Social media networking • Scriptwriting • Short video production • Visual arts • Performing arts • Theatre arts › Identify and engage mentors to coach/mentor students 	Artists, media	› Session plans prepared for media/arts training conducted by invited mentors	Q2 – Q3	
4. SCHOOL MOBILIZATION – Students engaged in awareness raising, learning and sharing stories on actions around healthy diets and physical activity					
4.1 Intra- and inter-school contests, competitions and challenges	<p>PREPARATORY</p> <ul style="list-style-type: none"> › <i>Aksi bergizi</i> School Committee plans logistics; adopts co-ideation, prototyping and concept-testing methodology⁴¹ › School Committee and student representatives from each level selects and plans activities and competitions for the year based on preliminary list or menu of activities below › School Committee allocates incentives and prizes <p>IMPLEMENTATION</p> <p>Schools select up to 4 activities per year: 2 that showcase healthy diets and 2 on physical activities):</p> <ul style="list-style-type: none"> › Creatives, essays and stories for publication via social media, wall magazines in school walls and for local media › Theatre arts: School theatre with crowd-sourcing with storylines around healthy diets and physical activities › Photography contest on <i>Aksi bergizi</i> activities › Photomontage challenge with crowd-sourcing › Visual arts: Painting/poster/infographic design contest › Short video production › Poetry challenge with crowd-sourcing › Storytelling with crowd-sourcing › Performing arts: Dance challenge › Aerobics, Zumba and other physical exercise routines for girls and for boys › Sports for girls and boys (to be determined by School Committee in consultation with student representatives) › (Students may contribute more ideas) 			Q2 - Q4	

⁴¹ See: Human Centered Design for Digital Adolescent Health (2018). Final Report on Co-ideation, prototyping and concept-testing. UNICEF: Jakarta, Indonesia, November 18, 2018.

IMPLEMENTATION MODALITY/ Milestone or target	Suggested activities	Implementing partner/agency ³⁹	Needed support/ communication materials	Time frame	Estimated cost (US\$) by milestone TBC ⁴⁰
4.2 <i>Aksi bergizi</i> cooking demonstrations and contests	<ul style="list-style-type: none"> Invite parents to pair with their son or daughter to demonstrate a nutritious cooking recipe during a fitting school event (demos may also be linked to school garden products) Encourage other parents and students to contribute recipes in an intra-school and inter-school competition Share video demonstrations of recipes in social media blog and compile recipes as a school project for inter-school competition and sharing 			Q2 - Q4	
4.3 School gardens	<ul style="list-style-type: none"> Recruit student gardeners for credit/merit points as extracurricular (physical) activity that promotes healthy diets Invite parents to pair with and support their sons/daughter's school garden and demonstrate nutritious recipes using garden produce Engage local agricultural extension workers to provide technical assistance and source gardening materials 			Q3 – Q4	
4.4 Tell your friends	<ul style="list-style-type: none"> Students use their social media accounts to tell their friends about a fun physical activity they are engaged in, and invite them to join the fun at a regular time and day; or share a photo of their colourful food plate for the week and ask everyone to do the same. Creative and innovative ideas for sharing <i>Aksi bergizi</i> initiatives will be encouraged, tracked and given recognition at monthly events, e.g., flag raising every first Monday 			Q2 – Q4	
4.5 Recognitions and awards	<ul style="list-style-type: none"> During school anniversary, School Management bestows certificates of merit/recognition awards for outstanding achievements and contributions to <i>Aksi bergizi</i> healthy diets and physical activities; e.g., role model peer counsellors, <i>Aksi bergizi</i> Ambassadors and Champions, role model parents who support <i>Aksi bergizi</i> school activities School committee to determine types of recognitions and awards based on planned activities and competitions agreed for the year 			Q2 – Q4	
5. COMMUNITY ENGAGEMENT – Parents, families, religious leaders, community leaders and other influentials support <i>Aksi bergizi</i>					
5.1 Parents, local leaders and food vendors oriented on <i>Aksi bergizi</i>	<p>PREPARATORY</p> <ul style="list-style-type: none"> Schools conduct sensitization/awareness raising for parents, food vendors, and community influentials <i>Posyandu Remaja</i> conduct awareness raising sessions in their respective villages 		<ul style="list-style-type: none"> <i>Aksi bergizi</i> information booklet for parents and community <i>Aksi bergizi</i> Guidelines for school canteen operators and food vendors 	Q2 – Q3	
5.2 Village heads, religious leaders oriented on <i>Aksi bergizi</i>	<ul style="list-style-type: none"> <i>Posyandu Remaja</i> invites head teacher and <i>Aksi bergizi</i> teacher to give orientation to village heads and religious leaders 		<ul style="list-style-type: none"> Booklet with <i>Aksi bergizi</i> key messages linked to passages in religious scriptures 	Q2 – Q3	
5.3 Out-of-school adolescents (OSA) oriented and engaged in <i>Aksi bergizi</i> activities	<ul style="list-style-type: none"> <i>Karang Taruna</i>, Forum Anak, <i>Posyandu Remaja</i> members participate in training in <i>Aksi bergizi</i> messaging <i>Karang Taruna</i>, Forum Anak, <i>Posyandu Remaja</i> engage OSA in village activities to promote healthy eating and physical activity 				

IMPLEMENTATION MODALITY/ Milestone or target	Suggested activities	Implementing partner/agency ³⁹	Needed support/ communication materials	Time frame	Estimated cost (US\$) by milestone TBC ⁴⁰
6. SOCIAL AND MASS MEDIA ENGAGEMENT – The media engage adolescents in content creation, sharing stories and motivating change					
6.1 <i>Aksi bergizi</i> website and app developed, accessed and used by students and teachers, partners, media and public	<p>PREPARATORY</p> <ul style="list-style-type: none"> Plan, prioritize and create media content and advocacy materials to support IPC or disseminated/distributed in a timely manner to adolescents or other intended participant audiences. Contract web developer to construct interactive digital infrastructure as website and/or application dedicated to <i>Aksi bergizi</i> information access and sharing of creative content, images, videos, texts, promising practices <p>IMPLEMENTATION</p> <ul style="list-style-type: none"> Web/app developer orients student/peer counsellors and teachers on maximizing use of digital media Appoint administrator to manage and oversee 	ToR for web/app developer and administrator	Q2- Q4		
6.2 Social media and mass media practitioners oriented on <i>Aksi bergizi</i> messages and	<ul style="list-style-type: none"> Develop media orientation session plan on <i>Aksi bergizi</i> key messages with examples of mass media and social media products (e.g., from Human Centred Design for Adolescent Health) Invite media practitioners to the school and conduct media roundtable to be facilitated by trained student counsellors and teachers 	Session plan for <i>Aksi bergizi</i> orientation for media practitioners	Q3 – Q4		
6.3 Students’ social media platforms and MOH, MOEC websites used for creating public awareness and promoting <i>Aksi bergizi</i>	<ul style="list-style-type: none"> Adolescents post key messages, images and short videos, updates of <i>Aksi bergizi</i> school activities, learnings and lessons through their social media accounts (Instagram, WhatsApp, Line, YouTube, Facebook, etc.) Local media partners and artist groups amplify the stories of adolescents through their media 		Q2 – Q4	-	
6.4 Adolescents involved in the arts and in media programmes	<p>PREPARATORY</p> <ul style="list-style-type: none"> District Task Force identifies and invites supportive media, artistic and creative groups to provide mentoring or coaching to adolescents on relevant productions based on plan <p>ACTUAL IMPLEMENTATION</p> <ul style="list-style-type: none"> Showcase students’ <i>Aksi bergizi</i> essays, stories, scripts, lyrics, visuals, photos, short videos in local newspapers, magazines, radio and TV and also made available online through their websites and social media accounts Involve students/peer counsellors, Brand Ambassadors as guest hosts in news programmes on radio and TV, or for on-air interviews 		Q3 – Q4		
7. MATERIALS DEVELOPMENT (for Phase 1 and 2 as prioritized)					
7.1 Review of existing materials completed	<ul style="list-style-type: none"> Assign a working group among partners to review relevant materials available in soft and hard copy Compile and make a roster of existing materials relevant to <i>Aksi bergizi</i> key messages from DHO and DOEC, other partners in the respective district Identify other materials to be developed or updated with <i>Aksi bergizi</i> brand to support planned activities for the year and subsequent years 	Soft and hard copies of list and compilation of relevant materials available with MOH and MOEC, CSOs, other partners	Q2-Q3		
7.2 Additional materials needed identified					
7.3 Photo novellas by and for adolescents developed and disseminated	<ul style="list-style-type: none"> Call on students who are interested to tell stories, take photos, sketch and draw and share thru their social media groups Train them on <i>Aksi bergizi</i> key messages and how to create photo novellas Challenge them to adopt the actions and create their stories into photo novellas 		Q3-Q4		

IMPLEMENTATION MODALITY/ Milestone or target	Suggested activities	Implementing partner/agency ³⁹	Needed support/ communication materials	Time frame	Estimated cost (US\$) by milestone TBC ⁴⁰
7.4 Guide/s for religious leaders and community influentials created	<p>PREPARATORY</p> <ul style="list-style-type: none"> › Hire a creative designer-consultant to develop <i>Aksi bergizi</i> guides for specific audience groups › Design, develop, pretest and produce the guide <p>IMPLEMENTATION</p> <ul style="list-style-type: none"> › Link religious guide to passages in scriptures › Orient influentials using the guides as supporting tools for sermons, group interactions, interpersonal outreach and counselling 			Q3-Q4	
7.5 Information booklets for parents and caregivers developed and used	<ul style="list-style-type: none"> › Creative consultant to develop booklet for parents and caregivers › Design, develop, pretest and produce the booklet 			Q3-Q4	
7.6 Information booklets for health care providers in UKS, <i>puskesmas</i> , <i>posyandu</i>	<ul style="list-style-type: none"> › Creative consultant to develop booklet for health care providers › Design, develop, pretest and produce the booklet 			Q3-Q4	
7.7 Information booklets for school canteen operators and food vendors developed and used	<ul style="list-style-type: none"> › Creative consultant to develop booklet/guide for school canteen operators and food vendors › Design, develop, pretest and produce the booklet/guide 			Q2-Q3	
8. MONITORING AND EVALUATION AND DOCUMENTING PROMISING PRACTICES					
8.1 Monitoring behaviour outcomes: know–feel–do	<ul style="list-style-type: none"> › Contract research agency to conduct baseline and monitor/track KAP behaviour changes through qualitative method and measure KAP in quantitative terms 		<ul style="list-style-type: none"> › ToR for research agency to conduct behaviour monitoring 	Q3-Q4	
8.2 Monitoring planned implementation activities	<ul style="list-style-type: none"> › Establish reporting/monitoring protocol for School Committee to track and report implementation › Tap same research agency to collate reports and to prepare year-end consolidated evaluation report of implementation for DTF 		<ul style="list-style-type: none"> › School monitoring protocol › ToR for implementation/ process monitoring 	Q2-Q4	
8.3 Stories of change, promising practices and lessons learned documented to guide scaling up	<ul style="list-style-type: none"> › Contract journalist-consultants with experience in case study writing, documenting promising/good practices, and have published human stories of change. Stories will be for digital posting, media and partner sharing to represent the 8 implementation modalities. 		<ul style="list-style-type: none"> › Criteria for promising practices; guide for documenting in print, audio and video formats 	Q3-Q4	

Prerequisites, assumptions and risks

In order for the SBCC strategy to be implemented as planned, several prerequisites and assumptions must be in place. The assumptions listed below are expected to hold true for the *Aksi bergizi* SBCC intervention, but of course need confirmation. If some of these assumptions do not hold true, achievement of SBCC objectives may be at risk.

- › National level endorsement, resource allocation and commitment.
- › District government supports the programme by assuring a mechanism for coordination between education and health sectors as well as with other sectors and partners.
- › District *Aksi bergizi* Task Force formed with defined coordination mechanism and ToR.
- › Buy-in from school management for *Aksi bergizi* SBCC activities is assured.
- › School Committees meet regularly to plan, oversee and monitor their respective school *Aksi bergizi* activities.
- › District level print, broadcast and telecommunications facilities can be accessed and function as expected.
- › Budget is available and covers projected expenses in the implementation plan.
- › Timeframe to achieve the planned milestones/selected activities is realistic and gives room for flexibility.
- › Monitoring of activities and outcomes and documentation of innovative and promising initiatives are captured in writing, photos and videos for sharing and application in future phases.

CHAPTER 7. MONITORING AND EVALUATION PLAN

A Monitoring and Evaluation Plan is central to any social and behaviour change communication effort. The M&E plan outlined here is designed to answer questions as to how the social and behaviour change interventions proposed in the SBCC strategy contribute to the programme and communication goals as well as to the SBCC outcomes at the individual, family, community, organizational and policy levels as per the initiative's Theory of Change (see *Figure 11, Chapter 3*).

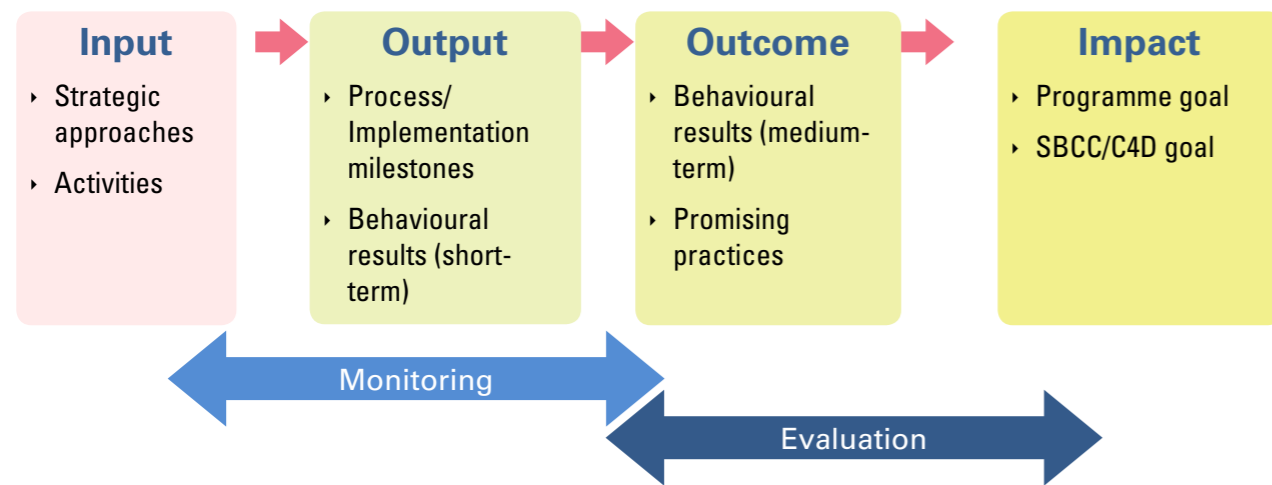
The strategic approaches and activities outlined in the strategy (see *Chapter 4*) are expected to contribute to the SBCC objectives, which align with the short term/intermediate results or outputs in the results chain. These changes in knowledge, attitudes, skills, aspirations or motivation must occur in order for the next level of change – the intended social and behaviour change outcomes – to take place. These outcomes, in turn, lead to the strategy's desired impact. When these changes occur, it is vital that they can be measured, validated and linked back to the intervention.

Monitoring and evaluation ensures that a cause-and-effect relationship between the social and behaviour change outcomes and the intervention – the SBCC approaches and activities proposed here – can be ascertained. This could be a direct relationship, where a causality is established between the behavioural outcome and the intervention (attribution) or one where an indirect relationship is established between the outcome and the intervention through the intermediate outcomes (contribution).

Evidence-based programme design and implementation requires concurrent monitoring and evaluation. The extent to which programmes are implemented according to plan (process outputs) and generate the projected short-term and medium-term outcomes can be measured and validated through the establishment of monitoring systems to accompany implementation. Impact assessment utilizing a robust evaluation research design allows for individual and social changes to be tracked and linked back to implementation, which allows for the measurement of programme effectiveness (see *Figure 23*).

This M&E framework details the indicators to measure change, outlines the ongoing monitoring to track implementation progress, and specifies how evaluation can be conducted at baseline and endline. We suggest several participatory M&E tools that fit well with the overall design of the strategy. The final section presents criteria and tools to document promising practices, innovations and lessons learned.

Figure 23. Monitoring and evaluation and the results framework



Monitoring



A government multi-sectoral coordination meeting in Klaten district

Monitoring is the ongoing and repeated collection of data on what a programme is doing (i.e., inputs and outputs) and the degree to which it is being implemented according to plan (ICRW, 2010). While monitoring is often limited to tracking activities and measuring how often an activity was conducted, or how many people were reached, more robust monitoring also tracks ongoing social and behavioural outcomes or intermediate results. This is particularly relevant to SBCC initiatives, as it provides evidence on SBCC-specific contributions.

Furthermore, programmatic shifts can

take time (going beyond typical programme cycles) and it is important to check-in and assess if the programme is headed in the right direction through intermediate results.

For this strategy two types of monitoring are recommended:

- **Behavioural outcome monitoring** that looks at intermediate (short and medium term) outcomes/results or interim changes in knowledge, attitudes and practices that must take place for the desired programme impact to occur.
- **Process monitoring that looks at implementation** – i.e., whether inputs are in place, milestones are being reached and activities and outputs are happening as planned – while tracking outputs against parameters such as reach, quality, participation and satisfaction.

Evaluation

Meaningful SBCC evaluation must be a coordinated effort alongside programme implementation that involves a systematic assessment of social and behavioural outcomes compared to a set of explicit or implicit standards (Weiss, 1998). Evaluations look at the merit, worth or value of processes and seek to ‘improve’ programmes or policies. It is a means of measuring the contribution of SBCC to the overall impact as well as improvement of the programme. Evaluation tells us if the social and behaviour changes we seek are happening; it allows us to see the evolution of change over time and to gauge the extent to which SBCC interventions contributed to programme objectives in both the short to medium term and to programme goals/impact in the long-term.

For this strategy, the evaluation includes:

- **Outcome evaluation** to ascertain to what extent the SBCC intervention contributed to achieving the programme goal of reducing the triple burden of malnutrition among adolescents in the pilot areas in Indonesia. Evaluation will also determine the positive behaviour changes (KAP or know–feel–do) that occurred as a result of the SBCC intervention in a given time frame.
- **Documenting promising practices, innovations and lessons learned** to capture the rich activities and learnings that could guide the next phase of the SBCC initiative as well as future nutrition initiatives addressing adolescents.

SBCC objectives and M&E indicators

The SBCC objectives have been presented earlier in Chapter 3. Commonly referred to as communication objectives, these detail the desired changes in knowledge, attitudes and practices that the intervention aims to achieve. For these objectives to be measurable, they need to be converted or cast as indicators. Simply explained, an indicator is a specific, observable and measurable characteristic that can be used to show changes or progress a programme is making towards achieving a specific outcome.⁴²

Indicators provide a simple and reliable means of measuring change in outputs and outcomes. For M&E purposes, monitoring indicators serve as progress markers that help determine whether programme implementation and behaviour and social change are taking place. It is this information that will tell us whether or not we are on track towards achieving our programme goals and objectives. Outcome indicators, on the other hand, are used to evaluate the final impact of interventions – in this case, on the nutritional well-being and physical fitness of students in the pilot schools.

The following section (see Table 7) presents the SBCC objectives by stakeholder or participant group, the corresponding behavioural outcome indicators and suggested participatory M&E tools. These tools can be utilized in conjunction with a KAP survey to gather quantitative data and determine changes over time.

⁴² www.endvawnow.org

Table 7. SBCC objectives by stakeholder, M&E indicators and participatory tools

SBCC objectives/outputs	M&E indicators ⁴³	Suggested participatory M&E tools ⁴⁴
Adolescents⁴⁵		
Know		
Adolescents know what foods to consume to improve their nutritional well-being	<ul style="list-style-type: none"> ▸ % of adolescents who can name 3 nutritious foods ▸ % of adolescents who can name at least 2 foods under each food group ▸ % of adolescents who can name 3 unhealthy foods 	<ul style="list-style-type: none"> ▸ Ask 5 ▸ Ideal plate ▸ Draw and describe ▸ Body mapping ▸ Card sorts and card ranking
Adolescents know the importance of good nutrition and physical exercise	<ul style="list-style-type: none"> ▸ % of adolescents who can explain the importance of nutrition and exercise ▸ % of adolescents who can cite 3 lifestyle changes (related to nutrition or exercise) that they can make to be healthier 	
Feel		
Adolescents are motivated to practise better nutrition and regular physical exercise	<ul style="list-style-type: none"> ▸ % of adolescents who are motivated to practise better nutrition and regular physical exercise ▸ Change over time (mean score) on a readiness to change scale⁴⁶ on motivation to practise better nutrition and regular physical exercise ▸ % of adolescents who believe better nutrition and regular exercise are important for their minds as well as their bodies ▸ % of adolescents who have a favourable attitude towards their body image 	<ul style="list-style-type: none"> ▸ A day in the life ▸ Confidence snails ▸ Social media posts
Para remaja merasa percaya diri untuk membuat pilihan diet dan latihan jasmani yang lebih sehat	<ul style="list-style-type: none"> ▸ % of adolescents who feel confident to make healthier dietary and exercise choices ▸ Change over time (mean score) on the perceived self-efficacy scale⁴⁷ on decision-making for healthier diets and exercise 	

⁴³ These indicators may need to be refined or modified slightly when developing the baseline instrument.

⁴⁴ Derived from Sood, S, Cronin, C and Kostizak, K (2018), Participatory Research Toolkit, Rain Barrel Communications, New York, November 2018.

⁴⁵ Adolescents are defined here as girls and boys aged 12–18 years.

⁴⁶ McConaughy E. A., Prochaska J. O., Velicer W. F. (1983), Stages of change in psychotherapy: measurement and sample profiles, *Psychotherapy: Theory, Research, Practice*, 20, 368–375. Also see Ceccarini, M, et al (2015), Assessing motivation and readiness to change for weight management and control: an in-depth evaluation of three sets of instruments, *Frontiers in Psychology*.

⁴⁷ Schwarzer, R., & Jerusalem, M. (1995), Generalized Self-Efficacy scale, In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio, Causal and control beliefs* (pp. 35–37). NFER-NELSON, Windsor, UK. The Readiness to Change and Self-Efficacy Scales are provided in Annex 6.

SBCC objectives/outputs	M&E indicators ⁴³	Suggested participatory M&E tools ⁴⁴
Do⁴⁸		
Adolescents discuss and promote healthy eating and regular exercise among their peers	<ul style="list-style-type: none"> ▸ % of adolescents who report discussing healthy eating with their peers in the past month ▸ % of adolescents who report discussing regular exercise with their peers in the past month 	<ul style="list-style-type: none"> ▸ Most significant change ▸ Social media posts, hits, likes <ul style="list-style-type: none"> ▸ Photo voice/video ▸ A day in the life ▸ Participatory theatre
Adolescents consume healthier diets and engage in regular physical exercise	<ul style="list-style-type: none"> ▸ % of adolescents who report that they consumed 5 servings of fruits and vegetables every day during the past 3 days ▸ % of adolescents who report that they included a fruit or vegetable with every meal in the past 3 days ▸ % of adolescents who report that they have increased the consumption of fresh foods in the past month ▸ % of adolescents who report that they have reduced the consumption of sweetened beverages in the past month ▸ % of adolescents who report engaging in at least 60 minutes of physical activity/exercise every day for the past week 	
Parents⁴⁹		
Know		
Parents know about the benefits of healthy eating and physical exercise for adolescents	<ul style="list-style-type: none"> ▸ % of parents who can explain healthy eating and its benefits for adolescents ▸ % of parents who can explain benefits of physical exercise for adolescents ▸ % of parents who can name 3 foods adolescents should consume and 3 foods they should avoid 	<ul style="list-style-type: none"> ▸ Ideal plate ▸ Card sorts and card ranking ▸ Draw and describe
Parents know about the gender-specific nutritional needs of adolescent girls and boys	<ul style="list-style-type: none"> ▸ % of parents who can explain the different nutritional needs of girls and boys 	
Feel		
Parents believe that nutrition and physical exercise are important for adolescent well-being	<ul style="list-style-type: none"> ▸ % of parents who believe good nutrition is important for adolescent well-being ▸ % of parents who believe they play an important role in supporting adolescents' nutritional well-being 	<ul style="list-style-type: none"> ▸ Most significant change ▸ Photo voice/video

⁴⁸ The 'do' objectives and indicators correspond to the outcome level or the medium-term results.

⁴⁹ Parents are defined here as biological parents, family caregivers or legal guardians of adolescents aged 12–18 years.

SBCC objectives/outputs	M&E indicators ⁴³	Suggested participatory M&E tools ⁴⁴
Do		
Parents discuss nutrition and exercise with adolescents	<ul style="list-style-type: none"> ▸ % of parents who report discussing nutrition and exercise with adolescents in the past week 	<ul style="list-style-type: none"> ▸ Oral histories ▸ A day in the life ▸ Photo voice/video
Parents provide nutritious foods and beverages at home	<ul style="list-style-type: none"> ▸ % of parents who report that they served their adolescent a fruit or vegetable with every meal in the past 2 days ▸ % of parents who report that their children have increased the consumption of fresh foods in the past month ▸ % of parents who report that their children have reduced the consumption of sweetened beverages in the past month 	
Community influentials⁵⁰		
Know		
Community influentials know the benefits of healthy eating and physical exercise for adolescents	<ul style="list-style-type: none"> ▸ % of community influentials who can explain healthy eating and its benefits ▸ % of community influentials who can explain the benefits of physical exercise for adolescents ▸ % of community influentials who can name 3 foods adolescents should consume and 3 foods they should avoid 	<ul style="list-style-type: none"> ▸ Ideal plate ▸ Card sorts and card ranking
Community influentials know the gender-specific nutritional needs of adolescent girls and boys	<ul style="list-style-type: none"> ▸ % of community influentials who can explain the different nutritional needs of girls and boys 	
Feel		
Community influentials believe that nutrition and physical exercise are important for adolescent well-being	<ul style="list-style-type: none"> ▸ % of community influentials who believe good nutrition is important for adolescent well-being ▸ % community influentials who believe they play an important role in supporting adolescents' nutritional well-being ▸ % community influentials who feel confident to discuss nutrition and exercise with adolescents and their families 	<ul style="list-style-type: none"> ▸ Most significant change/stories of change ▸ Photo voice/video
Do		
Community influentials discuss nutrition and exercise with adolescents and their families	<ul style="list-style-type: none"> ▸ % of community influentials who report discussing nutrition and exercise with adolescents and their families in the past month 	<ul style="list-style-type: none"> ▸ Oral histories ▸ A day in the life ▸ Photo voice/video
Community influentials take action to support adolescent nutrition	<ul style="list-style-type: none"> ▸ % of community influentials who report taking any specific action to support adolescent nutrition in the past month 	

⁵⁰ Community influentials are defined here as formal or informal leaders such as village headman, religious leaders, champions, role models or peer leaders.

SBCC objectives/outputs	M&E indicators ⁴³	Suggested participatory M&E tools ⁴⁴
Service Providers⁵¹		
Know		
School staff (management, teachers and canteen operators) and health service providers know the benefits of healthy eating and physical exercise for adolescents	<ul style="list-style-type: none"> ▸ % of school staff (management, teachers and canteen operators) and health service providers who can explain the benefits of healthy eating ▸ % of school staff (management, teachers and canteen operators) and health service providers who can explain the benefits of physical exercise for adolescents ▸ % of school staff (management, teachers and canteen operators) and health service providers who can name 3 foods adolescents should consume and 3 foods they should avoid ▸ % of policymakers who can identify 3 reasons for adolescent malnutrition 	<ul style="list-style-type: none"> ▸ Ideal plate ▸ Card sorts and card ranking
Feel		
School staff (management, teachers and canteen operators) and health service providers are motivated to promote healthy eating and physical exercise among adolescents	<ul style="list-style-type: none"> ▸ % of school staff (management, teachers and canteen operators) and health service providers who are motivated to promote healthy eating and physical exercise among adolescents ▸ % of school staff (management, teachers and canteen operators) and health service providers who believe they play an important role in promoting healthy eating and physical exercise among adolescents 	<ul style="list-style-type: none"> ▸ Most significant change/stories of change ▸ A day in the life
School staff (management, teachers and canteen operators) and health service providers feel confident to provide gender-responsive and adolescent-friendly nutrition and health counselling	<ul style="list-style-type: none"> ▸ % of school staff (management, teachers and canteen operators) and health service providers who feel confident to discuss nutrition and exercise with adolescents and their families 	

⁵¹ Service providers are defined here as teachers, school management, UKS in-charge, school canteen operators, and village and community level health workers.

SBCC objectives/outputs	M&E indicators ⁴³	Suggested participatory M&E tools ⁴⁴
Do		
School staff (management, teachers and canteen operators) and health service providers discuss nutrition and exercise benefits with adolescents and their families	<ul style="list-style-type: none"> ▸ % of school staff (management, teachers and canteen operators) and health service providers who report discussing nutrition and exercise with adolescents and their families in the past month 	<ul style="list-style-type: none"> ▸ Oral histories ▸ Charts
School management and teachers support school-based nutrition activities	<ul style="list-style-type: none"> ▸ % of school management and teachers who report taking any specific actions to support school-based nutrition activities 	
School canteen operators/vendors offer healthy food choices and follow guidelines on Healthy School Canteens	<ul style="list-style-type: none"> ▸ % of school canteen operators/vendors who report offering healthier food and beverage choices in canteens ▸ % of school canteen operators/vendors who can list 3 changes they have made to provide healthier food and beverage offerings ▸ % of school canteen operators/vendors who report positive changes in the foods and beverages adolescents are purchasing from the canteen 	
Policy makers⁵²		
Know		
Understand the importance of healthy eating and physical activity for adolescents	<ul style="list-style-type: none"> ▸ % of policymakers who can explain the importance of healthy eating for adolescents ▸ % of policymakers who can explain the importance of physical exercise for adolescents ▸ % of policymakers who can identify 3 reasons for adolescent malnutrition 	<ul style="list-style-type: none"> ▸ Interview ▸ Content analysis of relevant pronouncements and speeches
Feel		
Are committed to support adolescent-friendly and gender-responsive nutrition policies and programmes	<ul style="list-style-type: none"> ▸ % of policymakers who express commitment to supporting adolescent nutrition ▸ % of policymakers who believe that good nutrition is important for adolescent well-being ▸ % of policymakers who believe that they play an important role in supporting adolescents' nutritional well-being 	<ul style="list-style-type: none"> ▸ Photo voice/video ▸ Content analysis of relevant pronouncements and speeches
Do		
Mengambil tindakan untuk mendukung kebijakan tentang kecukupan gizi remaja	<ul style="list-style-type: none"> ▸ % jumlah pembuat kebijakan yang melaporkan bahwa mereka telah melakukan tindakan tertentu untuk mendukung kecukupan gizi remaja dalam sebulan terakhir 	<ul style="list-style-type: none"> ▸ Rekaman lisan

⁵² Policymakers are defined here as decisionmakers at the national and district level and programme managers.

Monitoring and evaluating process and behavioural outcomes

A well-planned and systematically executed M&E plan makes it possible to analyse the level of achievement of expected as well as unexpected results. It also provides evidence that enables timely adjustments and incorporation of promising practices, innovative activities, lessons and recommendations into decision-making for subsequent phases.

Table 8 below presents a framework for monitoring implementation that corresponds to the intervention modalities and milestones in the Implementation Plan offered in Chapter 6. The District Task Force, with support from partners, will develop a system for tracking progress and collection of data on the what, who, where, when and how of the programme.

The behavioural outcome indicators in Table 7 should be used to establish KAP baselines, track progress, and measure outcomes in the given time frame.

The SBCC M&E Plan should therefore be mainstreamed as part of the accountability and overall results framework of the adolescent nutrition programme in Indonesia that addresses the triple burden of malnutrition. This requires creation of a strong system for multisectoral coordination in research, planning, implementation, monitoring and evaluation, including documenting promising practices and reporting of results (UNICEF 2018b).⁵³

During the pilot phase, a research agency experienced specifically in social and behavioural research, monitoring and evaluation, tracking the communication process and outputs, and evaluating outcomes and impact, was contracted to evaluate the *Aksi bergizi* programme. This was done to ensure baseline measures were established that can be compared at endline. In order to assess if the programme has been effective, it is important to have data that can be compared either over time (pre- and post-intervention) or a treatment (intervention) and control (non-intervention) group. In a complex social setting where so many variables are involved, controlling for counterfactuals or confounding variables can be challenging. A baseline–endline design has the advantage of being able to be used with or without a comparison group. Given the relatively short project timeframe, a midline evaluation is not recommended. The endline evaluation design and sampling frames will need to be determined by a research agency.

⁵³ UNICEF (2018), Revised evaluation policy of UNICEF, New York, E/ICEF/2018/1.

Table 8. Framework for monitoring implementation: SBCC milestones, process indicators and means of verification

Implementation Milestones	Process Indicators		Mean of Verification (suggested)
	Quantitative	Qualitative	
1. Advocacy			
1.1 Advocacy tools developed for national and subnational policymakers, school management, media and private sector to raise awareness about the triple burden of adolescent malnutrition	<ul style="list-style-type: none"> Count of advocacy tools developed Count of advocacy tools disseminated Count of policymakers reached 	<ul style="list-style-type: none"> Quality of tools Appeal of tools Clarity of content 	<ul style="list-style-type: none"> Records Exit interviews Focus group discussions Survey
1.2 <i>Aksi bergizi</i> Ambassadors selected based on suggestions from adolescents and endorsement by partners.	<ul style="list-style-type: none"> Count of <i>Aksi bergizi</i> Ambassadors selected 	<ul style="list-style-type: none"> Level of participation in selecting Ambassadors Level of satisfaction among stakeholders regarding the selection 	<ul style="list-style-type: none"> Records Focus group discussions
1.3 Sensitization and training of media practitioners conducted through media events, lunch forums and roundtables to orient on issues related to adolescent nutrition.	<ul style="list-style-type: none"> Count of training for journalists/broadcasters and media sensitization events conducted Counts of attendees 	<ul style="list-style-type: none"> Quality of the events Participant satisfaction 	<ul style="list-style-type: none"> Records Exit interviews Focus group discussions Survey
1.4 <i>Aksi bergizi</i> public awareness campaign implemented to trigger public attention, promote the key messages on adolescent nutrition and create buzz.	<ul style="list-style-type: none"> Count of media materials developed Count of media channels and platforms used Reach of material 	<ul style="list-style-type: none"> Quality of material Appeal of material Clarity of content 	<ul style="list-style-type: none"> Records Survey Focus group discussions
1.5 A district task force formed and activated to oversee and monitor implementation of the SBCC intervention as well as the other two components of the Adolescent Nutrition Programme based on the agreed implementation plan	<ul style="list-style-type: none"> Number of district task forces formed 	<ul style="list-style-type: none"> Level of participation of task force members Level of satisfaction with the task force among stakeholders 	<ul style="list-style-type: none"> Focus group discussions Interviews
2. School mobilization			
2.1 Various school competitions organized to promote better nutrition and increased physical activity among adolescents.	<ul style="list-style-type: none"> Count of school competitions conducted Count of schools participating Count of students engaged 	<ul style="list-style-type: none"> Level of participation in selected competitions Level of satisfaction with the competitions among stakeholders Level of inclusion 	<ul style="list-style-type: none"> Records Social media feeds Participatory photography or video News stories or essays Direct observations
2.2 Cooking demonstrations/contests organized in schools as part of annual celebrations (e.g., school anniversary or national nutrition day).	<ul style="list-style-type: none"> Count of cooking demonstrations held Count of attendees at each demonstration 	<ul style="list-style-type: none"> Level of participation Level of satisfaction (students, teachers, family members) Level of inclusion 	<ul style="list-style-type: none"> Records Social media feeds Participatory photography or video News stories or essays Direct observations
2.3 Tell a friend programme modelled in schools.	<ul style="list-style-type: none"> Count of students reached through the tell a friend programme 	<ul style="list-style-type: none"> Level of satisfaction among stakeholders Level of engagement to 'spread the word' 	<ul style="list-style-type: none"> Survey Social media feeds Social network maps
2.4 School gardens initiated and student gardeners oriented and recognized for their extracurricular participation.	<ul style="list-style-type: none"> Count of school gardens initiated Count of student gardeners reached 	<ul style="list-style-type: none"> Level of participation Level of satisfaction among stakeholders Appeal of the initiative 	<ul style="list-style-type: none"> Records Social media feeds Participatory photography or video News stories or essays Direct observation
2.5 Recognition and reward schemes instituted in schools for student participation and excellence in <i>Aksi bergizi</i> school-based activities.	<ul style="list-style-type: none"> Count of recognition and reward schemes instituted Count of students recognized 	<ul style="list-style-type: none"> Level of participation in selecting student winners Level of satisfaction with the scheme among stakeholders 	<ul style="list-style-type: none"> Survey Interview Focus group discussion Most significant change stories

Implementation Milestones		Process Indicators		Mean of Verification (suggested)
3. Community engagement				
3.1	Youth volunteers at village health posts and members of <i>Karang Taruna</i> oriented to promote <i>Aksi bergizi</i> messages and physical fitness activities.	<ul style="list-style-type: none"> Count of youth volunteers oriented Count of districts or communities included in the orientation 	<ul style="list-style-type: none"> Level of satisfaction with the orientation among stakeholders Level of inclusion in the orientation 	<ul style="list-style-type: none"> Exit interviews Focus group discussion
3.2	Out-of-school adolescents oriented and engaged in <i>Aksi bergizi</i> activities through trained members of <i>Karang Taruna</i> or <i>Posyandu Remaja</i> and Forum Anak.	<ul style="list-style-type: none"> Count of out-of-school adolescents reached 	<ul style="list-style-type: none"> Level of satisfaction with the training Level of participation in the training Level of inclusion in the training Quality of the training content 	<ul style="list-style-type: none"> Social network maps Confidence snails
3.3	Conduct awareness-raising sessions for parents, local leaders and food vendors.	<ul style="list-style-type: none"> Count of awareness sessions held Count of participants reached 	<ul style="list-style-type: none"> Level of satisfaction with the training Level of participation in the training Level of inclusion in the training Quality of the training content 	<ul style="list-style-type: none"> Direct observations Focus group discussions Social network maps
3.4	Community events organized to promote adolescent nutrition and celebrate nutrition-specific and nutrition-sensitive annual observances in schools and communities.	<ul style="list-style-type: none"> Count of events held Count of participants reached 	<ul style="list-style-type: none"> Level of participation in the events Level of inclusion in the events Level of satisfaction with the events 	<ul style="list-style-type: none"> Direct observations Focus group discussions Local media reports Participatory photography/video
4. Capacity strengthening				
4.1	Peer counsellors trained and engaged in adolescent nutrition and interpersonal communication.	<ul style="list-style-type: none"> Count of peer counsellors trained Count of peer counsellors actively promoting nutrition messages 	<ul style="list-style-type: none"> Level of participation in the training Level of inclusion in the training Level of satisfaction with the training 	<ul style="list-style-type: none"> Focus group discussions Exit interviews Direct observations
4.2	Health workers at <i>puskesmas</i> and <i>kaders/volunteers</i> at <i>posyandu</i> trained on adolescent nutrition and conducting outreach efforts.	<ul style="list-style-type: none"> Count of health volunteers trained 	<ul style="list-style-type: none"> Level of participation in the training Level of inclusion in the training Level of satisfaction with the training 	<ul style="list-style-type: none"> Focus group discussions Exit interviews Direct observations
4.3	Religious leaders oriented on adolescent nutrition and incorporating <i>Aksi bergizi</i> messages in their teaching.	<ul style="list-style-type: none"> Count of religious leaders oriented Count of religious leaders incorporating nutrition messages in their teaching 	<ul style="list-style-type: none"> Level of participation in the training Level of inclusion in the training Level of satisfaction with the training 	<ul style="list-style-type: none"> Focus group discussions Exit interviews Direct observations
4.4	School canteen operators sensitized and mobilized to support adolescent nutrition.	<ul style="list-style-type: none"> Count of school canteen operators sensitized 	<ul style="list-style-type: none"> Level of participation in the training Level of inclusion in the training Level of satisfaction with the training 	<ul style="list-style-type: none"> Focus group discussions Exit interviews Direct observations
5. Social and mass media				
5.1	Media training for adolescents conducted.	<ul style="list-style-type: none"> Count of adolescents trained Count of media trainings organized 	<ul style="list-style-type: none"> Level of participation in the training Level of inclusion in the training Level of satisfaction in the training 	<ul style="list-style-type: none"> Training reports
5.2	Social media messaging utilized through channels such as Instagram, WhatsApp, Line, YouTube and Facebook.	<ul style="list-style-type: none"> Count of social media platforms utilized Count of messages disseminated Count of views, clicks, shares, followers or likes 	<ul style="list-style-type: none"> Level of engagement in social media Level of inclusion in social media outreach Popularity of social media as a platform for adolescent nutrition 	<ul style="list-style-type: none"> Hits and likes
5.3	An <i>Aksi bergizi</i> website or application developed, accessed and used by students and teachers in all pilot schools, partners, media and public.	<ul style="list-style-type: none"> Count of views, clicks, shares, followers or likes or downloads 	<ul style="list-style-type: none"> Level of engagement in digital media Level of inclusion in digital media Appeal of material Clarity of content 	<ul style="list-style-type: none"> Records Interviews
5.4	Local champions for nutrition promoted through media – social and mass.	<ul style="list-style-type: none"> Count of local champions engaged Count of messages on local media Count of people reached by the local champion 	<ul style="list-style-type: none"> Level of engagement of local champion Community members' level of satisfaction with interactions 	<ul style="list-style-type: none"> Most significant change stories A day in the life... Interviews Social network mapping

Implementation Milestones	Process Indicators	Mean of Verification (suggested)
6. Materials development		
6.1 Review of existing material completed and additional material needed (for Phase 2) identified. Online repository of relevant and useful materials created and shared with stakeholders.	<ul style="list-style-type: none"> ▸ Review completed ▸ Counts of people accessing repository of material 	<ul style="list-style-type: none"> ▸ Quality of existing material ▸ Appeal of existing material ▸ Clarity of existing material
6.2 Photo novellas by and for adolescents developed and disseminated.	<ul style="list-style-type: none"> ▸ Counts of photo novellas developed ▸ Counts of adolescents reached by photo novellas 	<ul style="list-style-type: none"> ▸ Appeal of the material ▸ Quality of the material ▸ Clarity of content ▸ Level of inclusion
6.3 Guides for religious leaders and community influentials created and used as tools for interpersonal outreach and counselling.	<ul style="list-style-type: none"> ▸ Counts of guides developed ▸ Counts of guides distributed ▸ Counts of religious leaders using the guides 	<ul style="list-style-type: none"> ▸ Appeal of the material ▸ Quality of the material ▸ Clarity of content ▸ Level of inclusion
6.4 Information booklets for parents and caregivers developed and disseminated	<ul style="list-style-type: none"> ▸ Counts of booklets developed ▸ Counts of booklets distributed ▸ Counts of parents reached 	<ul style="list-style-type: none"> ▸ Appeal of the material ▸ Quality of the material ▸ Clarity of content ▸ Level of inclusion
▸ Mapping ▸ Interviews	▸ Survey ▸ Focus group discussions	▸ Survey ▸ Interviews ▸ Focus group discussions
▸ Survey ▸ Interview ▸ Focus group discussions		

Participatory monitoring and evaluation

Save the Children, UNICEF and other child/adolescent development and participation-focused organizations (Lansdown, G and C. O’Kane, 2014) offer a 10-step guide to help undertake a participatory monitoring and evaluation process with children and other key stakeholders. It offers guidance to support children, young people and other stakeholders to identify relevant objectives and indicators against which to measure progress. It also supports systematic data collection, documentation and analysis of the M&E findings:⁵⁴

Step 1: Identify the programme and objectives to be monitored and evaluated

Step 2: Build support and buy-in

Step 3: Establish an M&E core group

Step 4: Build the capacity of the M&E core group

Step 5: Develop an M&E plan or integrate into an existing M&E plan

Step 6: Introduce M&E of children’s participation to the stakeholders

Step 7: Collect baseline data

Step 8: Use tools to gather information, to reflect on and to analyse the scope, quality and outcomes of children’s participation

Step 9: Document and report the process and findings

Step 10: Draw up an action plan on findings and feedback to key stakeholders

Participatory M&E tools

Aligned to behaviour outcomes in Table 7, key participatory monitoring tools for tracking intermediate behaviour changes are listed below. For a more exhaustive list, see Annex 7, and for descriptions on how to use them – including examples of some country applications – please visit the [RBC Toolkit](#) (2018).⁵⁵

- › Ideal plate
- › Draw and describe
- › Social media posts
- › A day in the life
- › Most significant change
- › Photo voice/video
- › Confidence snails
- › Body mapping
- › Oral histories
- › Card sorts and card ranking
- › Ask 5
- › Participatory theatre

⁵⁴ See: <https://resourcecentre.savethechildren.net/library/toolkit-monitoring-and-evaluating-childrens-participation-introduction-booklet-1>

⁵⁵ These M&E tools were derived from the 2018 Rain Barrel Communications Participatory Research Toolkit authored by Suruchi Sood, Carmen Cronin and Kelli Kostizak.

Documenting promising practices, innovations and lessons learned⁵⁶

Adolescent nutrition in middle-income country and international development contexts is a new or emerging area, given that the majority of maternal and child nutrition programmes tend to focus on the first 1,000 days. Sustainably improving diets and physical activity in adolescence is largely unexplored terrain in low- and middle-income settings, as is the contribution of communication to individual and collective health and well-being in these contexts. As such, this SBCC strategy addressing the triple burden of malnutrition among adolescents in Indonesia should be viewed as a vital contribution to an emerging area of theory and practice. The research, theory, evidence and stakeholder participation that have gone into its design are rigorous and comprehensive. It is hoped that the intervention will emerge as a cutting-edge contribution to the less-than-robust knowledge base of promising and innovative practices to improve adolescent nutrition and that it will provide significant lessons learned in SBCC programming.

In order to do so, a system for documenting the process – complete with appropriate tools and criteria – is needed to capture and share any promising practices, innovations and lessons that may emerge from inception to evaluation. Effective knowledge management of M&E evidence will not only support the delivery of the Theory of Change developed for this strategy (see *Figure 11 in Chapter 3*) but also will guide the effective design and implementation of future phases and possible scaling up of the programme.

Examples of documented promising practices in C4D and adolescent participation programming have been published by UNICEF East Asia and the Pacific Regional Office (2018);⁵⁷ UNICEF Middle East and North Africa Regional Office (2015),⁵⁸ and UNICEF Regional Office for Latin America and the Caribbean (2010).⁵⁹ However, none has been documented so far around C4D/SBCC on adolescent nutrition programming, monitoring and evaluation.

⁵⁶ RBC partner memria.org offers easy-to-use software and training to capture and disseminate participant stories and stakeholder feedback in social change initiatives. Visit: <https://www.memria.org/#how-memria-works/>

⁵⁷ UNICEF (2018d) / Heidrich, G (2018), Communication for Development Promising Practices – Examples from Cambodia, Malaysia, Philippines and Vietnam, UNICEF East Asia and the Pacific Regional Office, Bangkok. Visit: https://www.unicef.org/eap/sites/unicef.org/eap/files/2018-06/Promising_Practices_V7_0.pdf

⁵⁸ UNICEF (2015), Good Practices in Adolescent and Youth Programming: Analytical Report, UNICEF Middle East and North Africa Regional Office (MENARO) on behalf of the UNIATTTYP, R-UNDG Arab States/MENA. Visit: https://goodpracticessite.files.wordpress.com/2016/03/afs_unicef.pdf

⁵⁹ UNICEF (2010), Finding their voice: engaging adolescents in meaningful participation strategies, UNICEF Regional Office for Latin America and the Caribbean (LACRO), Adolescent Participation Unit, Panama City. Visit: <http://www.icicp.org/wp-content/uploads/2014/07/What-Works-Adolescent-Participation-in-Latin-America.pdf>

Promising practice

A promising practice (PP) is defined as, “a programme or intervention that meets a specific set of criteria. A documented PP describes what works to improve the lives of individuals and which is sustainable or replicable in a specific context” (UNICEF Indonesia, 2017).⁶⁰ Promising practices are understood as the mid-point on a continuum from emerging practice to good/best practice. They are defined both positively against emerging practice – as making progress or demonstrating greater potential than a practice that is undocumented or does not represent good practice; as well as negatively – against good or best practices that meet all or most of the criteria of ideal practice.⁶¹

UNICEF Indonesia (2017)⁶² provides a ranking to describe the continuum from an emerging good idea to a promising practice, leading to good/best practice (see Figure 24). To be classified as emerging, a promising or best practice will depend on the quality of evidence (horizontal) from ‘weak’, ‘moderate’, ‘strong’ to ‘rigorous’, and impact (vertical) based on the following criteria: effectiveness, reach, feasibility, sustainability and transferability (see Table 9).

- › Good/best practice – meets all criteria; rigorous evidence of effectiveness and sustainability/replication is provided;
- › Promising practice – meets most of the criteria for promising practice; strong evidence is provided;
- › Emerging practice – meets many of the criteria but there is insufficient information to determine if it currently meets most of the essential criteria for impact.

Figure 24. Conceptual framework for continuum of promising to best practice



Source: Spencer, Schooley et al, 2013 as cited by Sammon et al, 2017.

⁶⁰ UNICEF/Sammon, et al (2017), Overview of Promising Practices in Adolescent Programming in Indonesia, UNICEF Indonesia, Jakarta. Visit: https://www.unicef.org/indonesia/Overview_of_Promising_Practices_in_Adolescent_Programming_in_Indonesia.pdf

⁶¹ Ibid.

⁶² Ibid.

Innovation

An innovation may be a pilot project or new approach to a standard programming or operations model that can demonstrate initial results. It is a practice that has a strong potential for successful impact but has not been substantiated with a formal evaluation or scaled up beyond its initial scope (UNICEF, In Practice, 2011).⁶³

Lesson learned

A lesson learned is knowledge gained based on actual experience or through some form of objective review and validation process (not necessarily a formal evaluation) and has potential relevance beyond the area or country where the experience took place. Lessons should be stated as specifically as possible, together with an explanation of how the lesson was derived and validated. References should be provided to any related evaluations, reviews, consultations or other forms of validation and documentation (UNICEF, In Practice, 2011).⁶⁴

Criteria for a promising practice

Based on a literature review of promising practices in adolescent programming in Indonesia, 11 evidence-based criteria were derived. These criteria were cross-referenced with the five domains of the UNICEF adolescent development framework, namely health and well-being, education and learning, protection, transition to work, and participation and engagement.⁶⁵ Promising practice “meets most criteria, mainly those for evidence-based, equity, values orientation, innovativeness and youth involvement, but no evaluation of outcomes has been conducted and thus there is yet no evidence of effectiveness” (UNICEF MENARO, 2015).

Table 9 lists 11 criteria for reviewing a programme as a promising practice in adolescent health and well-being. Knowing these criteria before-the-fact – i.e., during strategy design and implementation – provides the programme a head start to evaluation, an advantage that could steer it to becoming a promising practice.

⁶³ UNICEF (2011), In Practice webpage, UNICEF, Programme Division, New York.

⁶⁴ Ibid.

⁶⁵ The definition, criteria and methodology for promising practice are derived from the combined experiences of UNICEF Indonesia (2017), UNICEF MENARO (2015), and US Centers for Disease Control and Prevention (CDC, 2010).

Table 9. Criteria for a promising practice in programming for adolescent well-being⁶⁶

Criteria	Area for development
1. Evidence-based programme design	How does programme design comply with international and national obligations and commitments on human rights and gender equality; how is the programme design evidence based?
2. A theory of change	How does the programme specify intended outcomes and describe the activities that are related to those outcomes?
3. Documentation	Are there guides, manuals or other available writings and training materials that specify the components of the programme and describe how to administer it?
4. Accepted practice	How do stakeholders demonstrate general acceptance of the programme as appropriate for use with children?
5. Monitoring and evaluation	Is there an effective monitoring and evaluation plan and evidence of its execution?
6. Cultural competency and partnerships	How does the programme consider the specific requirements of and involve adolescent boys and girls, adolescents of different religions or ethnic groups, adolescents with disabilities including intellectual disabilities?
7. Reaches the most vulnerable and marginalized	How does the programme identify and reach the poorest adolescents, adolescent girls, adolescents with disabilities, adolescents affected by HIV, adolescents affected by violence, other marginalized populations?
8. Evidence of positive outcomes and/or impact	Has the programme been subject to an external independent study demonstrating positive outcomes? Is the evaluation available for review? How do programme participants perceive the benefits of the programme?
9. Sustainable and replicable	How did the programme put in place plans for the project to be sustainable after the initial phase was complete? This includes finance, policy and delivery structures
10. Involved and empowered adolescents	How did the programme create a safe space for adolescents to actively participate and contribute to the programme's plan and delivery?
11. Innovative	Was the programme design flexible when required to change and adapt to new information and challenges?

⁶⁶ UNICEF/Sammon, E, et al (2017), How do you know what's good for me? A guide for planning and measuring promising practices in programming for adolescent well-being in Indonesia, Technical report prepared for UNICEF Indonesia and Oxford Policy Management, Jakarta.

Suggested template for documenting promising practice, innovations and lessons learned⁶⁷

Category: Promising Practice (PP) or Innovation or Lesson Learned (LL) (please choose one)
Thematic Focus Area or Cross-Cutting Strategy: <i>your text here</i>
Country: <i>your text here</i>
Title: <i>your text here</i>
Related links: <i>Please provide links to related study, report, evaluation, website that may provide additional information on the PP, LL or Innovation.</i>
Contact person: <i>Please provide the name and e-mail address of a person who can be contacted for any questions regarding this lesson or innovation.</i>
Abstract: <i>Please provide 2–3 short paragraphs to describe in brief the purpose of the sharing the PP, Innovation or LL. This should leave the reader with an overall picture of the context, the PP, innovation or LL (positive or negative), why it is important and the value it adds.</i>
Promising practice, innovation or lessons learned: <i>Please describe briefly the main elements why it is a PP, or the lessons learned or innovative elements from this experience that make it a PP, innovative or of interest. Please include information both on what worked and what did not, what you would continue to do and what you would do differently in the next phase.</i>
Potential application: <i>Please describe briefly the potential application of the PP, innovation or lesson learned to programming or operations beyond the original scope (e.g., to scale up regionally or nationally or to be replicated in other settings, other sectors).</i>
Issue: <i>Briefly describe the initial situation (context) and the problem/issue which prompted the initiative.</i>
Strategy and implementation: <i>Describe the strategy used and how it was implemented. This should link to the issue outlined above and highlight the main steps taken in implementing the strategy. Include a few relevant images with captions and credits that show stakeholders in action.</i>
Progress and results: <i>In summary, describe the progress and any verified results (using qualitative and/or quantitative evidence) in implementing or applying the initiative or innovation. Please describe factors that enabled or hindered progress.</i>
Next steps: <i>Describe any planned next steps in implementation and highlight any changes in strategy as a result of progress or results to date.</i>

⁶⁷ The template was adapted from the UNICEF In Practice webpage.

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ANNEXES

Annex 1. Communication-related barriers/challenges and opportunities to improve adolescents' dietary practices and physical activity

At the individual level

- Lack of knowledge about nutritious foods by adolescents and parents alike.
- Lack of motivation or capacity to put existing knowledge into practice. Time constraints, the convenience of commercially prepared foods, taste preferences, easy accessibility of processed foods, surrounding eating habits and the lack of good role models are all factors in the equation.
- Sedentary lifestyle exacerbated by increased access to and use of digital entertainment and modern modes of transport, leading to the decline in functional fitness.
- Attitudes that limit physical exercise to traditional sports, thereby impacting motivation and limiting opportunities to become physically active as a part of everyday life.
- Lack of support from family and friends to make healthy eating and functional fitness easier, and a sustained habit.
- Non-systematic hygiene behaviours (such as handwashing with soap at critical times) and use of unsafe water help spread infectious diseases (e.g., diarrhoea) that rob the body of important nutrients.

At the interpersonal level

- Influence of family members (especially parents) in introducing and maintaining suboptimal eating and exercise practices.
- Unsupportive family meal practices, including breakdown of traditions of shared family meals or home-based breakfasts. Consumption of nutritious proteins, vegetables and fruits is often restricted while preferring empty-calorie carbohydrates.
- Peer influence that promotes sedentary lifestyle, snacking behaviours and choice of 'cooler' fast foods as part of socializing.
- Persistent and harmful traditional beliefs, such as food restrictions for women and girls during menstruation, contributing to anaemia.
- Unequal distribution of household labour between parents, which tends to leave food shopping and family meal preparation as solely the woman's responsibility.
- Poverty that limits household food choices and dietary diversity, as well as access to information on optimal diet and physical exercise.

At the community level

- › Lack of public knowledge about nutrition in general and adolescent nutrition in particular.
- › Gender norms that restrict girls' access to information, participation and freedom of movement as well as amount of free time (e.g., stricter curfews, household chores).
- › Lack of adolescent participation and failure to encourage adolescents as allies in the creation of social movements and as advocates on issues that impact their well-being.
- › Weak participation of community members, especially community/traditional leaders, religious leaders and local influencers, in nutrition efforts.
- › Absence of local demand for improved access to and quality of nutrition services as well as the accountability of health service providers to fulfil their specific responsibilities as duty bearers.
- › Absence of a supportive environment and local solutions in support of adolescent nutrition in schools and health delivery systems.

At the organizational level

A. Schools: public, private, *madrasah*

- › Low knowledge regarding adolescent nutrition by decisionmakers and school staff.
- › Scarcity of educational materials on nutrition intended for adolescents.
- › Vague nutrition and physical activity messaging without clear, doable actions or alternatives offered.
- › Unregulated school canteens.
- › Old-fashioned physical education curriculum.
- › Lack of nutrition topics in school health curriculum.
- › Lack teaching/training modules on adolescent nutrition and physical exercise in nurse and teacher college materials and curricula, including adolescent-friendly counselling, interpersonal communication skills, and appropriate key messages.

B. Health system

- › Lack of adolescent-friendly health and nutrition counselling given by school and community health workers (e.g., IFA dose distribution lacks quality counselling that is respectful and includes broader advice regarding healthy eating habits and physical activity).
- › Poor quality interpersonal communication/message delivery by health care workers, community health volunteers, teachers and social mobilizers. The content, tone and repetition of messages as well as the follow-up of communication efforts are critical to adoption of recommended behaviours.
- › Inadequate staff orientation and training on health promotion in general and on adolescent nutrition education in particular.

- › Lack of relevant, action-oriented, visually heavy and attractive educational and communication materials and tools for use by health professionals and teachers. Health workers will also need basic orientation on the effective and strategic use of such materials.
- › Lack of sufficient outreach efforts by social mobilizers and health care workers, often owing to insufficient staffing/resources.
- › Lack of coordination mechanisms with and between various community-based organizations (CBOs) and NGOs that are supported by donors, causing inefficiency from duplication of efforts, missed synergies and wasted resources.
- › Absence of systematic monitoring and documentation of as well as information-sharing practices on behaviour and social change as well as advocacy communication efforts.
- › Missed opportunities to reach large populations with nutrition information at points-of-service and local gatherings (e.g., no education sessions held at many clinics; no relevant or strategically used educational materials available at points-of-service).
- › Lack of available and/or appropriate behaviour and social change materials that are suitable for local context, considering possible low literacy levels and cultural characteristics as well as local languages.
- › Paucity of modern approaches to health and nutrition promotion that take into account urbanization, demographic and cultural shifts in the real and virtual environment.

At the policy level

- › Low awareness on importance of adolescent nutrition among policymakers (Savica, 2017; Soekarjo, 2018).
- › Existence of numerous nutrition-specific and nutrition-sensitive programmes, policies and laws that address aspects of the problem, but are not comprehensive enough to offer encompassing solutions to prevent adolescent undernutrition and obesity.
- › Adolescents still insufficiently covered in nutrition and nutrition-sensitive policies at the level of detail required for concrete guidance for programming.
- › Low awareness of or interest in nutrition in general and adolescent nutrition in particular among decisionmakers due to competing priorities.
- › Absence of a national school curriculum on adolescent nutrition.
- › Siloed and fragmented sectoral policies and strategies on nutrition impacting adolescent girls and boys (Savica, 2017; Soekarjo, 2018).
- › Spotty organization and management of lunch programmes in secondary schools, leaving many adolescents with few healthy options in canteens and without proper nourishment during long school days.

Opportunities

A wealth of opportunities exists in Indonesia for moving adolescent nutrition and healthy lifestyles higher in public awareness and on the political agenda. There is greater awareness of the need to educate and encourage young people to take charge of their health, supported by improved and better-targeted policies and services. Indonesia's historical investment and global leadership in tackling communicable diseases, particularly in child survival and development, can now be leveraged to address nutrition-related NCDs, addressing the gaps in attention to the second decade of life.

Among the opportunities to be leveraged:

- The Government of Indonesia has a National Strategy on Adolescent Health underway, expected to be finalized in late 2018. **Opportunity to advocate for a strong component on improving adolescent nutrition and physical activity for school-going and out-of-school adolescents.**
- For the majority of adolescents attending school six days a week, schools are more than just learning centres; they are the social centres for engagement with their peers. **Opportunity to include nutrition-boosting activities and physical activities during the weekly Girl Scout and Boy Scout day every Wednesday (as part of the scout motto to "do a good deed for the day") and in extracurricular programmes every Saturday.**
- The Government of Indonesia has school health policies in place to ensure health education and essential health services for all children and adolescents. **Ensure that District Education Office implements the UKS/school health unit in every school providing adolescent-friendly health services (AFHS)/PKPR by trained teacher–health care providers.**
- The Ministry of Education and Culture (MOEC) and Ministry of Religious Affairs (MORA) are working to motivate both government and religious schools to become healthier environments through competitions (GAIN, 2014). **At the start of every school year, administrators, PTA and student council should plan competitive learning activities that are fun and productive.**
- Some schools have made initiatives to pilot jointly consumed, home prepared school meals – breakfast or lunch. However, actual school feeding programmes run only in select vulnerable communities hit by economic shocks or natural disasters. **It would be an opportunity to partner with FAO, Ministry of Agriculture and local agricultural extension workers to support schoolyard gardens with participation of parents and students.**
- Nutrition Learning Modules with 36 30-minute lessons have been developed by UNICEF's implementing partner and are currently being piloted. A series of training of trainers (TOT) has been conducted with teachers and health care providers in pilot schools and communities. Fun learning activities have been designed for each module. **Assigned teachers and peer mentors/counsellors for these modules can plan related SBCC activities that are linked to the topic identified for each week.**

- Through PTAs and other interaction with surrounding communities, school-based nutrition education activities have the potential of influencing family traditions and norms around food and physical activity, while also reaching into the larger external environment to mobilize out-of-school adolescents, parents and the community at large. **PTAs can spearhead the school's search for champions or positive role models in adolescent nutrition and physical activity, with participation of student council in criteria design, recognition and mobilization as peer counsellors/mobilizers.**
- Increased willingness of the private sector to offer healthier choices to adolescents and promote better health and exercise. **District Task Force or steering committee can invite business groups in district to commit their support to specific milestones in the action plan.**

Annex 2. Assessment of communication and media landscape in Indonesia:

Potential for adolescent nutrition promotion of commonly used health promotion channels (Adapted from Preliminary strategy draft)

Type of channel/ media and examples	Strengths/nature	Limitations	Implications for SBCC strategy
<p>Interpersonal communication (IPC) and small group +</p> <p>E.g., adolescent girl/ boy:</p> <ul style="list-style-type: none"> ▸ Attending literacy classes or school lesson on nutrition, or ▸ interacting with a health worker at an adolescent-friendly sexual and reproductive health (AFSRH) clinic. 	<ul style="list-style-type: none"> ▸ Potentially a two-way dialogue that feeds feelings of respect and equality ▸ Most effective way to educate, inform and influence knowledge, attitudes and behaviours ▸ Allows addressing individual-level concerns, questions and challenges as per individual needs and situations for increased support, motivation, commitment and empowerment as well as heightened knowledge + action ▸ IPC trainings benefit services and programmes across health topics 	<ul style="list-style-type: none"> ▸ Initial training of staff may be costly ▸ Training seldom reaches all relevant health care staff ▸ Time consuming and labour intensive ▸ Time consuming to monitor effectiveness, unless light spot monitoring (e.g., exit surveys) are used ▸ Effectiveness highly dependent on the quality of interaction (e.g., effective trainer, listening skills of participants, and presence of health worker) ▸ Reaches only a small portion of audience members at a time 	<ul style="list-style-type: none"> ▸ Can also be used in advocacy efforts ▸ Include as part of Annual District Health and Nutrition Action Plan: Interactive Training on Technical IPC and Nutrition Counselling Skills ▸ Develop modules, session plans and tools for adaptation in different locations ▸ If done well, does not require many (if any) supportive materials ▸ Prepare for and conduct a Training of Trainers (TOT) tapping local CSOs/NGOs.

Type of channel/ media and examples	Strengths/nature	Limitations	Implications for SBCC strategy
<p>Print media E.g., posters, leaflets, brochures, flipcharts, cue cards</p>	<ul style="list-style-type: none"> Can reach large populations at a time Can summarize key messages effectively in text and/or visually, even for those illiterate Easy and quick to produce Relatively cheap to develop 	<ul style="list-style-type: none"> Will need to be tailor-made to specific audiences to be impactful Often does not answer to individual-level concerns Requires careful planning in material use, positioning and distribution (incl. timing) to be effective; will also need regular, well-timed rotation of materials/messages to sustain attention-catching potential Expensive to produce if large numbers of people/locations are targeted Coordination of design, pretesting, production, supply, distribution logistics, storage and stocktaking requires clear roles and responsibilities + funds 	<ul style="list-style-type: none"> Requires careful planning in materials use, positioning and distribution (incl. timing) to be effective; will also need regular, well-timed rotation of materials/messages to sustain attention-catching potential Requires that these materials be part of a strategic plan and in coordination with other SBCC interventions to be effective
<p>Traditional community media as entertainment-education (edutainment) E.g., puppetry, storytelling, songs, theatre drama, dance, fine arts.</p>	<ul style="list-style-type: none"> Generally well-liked methods due to their familiarity in the communities/cultures Cheap or even free to produce Often mobilize and engage local artists and community members for added interest and participation Allow the execution of entertaining education (edutainment) principles for fun and entertaining ways to learn, engage and mobilize communities 	<ul style="list-style-type: none"> Reach relatively small numbers of people at a time Require careful strategic planning and follow-up activities (e.g., facilitated community discussions) to be truly effective Labour and time intensive If ready scripts or messages are shared with performing groups, close tutoring and monitoring are needed to ensure correct delivery of messages and prevent potential misunderstandings on critical information 	<ul style="list-style-type: none"> Artistic and creative groups are available and should be tapped to mentor artistically inclined adolescents/students on their respective art forms when planning school and community events on <i>Aksi bergizi</i>.

Type of channel/ media and examples	Strengths/nature	Limitations	Implications for SBCC strategy
<p>Small group activities E.g., school nutrition literacy classes, parent-teacher meetings; peer counsellor meeting with peers, community meetings, sports/social group gatherings, advocacy meetings.</p>	<ul style="list-style-type: none"> Often successful in social mobilization and advocacy activities when strategically executed Free or low cost to organize Allow for discussions while encouraging participation for increased knowledge, change in behaviours, shared action and increased ownership Potentially influence social norms in community by encouraging sustainability of actions 	<ul style="list-style-type: none"> Reach a somewhat small number of people at a time Will require facilitation by a skilled facilitator to be effective Will need attention from facilitator to ensure also those who are quieter or with differing voices among the group may contribute Require clear agendas and strategic plans to be impactful 	<ul style="list-style-type: none"> This strategy should be used with adequate guidance and planning with teacher-facilitators and peer counsellors.
<p>Radio E.g., national and local radio channels used to broadcast radio discussion programmes, PSA announcements, songs, radio spots and ads.</p>	<ul style="list-style-type: none"> Has the potential to reach large numbers of population at one go Relatively easy and quick to produce/record audio material and to distribute them to radio stations Many no-cost collaborations already exist at regional level radio stations; e.g., with nutrition/health discussion and call-in programmes; no stand-alone activities need to be created May be an effective channel for general awareness creation and information sharing; radio ownership and use remains high, especially in the rural areas 	<ul style="list-style-type: none"> May not reach the exact desired target audiences and, hence, may waste resources Airtime at peak listening times often too costly for reach of desired target audiences Requires systematic, intensive and strategic repetition of messages to ensure recall and penetration of these messages Without strategic, well-coordinated and timed approach, will not be very impactful Not very effective for prompting behaviour change, more useful for awareness creation May have limited reach in certain parts of the country 	<ul style="list-style-type: none"> Adolescents rated radio as low preference as a medium for informing them and mobilizing action for healthy diets and physical activity. However, to garner support, parents and members of the community are potential receivers of broadcast messages on <i>Aksi bergizi</i>.

Type of channel/ media and examples	Strengths/nature	Limitations	Implications for SBCC strategy
<p>TV and newspapers</p> <p>E.g., TV programmes, newspaper/human interest stories, press releases, media Q&As, printed ads.</p>	<ul style="list-style-type: none"> Has the potential to reach large numbers of people at once Is effective in creating awareness and informing audiences, if repeated systematically and frequently May promote change in social norms by showing example of desired behaviours; e.g., with TV dramas Potentially effective in creating public discussion and as an advocacy tool 	<ul style="list-style-type: none"> May require initial trainings, which come with a cost Can be expensive to produce and broadcast without media/ journalist allies and CSR partnerships Requires a well-planned strategic approach to be effective Is largely unsustainable Success in reaching specific and segmented key target audiences is a hit and miss Informs people... but is not necessarily a tool in behaviour change May have limited reach in certain areas of the country, also due to illiteracy and poverty 	<ul style="list-style-type: none"> TV is a preferred medium among adolescents in the two pilot districts. Most homes have access to TV. Need to advocate with broadcast executives to encourage TV programme managers to feature school activities, champions and ambassadors for <i>Aksi bergizi</i>.
<p>Digital media / Internet + mobile-based social media</p> <p>E.g., social media platforms such as Facebook, Twitter, Instagram, Snapchat, Pinterest.</p> <ul style="list-style-type: none"> Internet-based email, websites Mobile chat applications such as WhatsApp, BBM, Messenger, others SMS messaging applications 	<ul style="list-style-type: none"> Relatively cheap to design and sustain Often free channels to share information Potential to reach large amounts of people at one go Helpful in awareness creation, reminder messages, information sharing Reach and use constantly increasing 	<ul style="list-style-type: none"> May not reach the exact segmented target audiences Use restricted to mostly younger, educated and literate (more urban) populations, or those more well-off Requires strong repetition of messages to ensure recall As a stand-alone activity not effective apart from awareness raising and reminder messaging May have limited reach in certain areas of the country Competes with a lot of information, also incorrect and even harmful information on the internet 	<ul style="list-style-type: none"> Adolescents use digital media as a medium of choice for chatting and sharing information and activities. Will be tapped to the maximum for <i>Aksi bergizi</i> activities as appropriate.

Type of channel/ media and examples	Strengths/nature	Limitations	Implications for SBCC strategy
<p>Audio and audiovisual media</p> <p>E.g., songs, videos, animations, info/ message spots, documentaries.</p>	<ul style="list-style-type: none"> Potential to engage large audiences in entertaining and effective ways Engages multiple senses (visual, audio) for better recall and penetration A powerful aid in awareness raising when in support of other interventions Easy to copy and distribute widely 	<ul style="list-style-type: none"> Initially may be expensive to produce Potentially lacks in personal connection and, hence, careful segmentation of audiences; best if tied with other interventions such as group discussions, exit surveys, etc. before or after screening/listening Requires strategic planning for use to be effective 	<ul style="list-style-type: none"> These media should be produced to ensure a multichannel strategy that maximizes and reinforces engagement of participant groups, strengthens capacities and fosters self-confidence, participation and action. Will be used as support materials and tools for more effective interpersonal communication and counselling.

Annex 3. Recommended programme interventions suggested by FGD participants from Klaten and Lombok Barat, August 2017

Klaten		Lombok Barat	
Programme	Justification	Programme	Justification
NUTRITION-SPECIFIC INTERVENTIONS			
Iron and folic acid supplementation for adolescent girls	<ol style="list-style-type: none"> 1. Data from Riskesdas 2007–2015 showed an increase of anaemia from 9% to 26.4% among girls 5–14 years old. 2. Adolescent girls will eventually become pregnant women, so it is important to prevent iron deficiency that leads to anaemia. 3. Menstruation cycle depletes iron in the body when their daily food intake is low in iron, so they need iron supplements. 4. It is important for those who stay in school to stay healthy, and not sleepy during school hours. 5. To improve the nutrition of young women which will increase productivity. 6. Women as prospective mothers should have good nutrition to reduce mortality – MMR and IMR. 7. In producing the next generation, adolescent mothers should have optimal nutritional status so they will not give birth to LBW children. 8. Supplementation should be more selective (only for those with anaemia) because supply of iron tablets and IFA is often. 	Iron and folic acid supplementation for adolescent girls	<ol style="list-style-type: none"> 1. The rate of anaemia cases in adolescent girls is still high (43%). 2. Adolescent girls will become mothers, so iron is important. 3. Maternal and infant mortality (IMR) is still high due to bleeding (anaemia). 4. Ability to learn is impacted by anaemia. 5. Prevent low birth weight. 6. Focus on changes in behaviour patterns. 7. It will then be necessary for rural areas. 8. Current interventions will be implemented over the next 2 years.

Klaten		Lombok Barat	
Programme	Justification	Programme	Justification
Nutrition education/diet counselling	<ol style="list-style-type: none"> 1. It is important to improve nutrition knowledge and change the behaviour and diet of adolescents. 2. Should be done during parent meetings or on a division of report cards to ensure parent participation. 3. This point needs to be prioritized because it becomes the basis of behaviour change and will make other interventions be more easily executed. 4. Because nutrition education in schools is not yet complete. 5. Teenage diet is low in fruits and vegetables, but high in salty foods, preservatives. 	Nutrition education/diet counselling	<ol style="list-style-type: none"> 1. To increase adolescents' knowledge (knowledge, attitude and behaviour change). 2. To ensure changes in lifestyle. 3. Nutrition education is very important, including education about body image. 4. Changing of society's attitudes and behaviour relies on education and knowledge being provided. 5. It is important to consider the continuation of the programme (sustainability) and target not only adolescents but also their families.
		Weekly 'Bring a healthy lunch' movement	<ol style="list-style-type: none"> 1. Memberikan pendidikan melalui contoh. 2. Melibatkan orang tua agar siswa diharapkan dapat memberikan pendidikan bagi orang tuanya.
Screening BMI measurement	<ol style="list-style-type: none"> 1. Very important to know adolescents' health status and to get a description about which (health) programmes need to be prioritized. 2. Adolescents' health status needs to be monitored and health services provided. 	Other: Promotional media creation	Ideally the topic is changed every month.
NUTRITION-SENSITIVE INTERVENTIONS			
Reproductive health and HIV education	<ol style="list-style-type: none"> 1. The influence of social media 2. High incidence of HIV in Klaten 3. Adolescent knowledge about reproductive health is still low and curiosity makes them experiment with sex 4. Need a reliable source of information (health and teachers) to provide reproductive health counselling and materials so they do not look for other sources like the internet. 5. Reduce the prevalence of venereal disease. 6. Prepare healthy adolescents. 	Reproductive health and HIV education	<ol style="list-style-type: none"> 1. Prevent stunting. 2. Prevent early marriage. 3. Reduce Maternal Mortality Ratio and Infant Mortality Rate. 4. Stop the increasing rate of HIV cases. 5. Preparing teenagers for marriage and ensure they avoid high-risk relationships (free sex).

Klaten		Lombok Barat	
Programme	Justification	Programme	Justification
Child protection: Postponing marriage	High rates of early marriage in the region.	Child protection: Behaviour change communication for postponing marriage	<ol style="list-style-type: none"> 1. The rate of early marriage is high. 2. High divorce rate. 3. Rate of child neglect is high. 4. Protection of women and children because the reproductive organs are immature and emotions are not yet stable.
Child protection: discouraging school-based and online bullying	Because parents must understand the impact of abuse, given that bullying is a matter of great concern.		
Vocational education: Training and employment opportunities	To ensure adolescents have enough skills to join the workforce (or even become self-employed).	Child labour: Improving the condition of working adolescents	<ol style="list-style-type: none"> 1. There is a 'Back to School' programme for dropout children 2. Be directed to join BLK (Training Centre). The training ground is kept close to the target community, for example in the village office
WASH: Handwashing and personal hygiene	Handwashing with soap can reduce the rate of infectious disease by up to 30% (will increase productivity)		

Annex 4. Delivery mechanisms for recommended interventions as suggested by FGD participants, Klaten and Lombok Barat

Entry points/delivery mechanisms for recommended interventions as suggested by FGD participants, Klaten and Lombok Barat					
Programme intervention	Regency	Entry points/delivery mechanism by category of adolescents			
		School-going adolescents	Non-school-going adolescents	Married and/or pregnant adolescents	Adolescents in the workforce
Iron and folic acid supplementation for adolescent girls	Klaten	<ol style="list-style-type: none"> 1. One day a week, students are expected to take their IFA tablet 2. Make sure they do pre and post Hb checks. 3. In all schools through the School Health Unit. 4. IFA distribution in class through class leader. 5. Giving reward for those who diligently take the IFA tablet. 6. The need for a monitoring and evaluation system. 7. Preparing selected students as peer counsellors. 	<ol style="list-style-type: none"> 1. Through religious organizations. 2. Peer educator. 3. <i>Karang Taruna</i>, GPRS, Forum Anak, <i>Posyandu Remaja</i> (for adolescents) 4. Healthy Family 5. Programme through <i>Puskesmas</i>. 	<ol style="list-style-type: none"> 1. Community Health Centre Consultations, Maternity Clinic. 2. Class for pregnant mothers 3. Counselling through DAWIS, Quran recitations. 	Through the workplace (coordination between <i>puskesmas</i> and company management).
	Lombok Barat	<ol style="list-style-type: none"> 1. One day a week, students are expected to take their IFA tablet 2. In all schools through the School Health Unit. 3. Preparing the students as peer counsellors. 	<ol style="list-style-type: none"> 1. Through religious organizations. 2. <i>Karang Taruna</i>, <i>posyandu</i> for adolescents. 3. Before marriage there should be a pre-examination of the bride and groom at the <i>puskesmas</i>. 	<ol style="list-style-type: none"> 1. Community Health Centre Consultations, Maternity Clinic. 2. Class for pregnant mothers 3. Counselling through DAWIS, Quran recitations. 	<ol style="list-style-type: none"> 1. Through the workplace (coordination between <i>puskesmas</i> and company management). 2. Through religious organizations. 3. <i>Karang Taruna</i>, <i>posyandu</i> for adolescents.

Entry points/delivery mechanisms for recommended interventions as suggested by FGD participants, Klaten and Lombok Barat					
Programme intervention	Regency	Entry points/delivery mechanism by category of adolescents			
		School-going adolescents	Non-school-going adolescents	Married and/or pregnant adolescents	Adolescents in the workforce
Nutrition education/diet counselling	Klaten	<ol style="list-style-type: none"> 1. Include this in the curriculum. 2. Education involves not only students but also parents of students. 3. Through School Health Unit (UKS) and Counselling teachers. 	<ol style="list-style-type: none"> 1. Through youth groups such as youth or teenage mosques and also peer counsellors. 2. Education through Dasa Wisma 3. Chairman of RT held adolescent nutrition assistance. 4. Transfer of knowledge at the meeting of the PKK mothers and the arisan of fathers. 5. Installing posters in KUA. 6. Providing a book on nutrition counselling for future brides. 	<ol style="list-style-type: none"> 1. Counselling of the bride and groom. 2. Pregnant women classes. 3. Facilitated chairman Dawis held a programme for counselling pregnant teenagers (weekly). 4. Data collection of homes with pregnant teenagers, marked with yellow stickers, and residents get counselling time. 5. <i>Puskesmas/ Posyandu</i> for adolescents. 	<ol style="list-style-type: none"> 1. Education to managers and heads of workers' associations (TOT). 2. Distribution of weight and height measuring instruments. 3. PSG control on employees. 4. Measurement of nutritional status and Hb levels each month independently by the company clinic.
	Lombok Barat	<ol style="list-style-type: none"> 1. Include this in the school curriculum 2. Education involves not only students but also parents of students. 3. Through School Health Efforts (UKS) and Counselling teachers. 4. Health report book. 	<ol style="list-style-type: none"> 1. Through youth groups such as youth or teenage mosques. 2. Education through adolescent classes and/or organizations. 3. Social media 	<ol style="list-style-type: none"> 1. Class of pregnant women. 2. Social media. 3. Facilitated chairman Dawis held a programme for counselling pregnant teenagers (once a week). 4. Health counsellor (adolescent). 5. Education through adolescent classes and/or organizations. 	<ol style="list-style-type: none"> 1. Education to managers and heads of workers' associations (TOT) and through company clinic. 2. Social media. 3. Education through adolescent classes and/or organizations.
Screening BMI measurement	Klaten	<ol style="list-style-type: none"> 1. Once a year 2. Education of UKS teachers/officers 3. Monitoring and evaluation (monitor and compare results annually). 	Through youth organizations such as <i>Karang Taruna</i> or teenage mosques.		Company clinic.

Entry points/delivery mechanisms for recommended interventions as suggested by FGD participants, Klaten and Lombok Barat					
Programme intervention	Regency	Entry points/delivery mechanism by category of adolescents			
		School-going adolescents	Non-school-going adolescents	Married and/or pregnant adolescents	Adolescents in the workforce
	Lombok Barat	<ol style="list-style-type: none"> 1. Education of UKS teachers/officers 2. Peer educator 3. Should be one of the requirements to enter school. 	Through youth organizations such as <i>Karang Taruna</i> or teenage mosques.	<ol style="list-style-type: none"> 1. Health facilities and pregnant mother classes. 2. Through youth organizations such as <i>Karang Taruna</i> or teenage mosques. 	Company clinic and through youth organizations such as <i>Karang Taruna</i> or teenage mosques.
Reproductive health and HIV education	Klaten	<ol style="list-style-type: none"> 1. Centre for information and counselling of adolescent/student reproductive health. 2. TOT peer educator about reproductive health. 3. TOT reproductive health facilitator. 4. Establishment of Reproductive Health Clinic (PMR, PIKR, UKS) and Reproductive Health Village. 	<ol style="list-style-type: none"> 1. Centre for information and counselling of adolescent/student reproductive health. 2. Through <i>Karang Taruna</i> (youth organization) or teenage mosques. 3. Education on juvenile street/punk teenagers through Social Service. 	<ol style="list-style-type: none"> 1. Centre for information and counselling of adolescent/student reproductive health. 2. Through Dawis, community leaders or village midwives. 3. Pregnant teenagers from low-income families become 'foster children' of capable families. 4. Pregnant mother classes. 	<ol style="list-style-type: none"> 1. Centre for information and counselling of adolescent/student reproductive health. 2. <i>Puskesmas</i> PKPR (Health & Nutrition Care for Youth). 3. Through unions in the company 4. Spreading media leaflets, banners, billboards. 5. Videos during lunch hours in the cafeteria. 6. Commitments between workers and regency health office.
	Lombok Barat	<ol style="list-style-type: none"> 1. Centre for information and counselling of adolescent/student reproductive health. 2. TOT peer educator about Reproductive Health. 3. TOT Reproductive Health facilitator. 4. Social media. 5. School Health Units. 	<ol style="list-style-type: none"> 1. Through <i>Karang Taruna</i> (youth organization) or teenage mosques. 2. Peer counsellor. 3. Social media. 4. Adolescent radio stations. 	<ol style="list-style-type: none"> 1. Health facilities and pregnant mother classes. 2. Social media. 	<ol style="list-style-type: none"> 1. Through unions in the company 2. Through <i>Karang Taruna</i> (youth organization) or teenage mosques.
Education: Vocational training to increase skills and employment opportunities	Klaten	In school training.	Training Centre	Training Centre or other vocational training through Dawis or Head of Religious Affairs Office.	Training Centre or other vocational training through Dawis or advocacy with the company.

Entry points/delivery mechanisms for recommended interventions as suggested by FGD participants, Klaten and Lombok Barat					
Programme intervention	Regency	Entry points/delivery mechanism by category of adolescents			
		School-going adolescents	Non-school-going adolescents	Married and/or pregnant adolescents	Adolescents in the workforce
	Lombok Barat	In school training as extracurricular activities.	1. Training Centre, or through internships. 2. Inviting local successful business-persons who started with small seed funds.	1. Training Centre, or through internships. 2. Inviting local successful business-persons who started with small seed funds.	1. Training Centre, or through internships. 2. Inviting local successful businessman who started with small seed funds.
Child protection: Behaviour change communication for postponing marriage	Klaten	Through School Health Units.	Religious organizations.	Course for the bride and groom at Religious Affairs Office or church.	Company's health clinic.
	Lombok Barat	1. Increasing the minimum age to get married. 2. Penalty/fine for those who get married prior to graduating from high school (awik-awik). 3. Peer counsellor. 4. Include this issue in extracurricular activities.	5. Religious organizations (counselling the parents and adolescents about the minimum age for an adolescent to get married). 6. Social media. 7. GAMAK (Gerakan Anti Meranik Kodek).	8. Religious organizations (counselling the parents and adolescents about the minimum age for an adolescent to get married). 9. Course of the bride and groom at KUA and church. 10. Social media. 11. Other health facilities.	12. Company's health clinic (counselling adolescents about the minimum age for an adolescent to get married). 13. Social media, leaflet, posters throughout the company.
Child protection: Programme to reduce school-based and online bullying	Klaten	1. Religious organizations and counselling services. 2. Child friendly school campaigns.	1. Religious organizations and counselling services. 2. Using a variety of media (poster, leaflets, banners) in the community.	1. Religious organizations and counselling services. 2. Using a variety of media (poster, leaflets, banners) in the community.	1. Religious organizations and counselling services. 2. Using a variety of media (poster, leaflets, banners) in the community.
	Lombok Barat	1. Religious organizations and counselling services. 2. Social media. 3. Involve both teachers and parents.	1. Religious organizations and counselling services. 2. Social media. 3. Involve peer counsellor.	1. Religious organizations and counselling services. 2. Social media. 3. Health facilities and pregnant mother classes.	1. Religious organizations and counselling services in the company. 2. Social media.
'Bring a healthy lunch' movement – every week	Lombok Barat	One day each week, students are expected to bring their lunch from home.			

Annex 5. Gender-responsive communication checklist⁶⁸

- Do the communication programmes, materials and messages perpetuate gender inequality by privileging one sex over the other?
- Do the communication programmes, materials and messages promote gender stereotypes, inequitable gender norms, roles and relationships (e.g., communication materials that show only the mother responsible for childcare)?
- Do the communication programmes, materials and messages take into consideration the prevailing gender differences, opportunities and access to information and resources (e.g., an immunization campaign that targets full coverage without considering the differences in access to services for women or information and communication needs of women and men)?
- Do the communication programmes, materials and messages take into consideration gender-based norms, roles and relationships that may affect how the intervention is received, understood and acted upon (e.g., complex material may be difficult to understand for women with low levels of literacy)?
- Do the communication programmes, materials and messages take into consideration gender-based differences in access to resources (e.g., communication interventions that help mothers know about locally available and inexpensive nutritious foods to consume during pregnancy and lactation)?
- Do the communication programmes, materials and messages respond to the specific needs of girls, boys, women and men (e.g., school-based interventions that inform girls about menstrual hygiene and empower them to practise these behaviours)?
- Do the communication programmes, materials and messages attempt to reduce gender disparities by responding to barriers and bottlenecks that prevent a certain group from meeting their needs or fulfilling their rights (e.g., school-based radio listeners groups for girls in a safe space that is culturally accepted)?
- Do the communication programmes, materials and messages address underlying root causes of certain issues (e.g., a campaign on valuing girls/daughters)?
- Do the communication programmes, materials and messages aim to promote more equitable gender norms, roles and relationships (e.g., an early childhood development C4D effort that promotes the role of the father in childcare, nurturing and early bonding)?
- Do the communication programmes, materials and messages specifically aim to promote gender equality (e.g., a life-skills initiative for adolescent girls that addresses multiple rights and promotes empowerment and gender equality)?

⁶⁸ Gender responsive communication for development: Guidance, tools and resources. Developed by Ami Sengupta for UNICEF ROSA (2018).

Annex 6. Behaviour change measurement scales

Readiness to Change Scale

The Transtheoretical Model posits that behaviour change occurs when individuals move through a series of stages of varying levels of readiness to alter their behaviour (Prochaska and DiClemente, 1983; Prochaska and Velicer, 1997). Of the various scales available to measure readiness to change, the University of Rhode Island Change Assessment Scale (URICA) is widely used for a range of issues including smoking, addiction and substance abuse and psychotherapy (McConaughy, Prochaska, Velicer, 1983).⁶⁹

The URICA has been successfully used with nutrition-related behaviours including obesity, diet and weight management. The scale is a 32-item self-report measure that includes 4 subscales measuring the various stages of the Transtheoretical Model (*see table below*). The responses are rated on a 5-point Likert scale ranging from 1 (strong disagreement) to 5 (strong agreement).

University of Rhode Island Readiness to Change Assessment Scale
As far as I'm concerned, I don't have any problems that need changing.
I think I might be ready for some self-improvement.
I am doing something about the problems that had been bothering me.
It might be worthwhile to work on my problem.
I'm not the problem one. It doesn't make much sense for me to be here.
It worries me that I might slip back on a problem I have already changed, so I am here to seek help.
I am finally doing some work on my problem.
I've been thinking that I might want to change something about myself.
I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.
At times my problem is difficult, but I'm working on it.
Being here is pretty much a waste of time for me because the problem doesn't have to do with me.
I'm hoping this place will help me to better understand myself.
I guess I have faults, but there's nothing that I really need to change.
I am really working hard to change.
I have a problem and I really think I should work at it.

University of Rhode Island Readiness to Change Assessment Scale
I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.
Even though I'm not always successful in changing, I am at least working on my problem.
I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.
I wish I had more ideas on how to solve the problem.
I have started working on my problems but I would like help.
Maybe this place will be able to help me.
I may need a boost right now to help me maintain the changes I've already made.
I may be part of the problem, but I don't really think I am.
I hope that someone here will have some good advice for me.
Anyone can talk about changing; I'm actually doing something about it.
All this talk about psychology is boring. Why can't people just forget about their problems?
I'm here to prevent myself from having a relapse of my problem.
It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.
I have worries but so does the next guy. Why spend time thinking about them?
I am actively working on my problem.
I would rather cope with my faults than try to change them.
After all I had done to try to change my problem, every now and again it comes back to haunt me.

⁶⁹ McConaughy E. A., Prochaska J. O., Velicer W. F. (1983), Stages of change in psychotherapy: measurement and sample profiles, *Psychotherapy: Theory, Research, Practice*, 20, 368–375.

General Perceived Self-Efficacy Scale

A central construct of the Social Cognitive Theory, self-efficacy refers to an individual's confidence in their ability to take action or adopt a behaviour (Rimer, Glanz, Viswanath, 2008). Self-efficacy is considered to be an important precursor to actual behaviour change, as it influences how individuals approach goals, tasks and challenges, as well as the choices they make (Bandura, 1986). The general self-efficacy scale was developed to predict an individual's ability to cope with daily hassles and her/his ability to adapt after stressful life events (Schwarzer & Jerusalem, 1995).⁷⁰ The scale includes 10 items with 4 response options: 1 = not true at all; 2 = hardly true; 3 = moderately true; and 4 = exactly true (see table below):

General Perceived Self-Efficacy Scale
I can always manage to solve difficult problems if I try hard enough
If someone opposes me, I can find the means and ways to get what I want
It is easy for me to stick to my aims and accomplish my goals
I am confident that I could deal efficiently with unexpected events
Thanks to my resourcefulness, I know how to handle unforeseen situations
I can solve most problems if I invest the necessary effort
I can remain calm when facing difficulties because I can rely on my coping abilities
When I am confronted with a problem, I can usually find several solutions
If I am in trouble, I can usually think of a solution
I can usually handle whatever comes my way

⁷⁰ Schwarzer, R., & Jerusalem, M. (1995), 'Generalized Self-Efficacy scale', In J. Weinman, S. Wright, & M. Johnston, Measures in health psychology: A user's portfolio, Causal and control beliefs (pp. 35–37), NFER-NELSON, Windsor, UK.

Annex 7. List of participatory research tools⁷¹

Annex 7. List of participatory research tools, behaviour indicator and type of response (RBC 2018)				
Tool	Know	Feel	Do	Type of Response
A Day in the Life				Visual; Oral/Narrative
Ask 5				Oral/Narrative
Body Mapping				Visual
Cannot Do, Will Not Do, Should Not Do				Visual; Written
Card Piles and Card Sorts				Visual
Community-level Case Studies (Vignettes)				Oral/Narrative
Community Scorecard				Numeric
Complete-the-Story				Listening; Oral/Narrative; Written
Diaries				Written
Direct Observations				Visual; Numeric
Draw and Describe				Visual; Oral/Narrative
Empathy Mapping				Visual
Facility Surveys				Visual; Numeric
Free Listing/Word Associations				Oral/Narrative; Written
Letters				Written
Mobility Maps				Visual
Most Significant Change/Stories of Change				Listening; Oral/Narrative; Written
Oral Histories				Oral/Narrative
Participatory Video				Visual
Participatory Theatre				Visual
Phone Calls				Oral/Narrative
Photo Voice				Visual; Oral/Narrative
Public Declarations				Visual; Written; Numeric
Social Media Posts				Visual; Written
Social Network Mapping				Visual
The Confidence Snails				Visual
Transect Walk/Community Mapping				Visual
2X2 Tables for Social Norms				Written

⁷¹ Sood, S, Cronin, C and Kostizak, K (2018), Participatory Research Toolkit, Rain Barrel Communications, November 2018. For descriptions of the tools and how to use, visit: <https://static1.squarespace.com/static/5df678c23b758e75366c17cd/t/5e65c84187bd3863b8389431/1583728710133/Participatory+Research+Toolkit+Rain+Barrel+Communications.pdf>

