

BETTER INVESTMENT FOR STUNTING ALLEVIATION (BISA)¹



Country: Indonesia

Implementing partners: The Save the Children Fund and Nutrition International

Duration: Five Years [2019 – 2024]

Total Programme Value: \$10 million

The Power of Nutrition commitment: \$5 million (annual disbursement)

Co-financing: \$5 million

¹ BISA means 'we can' in Bahasa Indonesian.

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LIST of ACRONYMS

APC	Asia Philanthropy Circle
BAPPEDA	Badan Perencanaan dan Pembangunan Daerah (District Development Planning body)
BAPPENAS	National Development Planning Agency
BCC	Behaviour Change Communication
BISA	Better Investment for Stunting Alleviation
BKB	Bina Keluarga Balita (Family Welfare community groups)
BPM	Badan Pemberdayaan Masyarakat (Community Empowerment Agency)
CHA	Clean Household Approach
CSAG	Civil Society Action Group
CU2	Children under two years of age
CU5	Children under five years of age
DEO	District Education Office
DFAT	Department of Foreign Affairs and Trade (Government of Australia)
DHO	District Health Office
DIP	Detailed Implementation Plan
EED	Environmental Enteric Dysfunction
EPBGM	MoH online reporting system
FR	Formative Research
FTE	Full-time Equivalent
FY	Fiscal Year
GAC	Global Affairs Canada
GMP	Growth monitoring and promotion
GoI	Government of Indonesia
HDW	Human development worker
HEA	Household Economy Analysis
HMIS	Health monitoring information system
HWWS	Handwashing with soap
ICT	Information and Communications Technology
IFA	Iron-folate acid
INEY	Investing in Nutrition and Early Years
IPC	Inter-personal Communication
IYCF	Infant and young child feeding
KPI	Key performance indicator
KSP	Kantor Staf Presiden (Presidential Staff Office)
LogFrame	Logical Framework
LOE	Level of Effort
MCH	Maternal, Child Health
MEAL	Monitoring, Evaluation, Accountability, and Learning
MIYCF	Maternal, Infant, and Young Child Feeding
MIYCN	Maternal, Infant, and Young Child Nutrition
MMH	Mum's Magic Hands
MNCH	Maternal, newborn, and child health
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NI	Nutrition International
NTT	Nusa Tenggara Timur (East Nusa Tenggara)
OOS	Out-of-School

OPD	Organisasi Perangkat Daerah (Local Government Institution)
OR	Operations Research
ORS	Oral rehydration salt
PDQ	Partnership Defined Quality
PERDA	Peraturan Daerah (local regulation)
PHO	Provincial Health Office
PLA	Programme Learning Agenda
PLAG	Pregnant and lactating adolescent girls
PLW	Pregnant and lactating women
PoN	The Power of Nutrition
RANPG	Rencana Aksi nasional Pangan dan Gizi (National Plan of Action on Food and Nutrition)
RPJMD	Rencana Pembangunan Jangka Menengah Daerah (Regional Medium-Term Development Plan)
SBCC	Social and Behaviour Change Communication
SC	Save the Children
SCUK	The Save the Children Fund, or Save the Children UK
SDG	Sustainable Development Goal
SKPD	Satuan Kerja Pemerintah Daerah (local government unit)
SO	Strategic Objective
SOP	Standard Operating Procedure
SPM	Standar Pelayanan Minimal (Minimum Service Standards)
SS	Supportive Supervision
TA	Technical Assistance
TIPS	Trials of Improved Practices
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan (National Team for the Acceleration of Poverty Reduction)
ToR	Terms of Reference
ToT	Training of Trainers
UKS	Usaha Kesehatan Sekolah (Indonesia School health programme)
UNICEF	United Nations Children's Fund
VAS	Vitamin A supplements / supplementation
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation
WIFA	Weekly Iron Folic Acid
WJ	West Java
WRA	Women of Reproductive Age
YSTC	Yayasan Sayangi Tunas Cilik (Save the Children in Indonesia)

TRANSFORMATIVE PROPOSITION

Indonesia is the largest economy in Southeast Asia with a per capita GDP of USD3,800². In spite of the country's significant economic gains and sustained improvements in human capital, rates of stunting and malnutrition remain high and child development outcomes are poor. According to the 2018 National Health Survey, 10% of Indonesian children under five years (CU5) are wasted (low-weight for height), 18% are underweight and 31%³ are stunted (low-height for age) - with wide variations across Provinces (from 17% in Jakarta to 43% in Nusa Tenggara Timur), and between Districts and population groups. These high undernutrition rates place Indonesia among the top five countries globally with the highest burden of malnutrition.

The Government of Indonesia (GoI) recognises the negative impact of stunting on its economic growth ambitions. Since adopting the World Health Assembly (WHA) 2025 Global Targets for Maternal, Infant and Young Child Nutrition, the government has introduced a number of policy reforms and plans and significantly increased spending on nutrition interventions - in 2017 the government spent approximately US\$3.9bn. Despite the progress made to date (national stunting rate reduced from 37% in 2013 to 31% in 2018), there are still large nationwide gaps in the provision of basic nutrition services. The GoI recognises that to accelerate progress and ensure effective utilisation of resources, it needs to improve the convergence of policies and priority nutrition-sensitive and nutrition-specific interventions on households with mothers and children under two years of age (CU2). To achieve this, the GoI needs to ensure effective coordination of multi-sectoral interventions across 22 key ministries at the three levels of government (national, Provincial, District), and improve the management and accountability problems that have weakened service delivery. In line with this, the GoI launched the *National Strategy to Accelerate Stunting Prevention (2017-2021)* (StraNas) in 2018 to strengthen the execution of existing multi-sectoral policy frameworks and drive consolidation and convergence of national and sub-national programmes. The strategy targeted 100 districts with high stunting rates in 2018 and will be scaled up to 160 Districts and cities in 2019, 390 by 2020, and to all 514 districts and cities by 2021. The GoI has invited development partners to support implementation of StraNas, including the World Bank, which launched its \$21 billion *Investing in Nutrition and Early Years* (INEY) programme in 2018.

The \$10million, *Better Investment for Stunting Alleviation* (BISA)⁴ programme has been designed within this improving financing and policy context. It is an integrated nutrition-specific and nutrition-sensitive programme designed jointly by Save the Children (SC) and Nutrition International (NI) to assist GoI realise StraNas' goal by effectively implementing nutrition policies, plans, and catalysing effective utilization of government funding. BISA targets two Provinces – West Java and Nusa Tenggara Timur (NTT).⁵ The name 'BISA' reflects the programme's ambition to assist these Provincial governments to use their nutrition resources better, operationalise policies and plans more effectively, and improve management and accountability systems to facilitate the delivery of evidence-based, cost-effective, and sustainable interventions at household and community levels.

BISA has been developed drawing on national and global evidence of approaches that have been proven effective in improving caregiver and household behaviours, and public delivery and uptake of nutrition services. BISA draws on experience of SC and NI program portfolios in Indonesia and elsewhere. Recognising that Indonesia's stunting and malnutrition crises have significant gender dimensions, BISA has been designed to assist GoI in improving nutrition within the pre-pregnancy stage as well as across the critical first 1000 days of a child's life– from conception to age two. To sustainably impact a child's nutritional status, the surrounding environment must have the

² CIA World Factbook, [Indonesia](#), 2017.

³ NIHRD Riskesdas 2018.

⁴ Meaning 'We Can' in Bahasa Indonesian.

⁵ West Java has the highest population in Indonesia and a stunting prevalence of 31%.⁵ NTT has the highest stunting rate in the country at 43%.

appropriate capacity - including caregivers and households, community and health services, local governance and policy and resources. BISA has been designed as a comprehensive package of approaches targeting the different levels of StraNas implementation with the aim of enabling the GoI to address the disconnect between national commitment and local action.

To support the GoI's ambition to reduce stunting, BISA will:

1. Introduce a Social and Behaviour Change Communication (SBCC) Package focused on improved maternal, infant, and young child nutrition (MIYCN) and water, sanitation, and hygiene (WASH) practices of adolescents, pregnant and lactating women (PLW), and caregivers of children under two (CU2);
2. Provide technical assistance (TA) to District and Provincial government and health service providers to improve the delivery and enhance access to and use of IFA for pregnant women and pregnant adolescent girls; Weekly Iron Folic Acid (WIFA) for adolescent girls; VAS, zinc, and ORS for children U5, and MIYCN counselling for PLW, PLAG, and caregivers of CU2;
3. Provide TA to the national, Provincial and District government to improve the allocation and effective use of funding and human resources at Provincial, District and Village levels.

BISA is an evidence and learning-generating programme focused on providing decision-makers and influencers with the information and evidence they need to identify, plan, deliver, and support high-impact nutrition programmes. In line with this, over a five-year period it will test and scale-up two packages of interventions. The first, labelled 'Essential', is focused on strengthening the supply side of nutrition service delivery and will comprise technical assistance to strengthen health and nutrition systems at the provincial and district levels. The second, labelled 'Essential+' will combine the supply side services with the demand side services through the provision of direct support to communities. Communities will be supported to improve nutrition behaviours and practices and enhance utilisation of services provided by Government. The two packages will be tested in four districts (one each per Province) in the first two years to assess impact and generate evidence, and in the final 3 years the package will be scaled-up to an additional eight districts (total of 12 Districts). BISA aims to generate evidence of effective operationalisation and application of approaches and resources that have sustainable impact on the nutrition of young children with a view to influencing further scale-up by GoI over time.

Save the Children and Nutrition International are uniquely positioned to deliver this programme building on existing networks and relationships at the community, District, Provincial, and National levels in Indonesia, and leveraging our global experience and expertise to deliver evidence-based, high-quality health and nutrition programmes.

Over a five-year period, BISA will enable 3.3m people including 734,100 women, 489,343 children under two, and 1.45m adolescent girls to access high impact nutrition services and contribute to 4,794 lives saved, 6,314 cases of stunting averted, and 161,724 cases of anaemic averted.⁶

PROGRAMME CONTEXT AND NEED

Indonesia is the fourth most populous country in the world with a total population of 260 million, including 24 million children under age five. Despite being newly classified as a lower-middle-income country, with a per capita GDP of USD3,800⁷, and being the largest economy in Southeast Asia, Indonesia's human development indicators place it 116th in global rankings (out of 189)⁸ and the World

⁶ See Annex 9 for details.

⁷ CIA World Factbook, [Indonesia](#), 2017.

⁸ UN Human Development Index, [Indonesia](#), 2017.

Bank Human Capital Index (HCI) ranks it 87 out of 157⁹. Across the country, 10% of children under 5 years are wasted, 18% underweight, and 31% are stunted, with wide variation by province (from 17% in DKI Jakarta to 43% in NTT)¹⁰ and between Districts and population groups. These rates place Indonesia among the top five countries with the highest burden of malnutrition.

BISA will target East Nusa Tenggara (NTT) and West Java. Figure 1,¹¹ below, summarises their nutrition situations. See Annex 6 for UN Sustainable Development Goals Provincial Profiles.



Annex 5 summarises the drivers of stunting in Indonesia. These can largely be grouped in across three areas: health and nutrition practices; the health system; and the enabling environment.¹²

Health and Nutrition Practices

Child stunting begins during pregnancy and the risk of stunting increases after the child is born until the child is about 2 years. These are the First 1,000 days, the critical period of child growth and development after which stunting is more difficult to reverse. Child growth depends on the mother's health and nutritional status before and during pregnancy and caregiving practices (exclusive breastfeeding, appropriate complimentary feeding and hygiene) from 0-24 months.

Maternal Nutrition: Nationally, 17% of pregnant women are underweight (compared to 15% of non-pregnant women), with 37% in NTT (only 15% in West Java). Anaemia is particularly high – with 49% anaemia amongst pregnant women. Left untended, anaemia in pregnancy can lead to maternal death and low infant birthweight, both of which are risk factors for malnutrition and stunting.¹³ A study by NI suggests high rates of anaemia amongst adolescent girls too.

Maternal and Adolescent Nutrition (National)	
○	49% anaemia amongst pregnant women
○	52% anaemia amongst adolescent females ¹⁴
○	17% maternal underweight (37% in NTT, approx. 15% in West Java)
○	13% of women under age 18 are married (9% in NTT, 14% in West Java)
○	10% of adolescent females are pregnant or already mothers

Maternal underweight and anaemia relate to women and girls' food consumption and health habits as well as their use of micronutrients. Iron and Folic Acid (IFA) supplementation is one of the most effective ways of preventing anaemia and is free for all pregnant women in Indonesia. IFA adherence would prevent anaemia and improve maternal nutrition during pregnancy. Yet, while nationally 73%

⁹ WB Human Capital Index [Indonesia](#), 2018.

¹⁰ NIHRD Riskesdas 2018.

¹¹ Where possible, District-level data is also reflected; however, the NIHRD for Riskesdas 2018 is not yet disaggregated to District level.

¹² All data in tables from NIHRD for Riskesdas 2018 unless otherwise stated.

¹³ 2017; Ni Ketut Aryastami et al. BMC Nutrition. BMC series 2017, found that low birthweight was among the top predictors associated with stunting in children aged 12-23 months in Indonesia.

¹⁴ Nutrition International programme data; adolescents defined as ages 10 – 19 years.

report taking IFA during their last pregnancy, only 37% of pregnant women take the recommended amount.¹⁵ Amongst adolescents, national supplementation adherence as low as 1.4%. In many areas of Indonesia, there are traditional beliefs that restrict women's diets during pregnancy and after birth, with women avoiding some nutritious foods because they believe their baby will be too big or postpartum healing will be delayed. In Indonesia, 10% of babies are low birthweight (slightly higher in NTT and West Java), an indicator of growth restriction during pregnancy which is likely related to the mother's age and health and nutritional status.¹⁶

Adolescent Nutrition: Adolescents in Indonesia represent both the pre-pregnancy window (not yet mothers) and a significant portion of the pregnant / CU2 caregiver window. Young age of the mother increases the risk that a child will be underweight and undernourished; 43% of 15-19-year-old mothers have stunted children nationally. One in eight women under age 18 in Indonesia are married and 10% are pregnant or already mothers. Adolescent pregnancies, where the mother is between ages 10 and 18 years, comprise nearly one-quarter of all pregnancies (23%).¹⁷ Adolescents are more likely to have low birthweight infants.¹⁸

Young mothers are also more likely to be undernourished, compared to older women, with more than half of adolescent females anaemic (52%) nationally. Although IFA is also free for adolescent girls and 76% report taking IFA, only 1.4% complete the course.¹⁹ Dietary habits of adolescents are also poor – many girls in Indonesia do not eat breakfast, for instance, but may have one large meal a day and a lot of snacks - typically 'instant foods' high in salt and fat and low in nutrients. These habits, particularly snacking, are more common in West Java.

Infant and Young Child Nutrition: To grow and develop to his full potential, a child needs to receive adequate and appropriate nutrition and avoid recurring infections. This includes immediate breastfeeding, exclusive breastfeeding from 0 - <6 months, age appropriate complementary feeding from 6-23 months (including continued breastfeeding), and growing up in a clean and hygienic home environment with caregivers washing hands with soap at key times, safely disposing of faeces, food hygiene, safe drinking water and clean play environment (with no animal faeces). National Data shows that children become gradually more stunted between birth and 2 years suggesting inadequate dietary intake and caregiving practices throughout that period. Childhood anaemia is also common with 40% prevalence nationally.²⁰

0-<6 months (EBF)	6-23 months (Complementary Feeding)
<ul style="list-style-type: none"> 37% EBF (past 24h) (approx. 17% in NTT, 38% in West Java) EBF average 3.7 months Mix feeding, pre-lacteal feeds common 	<ul style="list-style-type: none"> Breastfeeding average of 20.5 months 33% not fed with appropriate frequency 25% do not meet dietary diversity minimum standard

Breastfeeding: Breastfeeding includes two key indicators: early initiation of breastfeeding (defined as within the first hour of life) and exclusive breastfeeding (EBF) up to six months of age (per WHO guidelines). Though, on national average, almost all (over 90%) children 0 - <6 months are breastfed, only 37% are exclusively breastfed. Fewer than half of all babies are breastfed in the first hour after

¹⁵ NIHRD for Riskesdas, 2018

¹⁶ Alive and Thrive, 2018 Desk Review (Annex 15, A+T). NIHRD for Riskesdas 2018 reports 6.2% national LBW, 9% in NTT and 7% in West Java.

¹⁷ Nutrition International programme data.

¹⁸ Kozuki N, Lee A, Silveira M, et al. The associations of birth intervals with small-for-gestational-age, preterm, and neonatal and infant mortality: A meta-analysis. BMC Public Health

¹⁹ NIHRD for Riskesdas 2018.

²⁰ NIHRD for Riskesdas, 2018.

birth. Common misconceptions around early initiation are that colostrum – a mother’s first milk – is cheesy, dirty, or indigestible for the infant.²¹ Women often practice delayed breastfeeding, giving newborns honey, banana, or breastmilk substitute instead. Infants are also often given water or other liquids when they have diarrhoea. The average length of time of EBF for a baby is 3.7 months. Mixed feeding is a common practice, with other foods and breastmilk substitutes (BMS) introduced as early as two months old.

Many women also believe they cannot breastfeed if they are on any medication, a misconception perpetuated by health workers. Health workers often promote the use of BMS in these instances and as a general solution if a woman experiences any challenges, which reduces a woman’s confidence in her ability to breastfeed. The reasons for stopping breastfeeding vary depending on the local context, but evidence indicate there are three main reasons²²:

- Misconceptions about what breastfeeding does to a woman’s body and lack of appreciation for how valuable breastmilk and breastfeeding are for a child’s development.
- Over half of women in Indonesia are employed (60%), taking them away from their infants; this will be particularly common in West Java compared to NTT. most workplaces do not offer facilities to express breastmilk; and women tend to stop.
- Heavy marketing by the Breastmilk Substitute (BMS) industry, especially in densely-populated and wealthier West Java, despite The WHO Code for the Marketing and Manufacturing of Breastmilk Substitute; many women use BMS as an ‘easy’ and ‘quick’ option. Use of formula is also perceived to indicate high social status or wealth.

Complementary Feeding: Global evidence and experience are clear that the introduction of complementary foods is a critical risk point, with the growth of many children faltering at this point as foods are inappropriately introduced or in the right balance with continued breastfeeding. Caregivers lack knowledge and confidence in child feeding patterns, schedules, and appropriate foods. Nationally, only 47% of children ages 6 to 23 months receive the appropriate diversity of foods. In NTT, for example, children are often fed ‘empty porridge’, a simple porridge with no added vegetables or protein. Whilst filling, it is not a source of dietary diversity or nutrients.

In many parts of Indonesia, there is a belief that milk is a complete food and thus other foods are not needed to provide vitamins and nutrients; unfortunately, the ‘milk’ chosen may be formula or sweetened condensed milk. Sugar consumption is a significant challenge among young children and closely related with the culture of snack foods.

Snacking is a common habit in Indonesia, especially in West Java. Whilst not inherently problematic, if snacks are given too close to meal times the child will not be hungry; snacks are also often high in salt, sugar, and fat. These are given to children to appease them, entertain them, or in response to any fussing or crying, often perceived to mean hunger.

A Cost of the Diet²³ analysis conducted in 2017 by the World Food Programme (WFP) and the National Development Planning Agency (BAPPENAS) found that while food availability was not a problem, many households cannot afford a nutritious diet.²⁴ Nationally, the assessment estimated

²¹ Alive and Thrive, 2018 (Annex 15, A+T).

²² Alive and Thrive, 2018 (Annex 15, A+T).

²³ The Cost of the Diet was developed by Save the Children; CotD entails assessments of local markets to evaluate the local availability and price of foods in order to calculate the lowest possible cost for a household to achieve a nutritious diet. CotD does not factor availability against knowledge of nutritious foods as that aspect is typically informed by formative research. CotD allows for better understanding of the impact of poverty, resource scarcity, and food market circumstances on nutrition. Findings are used to inform programme design and SBCC. Additional information [here](#). CotD has also been incorporated into WFP approaches, as outlined [here](#).

²⁴ The 2017 study is available [here](#) with a summary of findings and application of results [here](#); additional review of the approach, findings, and relevance published [here](#).

that 62% of the population can afford a nutritious diet. However, this drops to 32% for NTT – reflective of cost barriers resulting from poverty, less access to markets, and higher cost of foods.

WASH (National)
<ul style="list-style-type: none"> ○ 12% children under five with diarrhoea incidence ○ 47% of caregivers wash hands at key times ○ 67% of households have access to improved water sources, with significant regional variation (62% in NTT, 68% in West Java) ○ 50% of households have access to sanitation facilities (25% in NTT, 68% in West Java)

Water Sanitation and Hygiene (WASH): Water, sanitation, and hygiene are central elements of a child's health and nutrition, associated with infections and illnesses, such as diarrhoea, and transmission of and exposure to germs and contaminants. Estimates are that up to 50% of malnutrition is a result of poor WASH (WHO, see Annex 15 WHO WASH). Inadequate WASH behaviours – handwashing without soap, unsafe handling of faeces, and unclean drinking water – result in diarrhoea, parasitic infections and chronic gut inflammation (environmental enteric dysfunction, EED), a major contributor to undernutrition. Emerging evidence from other countries suggests that EED linked to ongoing ingestion of pathogens may be a key driver of stunting due to the impact on a child's ability to absorb key nutrients; there is little evidence yet for Indonesia. Indonesia is one of the top 15 countries with the highest burden of childhood diarrhoea.²⁵ According to 2012 DHS (the latest available), prevalence of diarrhoea amongst children under two years of age (CU2) nationally is 21%. Poor WASH behaviours are associated with increased diarrhoea, itself associated with stunting and undernutrition²⁶, and illnesses such as pneumonia.²⁷

Lack of water, including safe drinking water, continues to be a challenge in some parts of Indonesia (particularly NTT), with only 67% of the population using clean sources nationally.²⁸ Whilst clean water is closely associated with increased risk of diarrhoea, in Indonesia, evidence indicates that it is poor food and household hygiene practices which are main determinants for diarrhoea.

Despite high prevalence of soap in households (approximately 99% nationally), only 47% of the national population practice handwashing at the critical times – before and after meal preparation and feeding, after using the latrine, or after changing a child's diaper or aiding a child at the latrine. Though handwashing can mitigate one of the critical pathways of pathogens, over 50% of individuals do not practice handwashing with soap at these critical times.²⁹

Health Services for Nutrition and Utilisation

ESSENTIAL SERVICE ³⁰	COVERAGE
Exclusive Breastfeeding	37.3%
Maternal IFA	73.2%
Growth monitoring and promotion (GMP)	54.6%
Vitamin A (optional)	53.5%
WIFA for adolescents	76.2%
Pregnant women (ANC)	96.1%
Mother and child (PNC)	84%

²⁵ Lancet, 2013.

²⁶ Evidence is growing around the connection between diarrhoea and stunting, including this [report](#).

²⁷ SC Pneumonia Situational Analysis, 2018

²⁸ NIHRD for Rikesdas, 2018; Provincial data from UN SDG Provincial Profiles.

²⁹ Environmental Health Risk Assessment, 2013

³⁰ Data from NIHRD Rikesdas 2018; IDHS, 2012; and NIHRD 2013. See Annex 15 for additional data and references.

Diarrhoea treatment, ORS and zinc	35% and 16%	<i>Low access, utilisation, and quality of health and nutrition services are also contributing to poor maternal, infant and young child nutrition. Women receive nutrition counselling, supplements and treatment through the health system (ANC, PNC and GMP) that help her care for herself (during pregnancy and lactation) and her child. While most women have access to these essential nutrition services, they are not fully using them for a range of reasons. For example, 96% of women nationally complete their first pre-natal visit, but only 74% of women complete all four recommended visits (NIHRD, 2018). 73% of pregnant women received IFA during their last pregnancy but less than half completed the full course. Similarly, 76% of adolescent girls nationally reported receiving IFA but only 1% completed the course; other services remain very underutilised, like ORS and zinc.</i>
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The factors associated with low adherence and utilisation vary. Low IFA adherence is often linked to the IFA side effects (constipation, black stools, taste) and lack of understanding of the purpose and importance IFA supplements. Low attendance to Growth Monitoring and Promotion sessions (GMP; monthly community sessions led by Posyandu cadres) may be linked to the lack of perceived benefit. These sessions can take a long time, creating a challenge for women who work outside of the home and serving as a deterrent against attendance due to the waiting. Counselling is often deprioritised and not adapted to the mothers' needs. Other issues include shortages in supplies (IFA, vitamin A or ORS and zinc), lack of demand for these services (which is linked to lack of understanding of the importance of these services), cost, time and distance.

The above issues relate to deeper failures and weaknesses in the health system, particularly at the District and village levels. The health system needs to have the capacity and resources – both finances and staffing – to provide quality services. Health workers (Puskesmas and Posyandu) need the appropriate training, supervision, support, and tools to provide these services. The most challenging skills are counselling and facilitation, which are best learned through ongoing on the job training and supervision, as well as formal training. This *Supportive Supervision*³¹ particularly for counselling and group facilitation is lacking in the current system which effects the quality and relevance of the counselling and demand for it by women. There are also gaps in the supply chain and delivery of IFA, vitamin A, ORS and zinc affecting the availability at village level.

Recent political decisions and Presidential Instructions have decentralised decisions and resources related to the health system down to sub-national levels affecting nutrition services. The Presidential Instruction for Healthy Community Movement outlined tasks for Ministers, Provincial Governors, and Heads of Districts around indicators for improved health and how to engage communities and businesses to achieve them. The indicators (and associated tasks) include immunisation; exclusive breastfeeding; GMP; facility births; and access to water and sanitation. Associated Village Laws, including 6/2014, place responsibility with the village governance systems to achieve village development and community welfare. Villages have been granted budgets from the national government to achieve this. Village Regulation 16/2018 states that these resources should be used for basic social services, community health, and improvement of public services. However, as outlined in the following section, dissemination of authority and resources is not sufficient to address capacity gaps in resource planning and management. Though ambition is there to improve the health system and quality of services, the availability of financial resources only addresses part of the problem. Insufficient health worker training and skills, lack of appropriate guidelines and aids, and poor health seeking behaviours remain critical issues.

Policies and the Enabling Environment

³¹ Supportive Supervision (SS) is a method commonly used in global health and health system strengthening. SS is a process of helping health staff improve their own work performance and quality continuously. SS encourages open, two-way communication and building team approaches; focuses on monitoring performance towards goals; and using data for decision-making. (WHO). SS is cited in this [review of approaches](#), this [Lancet research](#), and in this [WHO publication](#) highlighting the value-add of quality supervision.

There is no shortage of policies and actors in Indonesia relevant to health and nutrition. Since joining the Scale Up Nutrition (SUN) Movement in 2011, the Government has issued numerous policies and initiatives focused on improving access to and utilisation of nutrition and health services. In 2012, the Government of Indonesia adopted the WHA 2025 Global Target for Maternal, Infant and Young Child Nutrition. In 2013, at the first Nutrition for Growth (N4G) Summit and the Second International Conference on Nutrition (ICN2, 2014) high-level commitments translated to various regulations and decrees, such as the National Movement on the First 1,000 Days of Life launched in 2013.³²

In 2015, the Government developed and adopted the National Mid-term Development Plan for the period of 2015-2019 based on the 2012 World Health Assembly resolution for Maternal, Infant, and Young Child Health and Nutrition (MIYCHN). The objectives focus on addressing the prevalence of stunting and wasting; reducing the prevalence of low birthweight; increasing exclusive breastfeeding; and addressing anaemia amongst women. Parallel to this is the National Plan of Action on Food and Nutrition (2015-2019, or Rencana Aksi nasional Pangan dan Gizi, RANPG) which focuses on nutrition and food security (access, availability, and utilisation) as well as the food choices within households was developed. This Plan promotes integrated nutrition services with hygiene, sanitation, and health services, caring practices for mothers and children, and early child development, and is intended to guide sub-national programmes and management to implement nutrition-specific and nutrition-sensitive interventions.

Since 2015, the Government has continued to demonstrate its commitment to addressing stunting at the highest levels of government. In 2017, the Vice-President launched a national stunting initiative, first targeting 100 Districts and scaling up to all Districts to prioritise and deliver more targeted support and investment of government resources to address the stunting burden. This SUN Roadmap to Accelerate Stunting Prevention (2017 – 2019) relies on effective coordination amongst 22 Ministries. An estimated USD 3.9 billion per year has been committed to converge priority interventions in their delivery system for families in need across health, water and sanitation, early childhood education and development, social protection and food security. The Initiative will cover 22,000 villages across the country.³³

Other relevant government policies and plans, outlined elsewhere in this document, are the Government's regulations on Minimal Service Standards (or Standar Pelayanan Minimal, SPM) for integrated programming; The Government of Indonesia's National Mid-Term Development Plan (2015-2019), Presidential Instruction on Healthy Community Movement (No. 1/2017), Presidential Regulation on Strategic Policy on Food and Nutrition (No. 83/2017), and RANPG. These plans reflect the government's intent to scale-up nutrition efforts but are not consistently resourced, implemented, or enforced sub-nationally.

With the 2018 launch of the World Bank's Investing in Nutrition and Early Years (INEY) programme in Indonesia, there is increased availability of resources.³⁴ Policies and standards are in place at a national level which express support for and prioritisation of nutrition. However, there is a significant gap between the adoption of such plans at national level and the delivery and actualisation of these plans at a sub-national level. With regard to this implementation gap at sub-national level and the need to accelerate progress, the GoI developed the National Strategy on Stunting Prevention (2018 – 2024). This Strategy includes priority interventions, priority beneficiaries, and priority locations.³⁵

Without critical intermediate capacity, the impact will not reach communities and households. The challenge in Indonesia has three main strands: coordination across the abundance actors, effective

³² Presidential Regulation 42.

³³ TNP2K, 2017.

³⁴ <http://projects.worldbank.org/P164686/?lang=en&tab=financial>

³⁵ BISA is closely aligned with these priorities, as shown in Annex 14.

delivery and dissemination of policies to sub-national levels, and resource management. A further challenge is the number and complexity of the policies and plans in place – overlapping remits and volume of information results in limited accountability or responsibility for delivery and impact. Nutrition in Indonesia falls into the remit of 22 government entities. A priority of BISA is to help streamline this so that *what* is meant to be implemented at sub-national level and *how* is actionable.

Underlying Socio-Political Factors

Poverty: As the World Bank so succinctly stated, ‘stunting is the face of poverty’.³⁶ Poverty increases the risk of malnutrition and perpetuates it. In Indonesia, 26 million people (approx. 6 million households) do not have sufficient means to access resources such as clean water, health services, or diverse, nutritious foods. The national poverty rate has reduced since 2014, now at 9.82%³⁷, but there are significant disparities – ranging from 7.5% in West Java to 21.5% in NTT. Whilst poverty reduction is beyond BISA, the role of poverty in the wider context of nutrition is important. BISA will inform communities of available support services, as outlined in Annex 1.

Gender: Indonesia’s socio-cultural context also influences its health and nutrition context. As such stunting and malnutrition have significant gender dynamics with women’s education, social and economic status playing a key role in their influence in decisions over how household resources such as food and income are allocated. Specific nutrition challenges include the high rates of adolescent marriage and early pregnancy (young age of the mother), decision-making power over household resources, and gender dynamics. In households where women have control over resources, a higher proportion tends to be spent on food and health-related matters for children.³⁸

The linkage to adolescents is clear – women who marry and become pregnant at an early age are not able to pursue or complete higher levels of education. This is correlated with breastfeeding rates, care practices, hygiene practices, and a child’s health and nutrition outcomes. The GoI have issued decrees on gender mainstreaming in order to prioritise the unique needs of women and girls to ensure inclusion in national and sub-national Ministries and Agencies.

PROGRAMME THEORY OF CHANGE

BISA is designed in direct response to the drivers of stunting in Indonesia across all levels in order to sustainably reduce it. Recognising that the drivers of stunting span household, community, health system, and policy levels, BISA is structured to intervene across each of them.³⁹ Because of the reality of finite resource and the opportunity to leverage other programmes, BISA is deliberately focussed at the critical opportunities for impact. BISA reflects the partners’ combined experience, nutrition expertise, building on learning from previous programmes, reliance on evidence, and leveraging linkages with stakeholders and related programmes, such as INEY.⁴⁰

BISA is comprised of three Strategic Objectives (SO) which focus on: the immediate context of communities and households (SO1); systems which underlie nutrition, including health workers and influencers (SO2); and the broader enabling environment, including policies and resources (SO3).

Essential and Essential+ Packages

³⁶ World Bank, Aiming High (2018).

³⁷ BPS 2018

³⁸ IDHS, 2012

³⁹ This is an approach which Save the Children commonly adopts in programming including in the recently closed START programme (Annex 15, START).

⁴⁰ Annex 15 (INEY and BISA) includes a reference on specific complementarity between INEY and BISA in terms of technical and programmatic priorities and opportunities for synergy.

The programme design takes into consideration that the support needed to impact change includes both technical assistance support to strengthen systems (national, sub-national, and local) as well as more direct support to demonstrate (as proof of concept) the packages, approaches, and interventions which can deliver results. BISA will use a dual approach:

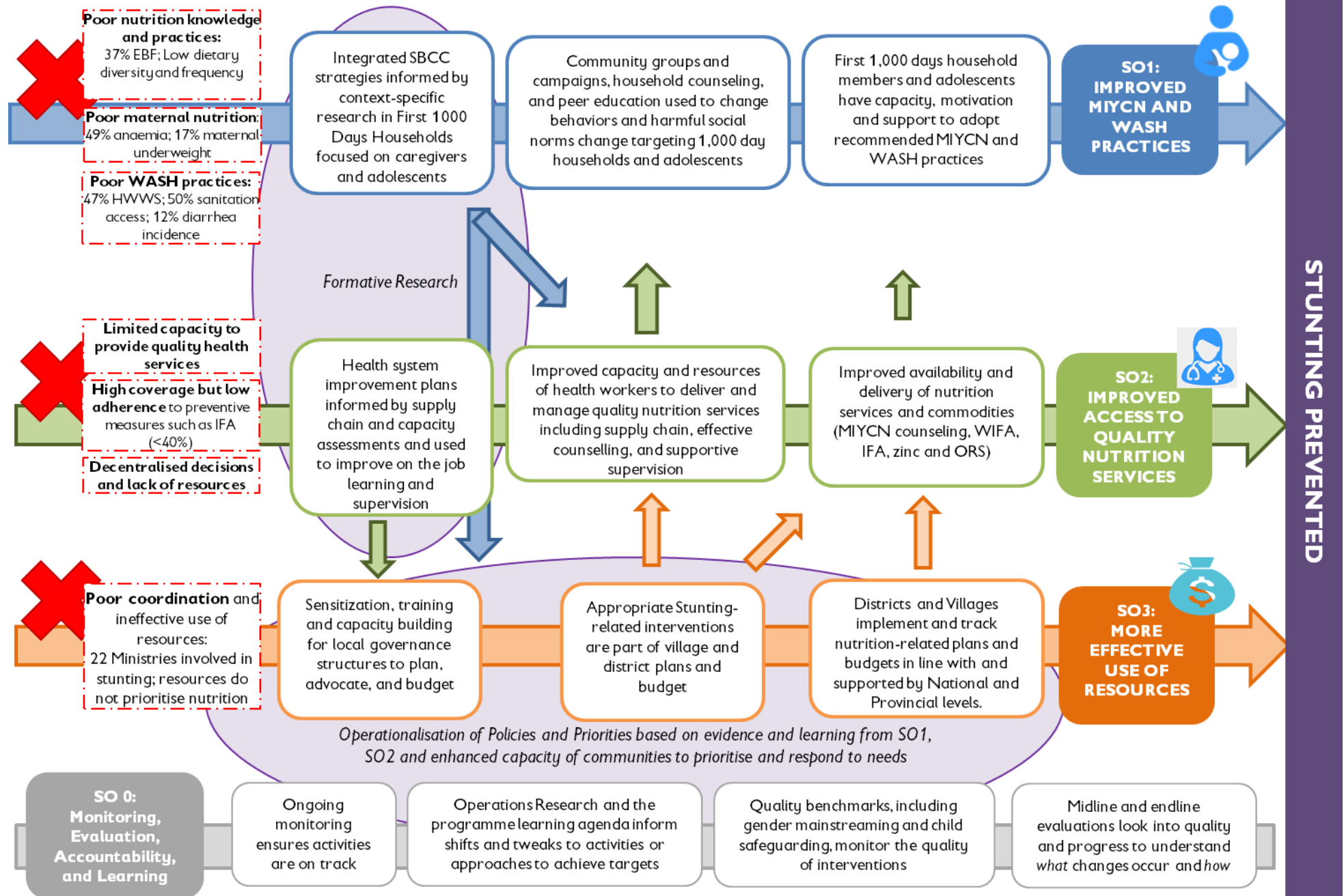
- **Essential Package:** This is the minimum package of interventions which is necessary to deliver at District level to see results. The Essential Package is technical assistance to strengthen health and nutrition systems and governance. This Package, technical assistance and capacity building, as well as replication and scale-up will benefit from the evidence and lessons generated through implementation in the Essential+ Districts.; and
- **Essential+ Package:** This package includes the core interventions of the Essential Package (system strengthening, capacity building) plus specific interventions at community and household-level targeting poor behaviours and enabling caregivers to utilise nutrition services. This direct implementation will allow BISA to develop, refine, and demonstrate the impact, effectiveness, and operationalisation of cost-effective approaches and interventions.

This dual-delivery approach responds to the reality that whilst policies and plans exist in Indonesia and resources are increasingly disseminated for local management, capacity to manage resources effectively is mixed as is knowledge of what is effective in addressing stunting. The Essential and Essential Plus packages will enable to demonstrate what might work in different resource and capacity district contexts.

Phasing and Sustainability

The robust evidence generated in programme's early years (Years 1 and 2) will directly inform policy guidance and scale-up to an additional eight Districts (four per Province, Essential and Essential+), starting in Year 3. This phasing is illustrated in Annex 4.

BISA Theory of Change



Improving Practices in Communities and Households: Strategic Objective 1

The drivers of stunting manifest specifically in Indonesia at the individual and household level, across the life-cycle through high rates of anaemia and underweight in pregnant women, including adolescents; low rates of exclusive breastfeeding for a child's first six months and inadequate complementary feeding up to two years of age; inadequate hygiene and sanitation practices.

Evidence is clear that a mother's health and nutrition during pregnancy directly correlates to the child's nutritional status from birth. BISA takes a life-cycle approach to capture the pre-pregnancy window as well as pregnancy and early childhood. In doing so, the programme emphasises that *prevention* is critical for sustainable impact; because of the high rates of adolescent marriage and pregnancy in Indonesia, targeting this pre-pregnancy adolescent phase is a critical window to impart knowledge and influence behaviours for future generations.

Strategic Objective 1 focusses on driving change at the community level through integrated social and behaviour change communication (SBCC) targeting caregivers and adolescents. The package of interventions included for community-based work will be driven by the local contexts of NTT and West Java, making them more relevant, feasible, and likely to have impact. BISA's SBCC strategy, which address the gaps identified Alive and Thrive national strategy⁴¹, will also encompass the evidence-based interventions prioritised by the Power of Nutrition (Annex 14) and the priority areas of the GoI as well as what is covered by other actors and programmes.

SBCC⁴² focuses on promoting and facilitating changes in knowledge, attitudes, norms, and behaviours. BISA targets priority behaviours known to impact stunting, and which data show to be low in NTT and West Java, such as breastfeeding, handwashing with soap, and optimum complementary feeding. To ensure context specificity, the SBCC strategy will be based on formative research (FR) which will include gender and social analyses to identify local barriers to good nutrition practices as well as motivators and influencers of change to encourage positive behaviours. BISA will engage with households and communities using existing structures of mothers' groups, caregiver groups, and household visits, as well as other community-wide events and campaigns to build and maintain momentum and awareness towards improved nutrition.⁴³

At household level, because of the evidence which shows the interplay between poor water, sanitation, and hygiene behaviours and high incidence of diarrhoea and infection⁴⁴, which are causal factors for acute and chronic malnutrition (Annex 15, WASH-Nutrition and WHO WASH), BISA integrates WASH into the SBCC strategy. Low resource settings are often typified by high rates of stunting, poor environmental sanitation and, where it has been studied, very high rates of environmental enteric dysfunction (EED). Building on this growing body of evidence around the impact of exposure to contaminants and pathogens on a child's nutritional status, BISA will look at WASH behaviours and environment for young children.⁴⁵ Research increasingly shows that attention to all potential contamination pathways is necessary to impact a child's nutrition.⁴⁶

⁴¹ Alive and Thrive [Roadmap for Indonesia](#) (2018)

⁴² The Johns Hopkins University Center for Communication Programs offers several SBCC theory documents and resources, such as this [infographic](#).

⁴³ Alive and Thrive: [Burkina Faso evidence](#) (2019).

⁴⁴ Evidence includes a [cross-sectional study in India](#) (2016); [hand hygiene and stunting](#) in Armenia (2017); and [sanitation and hygiene in India](#) (2015). [UNICEF](#) has issued similar findings.

⁴⁵ EED, formerly called 'enteropathy', is the basis of a new large research study being co-led by Save the Children, one of SC's major private sector partners, and two prestigious academic institutions. The purpose of this research is to identify contamination pathways at household level which can result in stunting, including via EED; to then develop a checklist to quickly identify risk factors in households; and to identify and test appropriate interventions to mitigate that risk.

⁴⁶ WASH Benefits Findings shared by Steve Luby to Save the Children 12 February 2019 (presentation). Published article available [here](#).

The Clean Household Approach (CHA), developed by Save the Children, was developed based on this area of evidence and research and reflects the importance of the central WASH elements (water, hygiene, sanitation) in the household environment for a child's development.⁴⁷ CHA identifies and mitigates the common pathogen pathways leading to childhood illness; handwashing with soap will be a key focus of household and community activities. By intervening at household level for WASH through targeted handwashing with soap activities and linking to the Government's rollout of the national Community-Led Total Sanitation (CLTS) strategy, as well as exploring and expanding the CHA, BISA addresses one of the pathways to stunting.

BISA will incorporate Unilever / Lifebuoy's Handwashing with Soap approaches (Annex 15, Lifebuoy), a proven, accredited methodology⁴⁸, to change handwashing with soap behaviour amongst women and children which is shown to reduce diarrhoea, helping prevent the chain reaction from diarrhoea to malnutrition (acute and chronic).⁴⁹

The third pillar within SO1 is the focus on adolescents. Because of the high rate of adolescent marriage and pregnancy in Indonesia, it is critical that this – often forgotten – group is specifically addressed. BISA expands the traditional First 1000 Days approach to this pre-pregnancy window, including both males and females. The priorities are two-fold: to optimise adolescent nutrition for their own development and well-being, and also to increase their knowledge and improve their practices before becoming parents so that if or when they become parents, positive practices are already embedded in their habits. BISA will use a school-based peer education approach to deliver key messages and training for the adolescents, including Lifebuoy School of Five, and linking to the national adolescent network led by UNICEF.

At the community level, there is a clear linkage with SO2 in the reliance upon skilled health workers and Posyandu Cadres to deliver interpersonal counselling (IPC), group counselling, and other support to households and caregivers as this is the 'first line of defence' in the health system. By emphasising the link and continuity between SO1 and SO2, BISA will ensure that the capacity to the health system and health workers is built in ways that respond specifically to community needs and demands, as identified in SO1.

Strengthening Nutrition Services: Strategic Objective 2

At a community and systems level, the main barriers and challenges are poor access to and quality of nutrition services; and, beyond community, the challenge of a complex policy environment at national level which does not consistently translate into local action.⁵⁰

SO2 focuses on strengthening nutrition services delivered through existing government health systems⁵¹, within the context of Indonesia's national strategy for the reduction of stunting ('StraNas') and INEY. BISA's priority is to build the capacity of the system to deliver quality nutrition services at the community level and ensure the system supports and sustains this.

BISA builds on NI's extensive experience of demonstrating that to sustainably improve results at the community and household levels, there must be convergence with robust policies and service delivery across the village, district, provincial and national levels (see NI's programme reports in Annex 15). The catalyst for impact at the community level is at this intermediary level and as such it

⁴⁷ See Annex 15, Tofail, F et al. 'Effect of water quality, sanitation, handwashing, and nutritional interventions on child development in Bangladesh (WASH Benefits Bangladesh). Lancet, 2018.

⁴⁸ Unilever Lifebuoy's handwashing with soap campaigns and materials have been accredited by the [Royal Society for Public Health](#).

⁴⁹ Results and analysis from Unilever Lifebuoy's India programme available [here](#).

⁵⁰ Beal, Ty, Alison Tumilowicz, Aang Sutrisna, Dobby Izwardy, and Lynnette M. Neufeld. 2018. "[A Review of Child Stunting Determinants in Indonesia](#)." Maternal & Child Nutrition 14 (4).

⁵¹ Based on previous successful programming and approaches delivered by NI focusing on [pregnant women and newborns](#) and for [integrating nutrition](#).

is critical that both national level policies and allocation of resources are effectively aligned with District-level prioritisation of resources which in turn must be focused on quality nutrition service delivery. By improving the technical capacity of health workers, quality of materials, and providing supportive supervision, BISA will support immediate and sustained improvements in the quality of the health system. BISA will build nutrition service capacity in the health system by delivering targeted trainings for health workers, supervisory staff as well as decision-makers and relevant stakeholders. Through FR, BISA will support the local health systems to identify gaps and bottlenecks in service delivery as well as in resources such as technical manuals and guidelines. Given the complexities of the Indonesian context, streamlining and integrating resources is a key priority to support health workers to know what the priorities are and how to act upon them.

Alongside capacity building of health workers, BISA will assist District authorities to improve supply chain management, ensuring that local facilities have the necessary supplies to meet demand of their catchment areas; use of data, including data-based decision-making and quality reporting; and counselling skills, to ensure that caregivers, adolescents, and children benefit from an informative, interactive session with their health worker. By building skills in these areas, the quality of services provided will improve.

The Districts receiving the Essential Package will receive Technical Assistance (TA) from BISA to enable them to better access and optimise the incentives provided to Districts, health workers and villages as part of the INEY programme. Experience from other World Bank Programme for Results have shown that such targeted support has been effective in enabling governments to realise their ambitions at the subnational level. TA leads to high quality programming and better delivery of services and improved adherence by women, girls and children.

The Districts receiving Essential+ Package will receive more intensive support as BISA directly invests in revising job aids, conducting assessments to identify needs, and trains health workers. This is a critical linkage to SO1 and speaks to the importance of the information generated through community-level work to ensure that the support, services, and TA provided by District-level decision-makers is appropriate, relevant, and responds to needs. From the District and Provincial levels, this is further rolled up into national level advocacy and policy work (SO3).

Fostering an Enabling Environment: Strategic Objective 3

As outlined earlier, the high-level political commitment to nutrition in Indonesia has not translated to action at the subnational level where delivery resides. There is a need to support translation of national policies into operationalisation at sub-national levels.

BISA's theory of change and value add is to support the translation of GoI ambitions into action at the provincial, district, village and community levels. BISA will build evidence of how technical support can enable communities (SO1) and district health authorities (SO2) to operationalise StraNas – outlining which interventions have been most effective. BISA will have rich content to inform advocacy initiatives and engagement with stakeholders and input specific, practical suggestions and insights to policies.⁵²

Under SO3, BISA will invest in capacity building for policy leaders and decision-makers, particularly at Village and District level as larger programmes such as INEY cannot engage as intensely at these lowest levels of governance. These leaders require technical assistance and capacity building to coordinate across multi-sector stakeholders, support evidence generation and research, develop

⁵² This is an approach with which Save the Children is very familiar. A recent programme in NTT, CERDES, was successful in advocating for District Education Department to adopt local policy and increase allocation to early childhood care and development, including support from the village funds for ECCD centres.

comprehensive understanding of context and potential interventions, and innovations for sustainable interventions and impact.

To support sub-national operationalisation of national policies, and building on how this can be effectively done as demonstrated in SO1 and SO2, BISA will focus on building village-level capacity for local planning and budgeting. The GoI allocates resources to villages for their programmes and activities (Annex 15, World Bank and Village Budget), but the lack of capacity often means plans and budgets do not reflect local needs or priorities. Strengthening the capacity of the leaders who develop these plans and budgets is key. Building these skills, as well as use of data for decision making (such as findings from assessments or Riskesdas), and in advocacy and negotiation will equip leaders – especially at village level – to pursue the resources and support needed for their communities. SO3 also links to INEY’s approach to offering the potential for incentives within communities. By investing in the systems and services which support optimum practices, caregivers will be further motivated and capacitated to sustain improved behaviours. Similarly, BISA will support villages to include specific resource for posyandu cadres, in accordance with INEY’s strategy for results-based-financing for health workers.

Leaders will also be closely involved in the SBCC strategy development (SO1) from the point of formative research through to the activity planning so that they have the knowledge and experience to help them continue to refine and develop strategies in future, as per national guides.

The Essential and Essential+ approaches for this SO do not differ significantly except at village level. In Essential+ Districts, BISA will directly train village leaders.

Linkages across Strategic Objectives

BISA has been designed such that the three SOs are interlinked and facilitate effective vertical coordination across the three levels of government and with communities. At SO1, SBCC at the community and household level will improve behaviours and stimulate demand for nutrition service delivery. Technical assistance to district health authorities will enhance their capacity to deliver quality nutrition services (SO2) and meet the increased demand stimulated by SO1. To ensure resources are available to enable effective delivery at SO2 and enhance households’ ability to put into practice positive behaviours, SO1 is focused on assisting village leaders, district authorities and provincial governments to better plan and allocate resources for improved nutrition outcomes. Furthermore, the information and knowledge generated from the communities and households (SO1) will directly inform the efforts under SOs 2 and 3, to ensure the technical assistance to improve the quality of nutrition services and capacity of the health system, health workers, and relevant decision makers at District and Provincial levels is responding to local needs.

This coordinated approach will first be implemented in four Districts (two per Province) in the first two years. These Districts will be case studies from which BISA will ascertain the most effective ways to enhance capacity for effective operationalisation of StraNas. Evidence of the most effective approaches will inform the scale up of the BISA to additional 8 districts and, as part of advocacy in SO3, will be used to influence other districts and communities to replicate the model. These examples will also be used in advocacy efforts with BAPPENAS to inform strengthening of the overall nutrition system and policies.

GEOGRAPHIC TARGETING

SC and NI have a short-list of 12 Districts (Annex 7), six each in East Nusa Tenggara (NTT) and West Java. This section outlines the BISA targeting strategy.

Provincial Targeting

Despite making significant progress from 2013 to 2018⁵³, reducing from 53% to 43%, NTT continues to have the highest stunting rate in Indonesia, and amongst the lowest coverage of services and behaviours. This speaks of the significant level of need to address stunting and also the opportunity for BISA and its stakeholders to have significant impact for this population. West Java, despite having a stunting rate comparable to the national level, did not have such a dramatic reduction as NTT, dropping only to 31% from 35%. As the most populated Province, West Java has a significant number of stunted children. This also speaks to the need for more concentrated investment in order to achieve stunting reduction given this persistent burden.

Whilst the programme has been designed to deliver a consistent quality and package of interventions based on the persistent challenges, some adaptations will be needed for each geography. This will be partially addressed in the Essential and Essential+ approaches in terms of the level of support needed. Other nuances will emerge in the specific SBCC content which may emphasise different behavioural barriers or enablers in each Province, such as working very closely with religious leaders who are the community gatekeepers in NTT. Furthermore, the availability of resources and infrastructure will differ across the two Provinces and across Districts within the Provinces. For example, higher mobile penetration in West Java renders it particularly suitable for INFOBunda compared to NTT. Both SC and NI work in these Provinces which affords them significant familiarity with the socio-cultural, political, and operating context. It also allows the partnership to build upon existing relationships and networks.

District Targeting

In selecting Districts for BISA, we applied a set of criteria conducive to testing the approaches proposed - see Annex 7. The criteria used includes high rates of stunting⁵⁴, government prioritisation (nationally and Provincially), political commitment (as an indicator for openness and resources), and partner experience. Figure 2, below, expands on this with the criteria taken into consideration in determining which Districts will receive the Essential versus Essential+ Package.

Criteria for All Districts:

- ✓ Political commitment and openness at District level
- ✓ Stunting rate higher than national average
- ✓ Government priority District for stunting reduction

Figure 2

Criteria for Essential Districts

- ✓ Higher capacity and resource, per Provincial assessment and consultation
- ✓ Relatively better nutrition situation: coverage of services; key behaviours

Criteria for Essential+ Districts

- ✓ Lower capacity and resource, per Provincial assessment and consultation
- ✓ Relatively worse nutrition situation: coverage of services; key behaviours

The priority criterion is the rate of stunting. Because the 2018 Riskesdas data has not yet been publicly disaggregated to the District level, the figures used are from 2013.⁵⁵ Ongoing engagement with Provincial government will ensure the final selection of Districts and BISA Package reflects needs and priorities but also aligns with the evidence and learning which Provincial government need in order to inform their decision-making around resources, replication, and scale-up.

⁵³ All data from NIHRD for Riskesdas 2013 and 2018.

⁵⁴ NIHRD for Riskesdas, 2013

⁵⁵ Notably, this is also the data the Government of Indonesia used when prioritising the 160 Districts for 2019.

In the first two years, BISA will be delivered in four Districts, two per Province. In each Province, one District will receive the 'Essential' package and the other 'Essential+'. The rationale for this approach is to reflect the fact some Districts in Indonesia are richer in resource and capacity than others. By adopting and demonstrating the effectiveness of the BISA model across these different District typologies in each Province, allows BISA to generate adequate evidence and experience to inform scale-up from Year Three onwards. This evidence will also directly inform any revisions needed to the BISA model and support SC and NI, Provincial and District leadership to identify which Package is the most appropriate for which Districts during the scale-up phase. Furthermore, it is envisaged that BISA will generate sufficient contextual relevance and evidence to demonstrate to other Districts and Provincial leaders the potential for impact – which will stimulate replication. Fewer Districts and/or failure to demonstrate the balance of the two Packages would limit the relevance and potential of BISA to extrapolate evidence and lessons to other contexts.

BISA will begin with a base coverage of 40% direct reach (based on Puskesmas and associated catchment areas, which include relevant Posyandu Cadres) at the District level. Coverage will be phased gradually over the five years with a target coverage of 80% by Year 5.

In consultation with the Governments of West Java and NTT, it is currently envisaged the first 4 Districts will be Kota Kupang and Kupang District in NTT, and West Bandung and Sumedang in West Java (see Figure 4). These will be reviewed and finalised during the programme inception phase when district data from RISKESDAS 2018 is available. The remaining Districts of the shortlist (Annex 7) will be the Districts prioritised for the scale-up portion of the programme, starting in Year Three. However, should the socio-political or nutrition contexts shift, these could also be revisited. Similar differentiating criteria will be used at that point, in conjunction with lessons and evidence from Years One and Two, to determine which Package is most appropriate for which Districts.

	District	Stunting %	Total Population
NTT	Sumba Timur	51.31	258,486
	Sumba Barat	55.35	129,710
	Kota Kupang ⁵⁶	36.7	423,800
	Kupang district	46.3	387,479
	Manggarai	58.78	338,424
	Manggarai Timur	58.92	287,207
West Java	Cianjur	41.76	2,263,072
	Tasikmalaya	41.73	1,754,128
	West Bandung	52.55	1,699,896
	Sumedang	41.08	1,152,400
	Kuningan	42	1,080,804
	Bandung	41	3,775,279

Figure 4

PROGRAMME INVESTMENT DESCRIPTION

This section outlines in greater detail the design of the BISA programme. It is organised by Strategic Objective and Outcome. Additional details on the outputs and activities can be found in Annexes 1 and 2 (Programme Investment Details and LogFrame).

STRATEGIC OBJECTIVE 1: Improved MIYCN and WASH practices of adolescents, PLW and caregivers of CU2

Outcome 1.1: Improved knowledge, skills, and motivation of PLW, PLAG, and caregivers of CU2 to practice the recommended MIYCN behaviours

⁵⁶ In Kota Kupang, BISA builds upon and expands on groundwork laid during NI's DFAT-funded MITRA Youth program, which focused on WIFAS and adolescent nutrition education at schools. BISA does not duplicate any existing MITRA Youth activities within the programme's timeframe. Under BISA, pregnant adolescents are included, whereas they were not included in the MITRA Youth program. NI will ensure that there is no duplication of funds allocated between MITRA Youth and BISA.

Outcome 1.2: Improved household WASH practices and environment for CU2
Outcome 1.3: Improved knowledge, skills, and motivation of adolescents to practice recommended health and nutrition behaviours
Outcome 1.4: Improved delivery of WIFA and nutrition education for adolescents

SO1 complements the village-level community mobilization and capacity strengthening described in SO3 and health system improvements described under SO2 with direct work at community, household, and individual levels to improve adolescent, maternal, infant, and young child nutrition (MIYCN)⁵⁷ and WASH behaviours and increase demand for nutrition services. These behaviours include ensuring dietary diversity, nutrient and caloric needs at different life stages, and feeding practices. Existing data and research from Indonesia show that while there has been significant progress in the past decades in improving these MIYCN and WASH behaviours⁵⁸, there are still substantial gaps affecting children's health, growth and development. BISA SO1 has been designed to enable communities and households to address these gaps.

Formative research⁵⁹ (FR) will be used to develop BISA's SBCC strategy, as outlined in the Theory of Change. It will be conducted in first year of implementation (2019) to identify the MIYCN and WASH behavioural drivers in NTT and West Java. FR informs the sub-national SBCC strategy and the necessary tailoring to respond to the unique contexts of selected districts in NTT and West Java. BISA's SBCC strategy will follow behaviour-centred design to identify and implement integrated activities at the household and community levels. To avoid duplication of effort and leverage existing resources, BISA will build upon the significant research already conducted and planned by Alive and Thrive (Annex 15, A+T and previous references).⁶⁰ BISA SBCC strategy planning will also include a review of the Cost of the Diet study, Riskesdas, Aiming High and INEY. If additional FR is needed for specific areas which BISA will cover, it will be conducted in the first year of implementation. This may include:

- ✓ Qualitative assessment and analysis to identify factors influencing behaviours;
- ✓ Analysis⁶¹ to assess availability, access, and affordability of nutritious foods in local markets;
- ✓ Trials of Improved Practices (TIPS)⁶² to identify and test "Small Doable Behaviours" to ensure recommended behaviours are relevant, feasible and appropriate; and
- ✓ Gender analyses, in recognition of the role that gender dynamics play in access to services, resources, decision-making, and caregiving. The analyses will ensure the programme is identifying, understanding, and responding to gender dynamics at the community level.

The resulting SBCC strategy will incorporate best practices for SBCC⁶³, programming priorities for nutrition-specific and nutrition-sensitive behaviours and respond to context-specific barriers and opportunities related to these objectives, communication topics and content, tools and job aids, target audiences, activities and roll out mechanisms. The strategy will build on existing community platforms and draw on successful behaviour change experience and materials from Indonesia to avoid duplication and "reinventing the wheel". The strategy will involve a series of targeted community-led activities for meaningful engagement by women and adolescents. The SBCC strategy

⁵⁷ MIYCN encompasses the principles and practices for optimum nutrition among pregnant and lactating women, infants, and young children (under two years of age).

⁵⁸ Nutritious diet recommendations align with recommended content, e.g. *Isi Piringku (my plate)* or "Menu 4 bintang-the four-star menu".

⁵⁹ FR is used to better understand of local context, practices, traditions, and opportunities which then informs the development of specific programme content, such as a behaviour change strategy which can be specifically targeted to the local nuances.

⁶⁰ Alive & Thrive is an initiative funded by the Gates Foundation, Canadian and Irish governments to save lives, prevent illness, and ensure healthy growth and development through promotion of optimal maternal nutrition, breastfeeding, and complementary feeding.

⁶¹ Such as Cost of the Diet, or Household Economy Analysis (HEA) which was developed and piloted by Save the Children assesses community and household vulnerability to shock or crisis, such as drought or a change in food prices. The HEA looks at how families manage and spend their income and provides a framework to analyse how people access resources, such as food and services.

⁶² An overview of TIPS is available [here](#). TIPS has been widely used and was assessed in India in 2015, results and analysis available [here](#).

⁶³ Literature review of southeast Asia SBCC best practices (2016) available [here](#). Similar insights available in this [cluster-randomised trial](#) on SBCC and breastfeeding in Bangladesh and Vietnam.

will also inform and be informed by SO2 and SO1 activities – the health system and services capacity assessments and village and District level planning and capacity building.

Promoted behaviours will be nutrition-specific and nutrition-sensitive, such as promotion of exclusive breastfeeding, improved feeding practices (frequency, quantity, interaction) for young children, food hygiene, handwashing with soap, use of latrines, as well as increasing utilisation of nutrition services and products. The strategy will be based on analysis (SO1) to enhance understanding and ensure responsiveness to the context. The timing of the FR will align with the national SBCC strategy development for stunting in Indonesia supported by BISA will use this to develop and strengthen District SBCC strategies.

BISA's SBCC strategy will likely include the following approaches and activities, which are common elements of comprehensive SBCC⁶⁴:

SBCC approaches	Specific activities
Interpersonal communication	One-on-one counselling, through Posyandu Cadres and home visit; and group sessions, e.g. pregnant mother classes and caregiver classes
Media	Mass media; posters, flyers, calendars; traditional media, such as songs or dramas; and social media, including WhatsApp, Facebook, and Instagram
Community mobilization	Campaign events (village and District) e.g. and Global Handwashing Day
Gender and Adolescent Empowerment	Building women's and adolescents' capacity to engage and influence planning and budgeting; engaging all household members, e.g. fathers, mothers-in-law, school children, and youth to address inequalities

Figure 5

Each component under SO1 will have a separate package of related behaviours and will be phased in one at a time to avoid activity overload. For instance, the first tranche of SBCC will focus on WASH, given the ready availability of Lifebuoy's handwashing with soap approach (Annex 15, Lifebuoy); the final tranche will focus on maternal nutrition. Activities will also encourage families to seek nutrition-health services supported under SO2, both at school and community level. Empowering care givers to change responsive care practices if linked to positive health growth and development outcomes is likely to have long term consequences. Government stakeholders, influential leaders and women and adolescent groups will be engaged at every stage to maximise ownership and buy-in, validate findings and recommendations and ensure it is appropriate, relevant and sustainable. BISA will work within the context of the communities to identify the main influencers and opportunities for engagement, such as the prominent role of religious leaders and community ceremonies (e.g. such as funerals in NTT).

SO1	Outcome	ESSENTIAL	ESSENTIAL +
Improved MIYCN and WASH Practices	1.1 Improved knowledge, skills, and motivation of PLW, PLAG, and caregivers to practice recommended MIYCN behaviours	<ul style="list-style-type: none"> ✓ Engage district MoH in SBCC research and strategy development ✓ Share SBCC research and strategy highlights 	<ul style="list-style-type: none"> + Develop SBCC strategy + Mobilize village leaders to champion stunting prevention + Train nutrition champions to facilitate sessions and counselling + Promote, expand INFOBunda
	1.2 Improved household WASH practices and environment	<ul style="list-style-type: none"> ✓ Train Posyandu Cadres, nutrition champions to promote clean households 	<ul style="list-style-type: none"> + Promote WASH behaviours through group and counselling sessions and campaigns

⁶⁴ See Alive and Thrive [Roadmap for Indonesia](#).

1.3 Improved knowledge, capacity, and motivation for adolescents to adopt positive nutrition behaviours	✓ Share findings of adolescents' study	+ Engage school-based peer education groups + Integrate with AKSI BERGIZI
1.4 Improved delivery of school-based WIFAS and nutrition education for adolescents	✓ Technical assistance to schools for effective delivery of WIFAS	+ School Capacity Assessment + Cascade training

Outcome 1.1 Improved knowledge, skills, and motivation of PLW, PLAG, and caregivers of CU2 to practice the recommended MIYCN behaviours

The main objective under Outcome 1.1 is to ensure pregnant and lactating women and adolescents and caregivers of children under 2 years old (CU2) have the knowledge, skills, support and motivation to practice the recommended behaviours. BISA will work through nutrition champions, a set of community members who will be oriented on basic MIYCN to be able to serve as peer influencers and supporters within the community (see Output 1.1.2), and village committees to strengthen the Posyandu/health system led services (described under SO2) and other community-based platforms (pregnant mother classes, Bina Keluarga Balita (BKB) parenting groups, adolescent clubs) to promote recommended behaviours and ensure PLW and all caregivers of CU2 receive relevant, accurate and consistent information and supportive counselling and advice. West Java communities tend to be closely engaged with these community groups.

Outcome 1.2 Improved household WASH practices and environment

Estimates suggest that around 50% of stunting is related to poor WASH, through diarrhoeal disease, parasitic infections and chronic gut inflammation (Annex 15, WHO). Preventing WASH-related illness is therefore as important as improving nutritional intake to improving child nutrition. Recent evidence suggests that the most promising WASH interventions to prevent contamination amongst younger children should focus on the household environment, where young children spend most of their time, and caregiver hygiene practices. BISA will pilot Save the Children's Clean Household Approach⁶⁵ in Indonesia (CHA, see Figure 7) to address this. The CHA also complements the national programme on sanitation (Community-Led Total Sanitation).

BISA research, supported and implemented through one of Save the Children's private sector partners, will look more closely at the WASH factors including assessing the household environment and identify both causal pathways and protective factors shaping a child's nutrition. The Clean Household Approach will be adapted and used to assess where the likely contamination pathways for young children focusing on each age range (0-5 months; 6-11 months; 12-23 months). The strategy will follow Unilever / Lifebuoy's⁶⁶ Five Levers of Change to make the behaviours: [1] understood; [2] easy; [3] desirable; [4] rewarding; and [5] habitual.

Outcome 1.3 Improved knowledge, skills and motivation of adolescents to practice recommended health and nutrition behaviours

Adolescence is considered the second window of opportunity to ensure young people are achieving optimum nutrition for their current and future wellbeing as well as for if and when they become parents. Adolescence is a period of rapid physical, mental, and social growth, learning and brain development; in Indonesia, it is also a period when many become parents. Early pregnancy has

⁶⁵ The Clean Household Approach has been trialled by Save the Children. It is not yet a validated public tool. BISA, and programme research, will add to the evidence base and refinement of this approach.

⁶⁶ Unilever / Lifebuoy and Save the Children have agreed, in principle, to partner on the BISA programme; final details under discussion.

consequences both for the mother and her child as it will stunt her own growth, that of her child and increase the risk of complications, including anaemia or low birthweight, contributing to a vicious generational cycle of undernutrition.

BISA will engage adolescent boys and girls to design, implement and evaluate adolescent-focused interventions. All engagement with adolescents and beneficiaries under the age of 18 will be designed and managed in accordance with the highest standards of Save the Children⁶⁷ and Nutrition International's child safeguarding policies.

Outcome 1.4: Improved nutrition-sensitive education for Adolescents

The MoH has stated that WIFA for adolescent school girls will be rolled out through the national School Health Programme (UKS). However, utilisation and adherence continue to be a challenge. BISA will work with school teachers, Puskesmas, and especially peer groups to promote adherence to WIFAs and their importance in supporting optimum nutrition for adolescents.

STRATEGIC OBJECTIVE 2: Improved access to and use of IFA for pregnant women and pregnant adolescent girls, WIFA for adolescent girls, VAS, zinc & ORS for children U5, and MIYCN counselling for PLW, PLAG, and caregivers of CU2

Outcome 2.1: Improved supply chain management system in Puskesmas, private providers, and Posyandu

Outcome 2.2: Improved quality of nutrition services and MIYCN counselling by Puskesmas staff, private providers, and Posyandu Cadres

SO2 will be led by NI and focuses on building the capacity of the health system to deliver and manage quality nutrition services, primarily through Puskesmas and Posyandu cadres.

SO2 aims to increase access to key health and nutrition services vital to preventing stunting by addressing gaps and strengthening those elements of the health system responsible for providing these services. The specific services that BISA will focus on are Iron and Folic Acid (IFA) supplements for pregnant women and pregnant adolescents, Weekly Iron and Folic Acid (WIFA) supplementation for adolescent girls, Vitamin A supplementation (VAS) for children under five (CU5), zinc and Oral Rehydration Salt (ORS) for CU5, and Maternal, Infant, Young Child Feeding (MIYCN) counselling for pregnant and lactating women (PLW), pregnant and lactating adolescent girls (PLAG), and caregivers of CU2. These services are currently provided through the health system - including Puskesmas, Posyandu cadres, school teachers, and village midwives.

Under SO2, BISA will conduct a series of systems-level assessments to identify the bottlenecks and capacity needs which must be addressed to improve the quality and access to these services. These assessments will be conducted with and for District and Provincial level stakeholders (Puskesmas, Posyandu cadres and village midwife representatives) as well as beneficiaries (mothers and adolescents) to ensure ownership of findings and user-driven solutions.

SO2	Outcome	ESSENTIAL	ESSENTIAL +
Improve d access	2.1 Improved supply chain management system in Puskesmas and Posyandu	✓ Technical assistance for strengthening supply chain management	+ Assessment of bottlenecks + Improved tools (SOPs) + Cascade training

⁶⁷ Save the Children's Child Safeguarding Policy can be found [here](#).

	2.2 Improved quality of nutrition services and MIYCN counselling by Puskesmas staffs, Posyandu Cadres	✓ On-the-job training to health workers on Supportive Supervision (quality assurance, mentoring, capacity building, accountability, action plan)	+ Capacity Assessment
		✓ Disseminate revised Job Aids	+ Improve job aids + Cascade training + Pilot eLearning

Outcome 2.1: Improved supply chain management

The Government has committed to provide an estimated 80-100% of IFA supplements for pregnant women and pregnant adolescents (90+ days), and the MoH has committed to provide funding to cover 30% of the WIFA needs for adolescent girls in 2019 and 100% of the vitamin A, Zinc and ORS for CU5. However, due to gaps in procurement and supply, there is low coverage. Delayed procurement, inaccurate forecasting, and poor stock management often lead to stockouts at the Puskesmas and Posyandu levels.

In Essential+ Districts, BISA will provide technical support to the PHO and DHO to strengthen the supply chain mechanism. The support will include identification of the main bottlenecks in the supply chain, development of supply chain improvement plans, improving the standard operating procedures, guidelines and job aids and build supply chain staff capacity to effectively manage stocks. The assessment findings and supply chain improvement plans will be shared and discussed with the BISA Essential districts to encourage these districts to initiate similar improvements (if they are facing similar bottlenecks). Essential Districts will also be able to draw on the revised guidelines, operating procedures and tools developed and tested in the Essential Plus Districts.

Outcome 2.2: Improved quality of nutrition services and MIYCN counselling by Puskesmas staffs, private providers, Posyandu Cadres

Demand for and adherence to IFA, vitamin A and uptake of recommended behaviours (described in SO1) and services depends, in large part, on the quality of the counselling and service delivery provided by the community's frontline health workers - Posyandu Cadres and village midwives.

Counselling is often de-prioritized or delivered poorly (such as in a directive way) due to lack of time, support, gender-responsive job aids, or skills for delivering quality counselling. The result is that the recommended behaviours are unlikely to be adopted. There are also challenges in delivering the IFA, VAS, zinc and ORS treatment, providing the appropriate guidance to women and caregivers related to side effects and how to use the supplements and monitoring adherence.

BISA will build the capacity of Posyandu cadres, village midwives, Puskesmas and private health providers to provide effective counselling to PLW, caregivers of CU2 and adolescent girls through existing activities (GMP, mother classes, parenting classes etc.) through training, ongoing supportive supervision, improved job aids, and INFOBunda⁶⁸, which will be especially relevant in West Java where data connectivity and mobile penetration is higher.

The assessment and development of the training materials, job aids and mobile solutions will be conducted in the BISA Essential+ Districts and the outputs will then be shared with BISA Essential Districts through peer-to-peer learning (between the Districts) and engagement platforms, such as Rembuk Stunting, encouraging these to integrate these in their budget, plans and activities with minimal technical support from BISA staff. BISA will conduct implementation research for delivering quality ANC to pregnant adolescent girls and IYCF and post-partum counselling for adolescent mothers (see MEAL plan).

⁶⁸ INFOBunda is the Ministry of Health's mHealth platform specifically for mothers and health workers. See Annex 15 (SMSBunda) for additional information as well as this [report](#) on INFOBunda's role in supporting pregnant and postpartum women.

STRATEGIC OBJECTIVE 3: Additional and more efficient and effective use of funding, policies and regulations, and human resources to prevent stunting

Outcome 3.1: Increased inclusion of actionable stunting reduction-related health and nutrition objectives in village plans, budgets, and governance mechanisms
Outcome 3.2: Improved technical guidance and monitoring (supportive supervision) from Provincial officials for stunting reduction programmes in Districts and villages
Outcome 3.3: Increased commitment amongst national MoH policy makers to support effective and improved implementation of StraNas and the INEY programme

In Indonesia there are 22 Ministries involved in nutrition; poor coordination amongst these actors and limited understanding of their respective policies and plans contribute to the lack of operationalisation at sub-national levels. Policies and strategies, including Ministerial decrees and Presidential initiatives like StraNas as well as programmes like INEY, come together at the District and village levels as it is from these levels that plans are to be delivered and overseen, requiring coordination between Districts and villages including the role of District authorities to support the village planning and budgeting process (Annex 15, Indonesia Planning Cycle). However, often these policies and strategies are not well understood at sub-national level and are not effectively prioritised, resourced, or implemented. Whilst there is an existing budget committed at national level and the mechanism of village disbursements works (Annex 15, Village Budget), the budget requests and associated strategies coming from villages are not consistently aligned to policies and strategies. Because villages are where the work happens (Annex 15, World Bank), BISA will strengthen the capacity and skills at village and District level to improve the alignment of the plans and budgets with national nutrition priorities.

The purpose of SO3 is to influence and inform the policy and strategy environment – particularly at village and District levels – to reflect national nutrition priorities and be adequately resourced. SO3 will draw from the evidence generated through SO1 and SO2. All activities in SO3 are oriented towards understanding the complicated policy and strategy environment in order to identify gaps or overlaps as well as how to influence and optimise the commitments and resources available to address undernutrition. Villages have access to resources (Annex 15, World Bank) but need to be supported in how to request and plan for those resources. These village funds will support initiatives and interventions, as referenced in the Theory of Change, aligned with national nutrition priorities and as demonstrated through this programme. Partnerships at provincial and national level with relevant stakeholders (government ministries, BAPPENAS, World Bank and INEY, civil society, SUN platform etc.) will build a supportive policy environment for successful implementation of the project and development of a long-term sustainable model. Strategic Objective (SO) 3 will be jointly led by SC and NI.

SO3	Outcome	ESSENTIAL	ESSENTIAL +
More effective use of resources	3.1 Stunting-related interventions are an integral part of village and District budgeting and planning	<ul style="list-style-type: none"> ✓ TA to village committees for action planning, budgeting, and tracking progress and expenditure 	+ Train committees for action planning, budgeting, tracking progress and expenditure
		<ul style="list-style-type: none"> ✓ Relevant District regulations for stunting reduction approved ✓ Develop, monitor, evaluate guidelines for stunting reduction ✓ Establish SUN Task Force to monitor progress of PERDA and associated guidelines 	

	✓ Train Civil Society Advocacy Group ⁶⁹ (CSAG) to monitor progress of PERDA and associated guidelines
3.2 Provincial guidance and monitoring support effective stunting reduction programmes at District and Village level	<ul style="list-style-type: none"> ✓ Engage and influence key policy makers, including under the SUN Movement ✓ Contribute programme evidence to guide national policies and priorities
3.3 Increased commitment amongst national policy-makers to support StraNas and INEY	<ul style="list-style-type: none"> ✓ Engage national stakeholders ✓ Share results of formative research, assessments, and response plans as well as results

Outcome 3.1: Increased inclusion of actionable stunting-reduction related health and nutrition objectives in village plans, budgets, and governance mechanisms

The purpose of Outcome 3.1 is to understand the policy, strategy and legal environment at village level as this will allow for more targeted plans to be developed and delivered, for instance sustained delivery of the activities and interventions demonstrated in SOs 1 and 2. Activities in SO3 are a large part of BISA's sustainability as the programme works through the existing mechanisms (Annex 15, World Bank) to access village resources and authority to support village priorities and development. Throughout the programme, a key priority will be to ensure that the unique needs and situation of women and adolescents, people living with disabilities, and other marginalised groups are appropriately considered and reflected in these guidelines.

Building on the evidence and impact demonstrated through SO1 and the capacity built through SO2, SO3 will support village authorities to optimise the village planning and budgeting process to ensure community needs are appropriately reflected and resourced. District authority and capacity is central to support villages in their planning and execution, which goes through District and Provincial level to be formalised and operationalised⁷⁰ (Annex 15, Indonesia Planning Cycle).

Outcome 3.2: Improved technical guidance and monitoring (supportive supervision) from Provincial officials for stunting reduction programmes in Districts and villages

Provincial government staff, including line ministries and offices, e.g. PHO and BAPPENAS, are responsible for coordinating District staff as well as overseeing the implementation and dissemination of National and Provincial-level strategies and policies. BISA's focus is on ensuring that these staff and officials are engaged in the implementation of the programme, including ongoing dialogue and consultations on programme progress, such as the development of updated guidelines, monitoring approaches and implementation plans.

A key mechanism for their engagement in the programme as well as their contribution to the overall ambitions of BISA in improving coordination, consistency, and quality across all levels of policy and strategy. In this, the programme's advocacy strategy will be key. The purpose of the advocacy strategy will be to identify the key influencers in the Provincial and District administrations and then work closely with them in the review and implementation of national and sub-national policy strategy and regulation. This will also support the Provincial level to be change agents, advocates, and advisors to the national government around areas of policy overlaps, gaps, or opportunities for

⁶⁹ Or similar active and representative community-wide groups.

⁷⁰ Government reference outlining the process is available [here](#). Note not the full resource is applicable to BISA.

refinement and strengthening. A clear linkage in this strategy will be the evidence and learning generated through SO1 and SO2.

Outcome 3.3: Increased commitment amongst national MoH policy makers to support effective and improved implementation of stunting programmes

There is strong commitment to improving nutrition and reducing stunting at the national level in Indonesia, as outlined earlier. However, it is critical that these plans and ambitions be effectively translated into impact and action at sub-national levels – the purpose of Outcomes 3.1, 3.2, and 3.3. BISA will leverage and further strengthen Save the Children and Nutrition International's existing partnerships through these strategic advocacy initiatives, including meetings, joint learning visits, programme documentation, and sharing policy briefs (as outlined in the MEAL section).

PROGRAMME VALUE ADD AND RATIONALE

Recognising that BISA is being delivered within a wider context of other government initiatives, multilateral programming (e.g. the World Bank) and other NGO initiatives, Save the Children and Nutrition International have designed the programme to have a clear value-add, complement other programmes where appropriate, and avoid duplication. Annex 15i (Programme Complementarity) outlines some specific programmes and initiatives with which BISA will closely coordinate, including how the programmes will benefit from and leverage those resources. The key challenge in Indonesia is not insufficient resources for stunting reduction programmes, but tested and effective methods to translate high-level policy and budget commitments into impact at the household level (SO1); high-quality and evidence-based operationalisation by District and Provincial health officials and systems (SO2); and coordination amongst the complexity of stakeholders engaged in health and nutrition governance (SO3).

BISA's main value add is the transition from direct service delivery by NGOs to supporting GoI at the Provincial, District and Village levels and communities and households to better utilise existing resources to achieve improved nutritional outcomes. This approach enables SC and NI to effectively use \$10 million to leverage substantial resources for high impact at scale. In addition to the critical ways which BISA is different from previous programmes, there are also specific areas of value-add.⁷¹ Some of these are new elements, some are the areas of complementarity with other programmes, and some are unique attributes offered by SC and NI.

- ✓ **Life-cycle approach:** BISA goes beyond the First 1000 Days window to capture women (primarily but not exclusively adolescents) in the pre-pregnancy window. This is necessary in the Indonesian context where women become mothers at a young age. This approach also reflects the importance of a mother's health and nutrition status to support optimum growth and development of a child from the point of conception. BISA carries this focus through the full First 1000 Days window, in keeping with global nutrition evidence and best practice as well as the government's national stunting reduction strategy.
- ✓ **Integrated stunting prevention package** which is both nutrition-specific and nutrition-sensitive and builds on evidence-based interventions, partner experience, and lessons learned from other organisations and programmes which have typically focused on acute malnutrition, to the neglect of stunting.
- ✓ Developing a specific package of nutrition interventions for **adolescent girls**, building on the UNICEF Adolescent Nutrition Network, and including SBCC targeting this critical pre-pregnancy growth window, including optimising their nutrition, adherence to WIFAs, and influencing nutrition-sensitive behaviours such as WASH, all through school-based peer education. BISA will capture case studies and best practices for reaching and engaging adolescents and will

⁷¹Strategi Nasional Percepatan Pencegahan Stunting, 2018 – 2024 (National Stunting Reduction Strategy).

disseminate and using these resources to influence policy and programme development within and beyond Indonesia

- ✓ Measuring budget **expenditure** at the local (village) level and not just budget commitment, which is where budget and advocacy typically reduces its focus.
- ✓ Delivering with a clear **programme learning agenda** reflecting BISA's focus on demonstrating what works and using evidence and results to scale out (coverage) and up (new Districts) as well as inform and influence replication across Indonesia through ongoing engagement and advocacy.
- ✓ Developing and delivering strategies, including SBCC, **closely aligned with national priorities and policies** versus developing parallel systems or resources.
- ✓ Delivering at the **community level** addresses a clear gap – resources from the World Bank, national government, and other multi-laterals are significant, but they cannot access the same level of community-based and community-oriented work which is at the core of BISA.
- ✓ Works with and through **government systems and human resources**
- ✓ Incorporating and reflecting **global evidence and international best practice**, as demonstrated throughout and including the prioritised Power of Nutrition interventions, SBCC, Lifebuoy Handwashing with Soap, and the WASH-nutrition nexus, amongst others.
- ✓ Linking with **global networks and resources** such as SUN. Save the Children's hosts the SUN Civil Society Network (SUN CSN) global secretariat, provides the Vice-Chair to the steering group and its many country offices are engaged in national SUN civil society alliance activities.⁷² Both NI and Save the Children are leading voices in global, regional and national coalitions on nutrition including the International Coalition on Advocacy for Nutrition's global and national branches.
- ✓ Use and expansion of **technology (InfoBunda)** to increase coverage and reach, particularly of SBCC, ensuring BISA uses the available and most relevant and meaningful engagement tools
- ✓ Engaging with **the private sector**, through BISA's match funding partners, the programme steering group, and other platforms, such as the SUN Business Network, to promote positive engagement and practice in line with the SUN Business Network Principles for Engagement
- ✓ **Coordinating** with other implementers, including UNICEF and the World Bank, to capture and share resources, evidence, lessons, and best practices to improve coordinated delivery of nutrition programming (Annex 15i, Complementarity Matrix)
- ✓ Intentionally bridging civil society, private sector, and government space **by leveraging the existing networks and relationships** held by Save the Children and Nutrition International with entities such as SUN (including Civil Society and Business Networks), BAPPENAS, TNP2K, the World Bank, and the Provincial governments.

PROGRAMME SUSTAINABILITY

As outlined in the Theory of Change, BISA was designed with sustainability at the core – defining, delivering, and generating evidence and learning of effective interventions and approaches to prevent stunting so that government, private sector, or civil society can readily access these learnings to replicate and sustain impact. BISA will achieve sustainability in four key ways:

1. Government: enabling Provincial and District governments to effectively and efficiently plan for and use resources for better nutrition outcomes
2. Village and Community: enabling villages and communities to use village resources to influence and incentivise service providers and households to achieve improved nutrition outcomes
3. Households: providing households (especially women and adolescent girls) with the knowledge and tools to utilise nutrition services and adopt improved behaviours
4. Evidence: documenting, disseminating evidence of what works to facilitate scale-up by others.

⁷² The SUN CSN network comprises more than 3000 local, national and international organisations and 40 national civil society alliances who are working to address malnutrition in their contexts. The SUN CSN has potential to reach and improve nutrition of over 85 million stunted children under 5 across the 60 SUN countries.

The overarching ambition is that BISA will generate practical and actionable evidence and lessons for the Government to feel motivated and capacitated to deliver these interventions going forward. By demonstrating cost-effective impact and engaging the government nationally and sub-nationally throughout the design and delivery of the programme, BISA is, in effect, a proof of concept programme for the government to scale. The programme's focus on capacity building, operationalisation, and streamlined guidance and approaches makes transition to government and other actors more feasible and sustainable. BISA is designed in alignment with Government priorities and strategies, and the Government has committed resources to stunting reduction. What is missing is the practical evidence and examples of how resources and policies can be effectively translated into action and impact. As this is the focus of BISA, Save the Children and Nutrition International are confident that the Government will be committed to continuing to support these interventions and approaches.

SO1: SO1's focus is on changing behaviours and norms at the community and household level. These changes must happen at the individual level, based on the motivation, knowledge, and support provided through the interventions outlined. Once an individual is motivated to adopt a change and can observe the impact of that change, the behaviour will become engrained in their habits and routines and can be taught and encouraged in other parents and caregivers. Because the structures through which BISA will deliver this content are existing elements of the communities (pregnancy groups, parenting classes, monthly GMP, and Posyandu cadres), SO2's work is a key part of the sustainability of community support. Further, with SO2's focus on improving the resources and job aids for these community structures, this knowledge and content will continue to be shared. The government will be closely involved throughout the development and delivery of these resources, as outlined below.

SO2: SO2 focuses on building the capacity of the programme implementers in the existing system of DHO-Puskesmas, as well as the UKS to help ensure replicability and scalability, both within and beyond the BISA-targeted Districts. Ongoing coordination with the PHO will further support this replication. Further, BISA emphasises how to institutionalise on-the-job training by focusing on problem solving and skills-building at all levels of the health system.

SO3: SO3 builds an enabling environment from the village level upwards to ensure sustainability of the activities (in the short term) and inclusion of the nutrition agenda (over the long term) in the village plans to improve nutrition and decrease stunting. Specifically, this includes:

- ✓ Inclusion of nutrition agenda at the village level, training and capacity building of village level bodies, women's and adolescent groups, and developing them as 'change agents' will ensure the sustainability of this program.
- ✓ District-level regulations support long-term implementation of village-level interventions.

By working alongside government from Year One, these stakeholders will be able to engage in the delivery and progress of the programme, ensuring that BISA is generating useful information that is relevant to other parts of the Provinces and country. Because there are a number of policies and strategies in place already at national level and there are resources available, the key element of sustainability under SO3 is the sub-national operationalisation of these plans; at national level the key consideration is to ensure the strategies reflect and incorporate the appropriate interventions and actionable policies. The phased approach allows the programme to capture this information in the early years of implementation before taking it to scale at a national level, in partnership with local government and local civil society. BISA is intended to be replicable in a cost-effective (e.g. affordable), efficient, and impactful way.

PROGRAMME MANAGEMENT AND IMPLEMENTATION

Save the Children and Nutrition International each became approved implementing partners of the Power of Nutrition in 2018. Both organisations have extensive experience in nutrition as well as established trackrecords of successful programmes in Indonesia.

Save the Children

Save the Children (SC) is the lead partner for the BISA programme. SC has been working in Indonesia since 1976 and has worked in 16 of Indonesia's 34 Provinces. In 2017, SC worked in 11 Provinces and 43 Districts, reaching over 230,000 direct beneficiaries. SC's programming and technical expertise is primarily in the areas of health and nutrition, education, and child rights – including child protection, child poverty, and child rights governance. Save the Children is also an active player in the national policy and advocacy space, particularly in the realm of working with sub-national government actors on effective management of financial and technical resources.

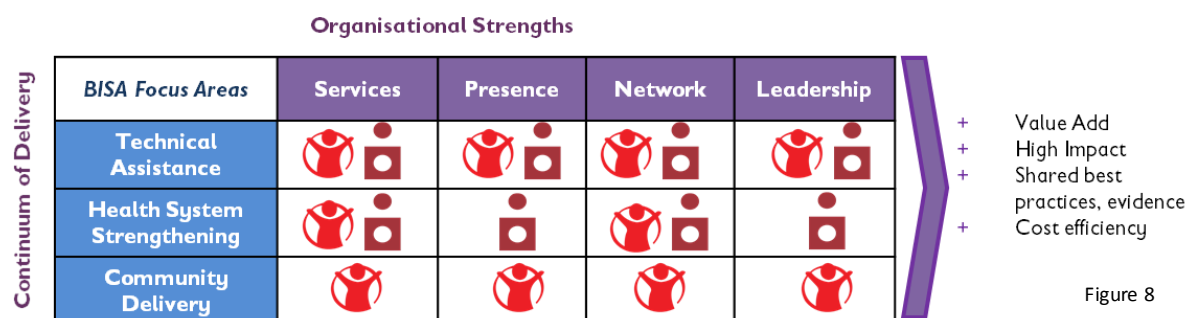
As one of the country's leading non-governmental organisations (NGO), SC is highly engaged in national and sub-national platforms and networks, including having strong relationships with key government stakeholders. These stakeholders include, amongst others, the National Development Planning Agency (Bappenas), the Ministry of Health (MoH), Ministry of Social Affairs, and the Vice-President's Office (which oversees the national stunting programme), amongst others. SC is also actively involved in key non-governmental organisation (NGO) networks, such as the Scaling Up Nutrition Movement and its associated Civil Society and Business networks and platforms; and the Partnership for Maternal, Newborn, and Child Health, led by the World Health Organisation. More comprehensive details on Save the Children's work in Indonesia is included in Annex 13.

Nutrition International

Nutrition International (NI) has been implementing high-impact, high-coverage health and nutrition initiatives for vulnerable communities in Indonesia since 2006. NI's priority objectives in Indonesia include the survival and health of children, adolescent girls, and women, primarily through improved coverage and use of key nutrients, such as vitamin A, zinc, iron and folic acid, and iodised salt. Through NI's *Right Start* programme (2015-2020), 13.9M women of reproductive age and adolescent girls across Indonesia will access wheat flour fortified with iron and folic acid and 4.9M adolescent girls in 35 districts of West Java and Banten provinces will receive iron and folic acid supplementation and nutrition education at school.

NI uses a health system strengthening approach, and provides extensive technical assistance to the government to design and implement nutrition programmes aligned with government priorities and plans, for instance the National Mid-Term Development Plan. NI's key government partners include the MoH, Ministry of Education and Culture, Ministry of Religious Affairs, Ministry of Religious Affairs, and Bappenas, amongst others. As outlined in Annex 13, NI's global Technical Assistance for Nutrition (TAN) programme includes Indonesia and encompasses direct technical assistance to government to support needs identified through a consultative process led by SUN.

Partnership in Action: Building on each organisation's expertise, BISA brings together a unique and strong combination of direct community engagement and household-level interventions (SC) as well as support to government stakeholders and the health system (NI). It is this combination of expertise and experience that underpins the programme's approach and theory of change as it allows for the direct community work which will demonstrate impact and generate evidence to inform and be taken to scale through ongoing engagement at the government level. Figure 8 below outlines some of these specific areas of strength and complementarity.



Each of the descriptions for the Strategic Objectives identifies the roles of the partners. The SOs are very closely linked in their design and delivery and thus whilst the partners will operate in their areas of strength, there will be extensive collaboration. This is further demonstrated in the programme management structure which reflects the unified leadership for the BISA programme.

Strategic Objective 1:

- SO1 will be led by SC given experience and expertise to work directly with communities
- Link with SO2 particularly on health system strengthening, service utilisation.

Strategic Objective 2:

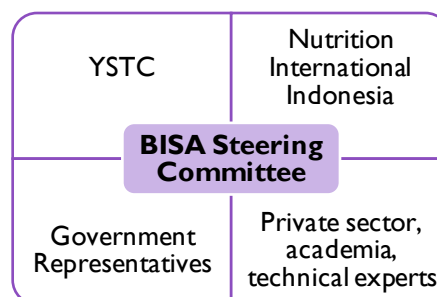
- SO2 will be led by Nutrition International given experience and expertise delivering direct technical assistance to government and health system.
- Link with SO1 to ensure community needs are reflected in the capacities built and services strengthened; with SO3 as the operationalisation of national priorities, policies, and plans.

Strategic Objective 3:

- Jointly delivered by SC and NI given complementary strengths and experience delivering policy and advocacy support, including technical assistance and budget tracking

Programme Governance

BISA's management and staffing structure is outlined in Annex 11. This structure demonstrates the importance of quality assurance, staffing, and management to oversee successful delivery of BISA. To provide additional governance beyond the management and oversight done by BISA staff, SC and NI propose a programme Steering Committee (see Annex 12). The purpose of the Steering Committee is both to serve as a high-level support structure to provide guidance and input in the programme and to serve as a key vehicle to communicate externally on programme achievements. Members of the Steering Committee will be selected intentionally as key stakeholders and experts who can provide meaningful inputs and guidance.



Additional Partners and Due Diligence

As outlined in the Theory of Change as well as the programme phasing and sustainability, Save the Children and Nutrition International will begin working with local partners from Year 3. This is in line with organisational approaches and ambitions to work increasingly with local civil society and will contribute more broadly to the programme's contribution to building local capacity.

Local partners will be identified from a District perspective, to ensure selected partners have knowledge or experience relevant to the BISA targeted areas. Some partners may support in more than one District. The scope of work for the partners is not yet defined as it will be informed by the

first two years of implementation and ongoing consultation with stakeholders. In Save the Children's experience, identifying, vetting, and securing these partners takes approximately three months. The steps in this process are broken down as follows:

1. Partnership Scoping and Selection: mapping and stakeholder analysis at District level. Scoping of potential partners will be conducted after Year 2 is completed and partner scopes of work are developed by the BISA programme team in consultation with stakeholders.
2. Partnership Assessment and Selection: select appropriate and qualified partners and identify the capacities those partners need to ensure successful programme delivery; risk minimization; capacity strengthening plans. This will occur prior to issuing any partnership agreements.
3. Partnership Agreement: developed for each individual partner. This agreement must be developed and agreed to prior to any work commencing or any transfer of funding. Agreements include clear terms of the relationship with the partner, compliance obligations, reporting and information sharing, and agreements on deliverables.

CO-FINANCING

SC and NI confirm agreement to the match funding requirements for the BISA programme. Together, the partners will secure the required \$5 million over the course of implementation.

SC is in advanced discussions with Unilever's Lifebuoy brand about a specific investment for handwashing with soap, including behaviour change activities, community mobilisation, and communications and advocacy. This partnership has been agreed in principle, including the delivery platform, target populations, and cycle of investment. The specific details, including amount and composition of match support, continue to be under discussion parallel to the finalisation of the BISA programme and stakeholder consultations.

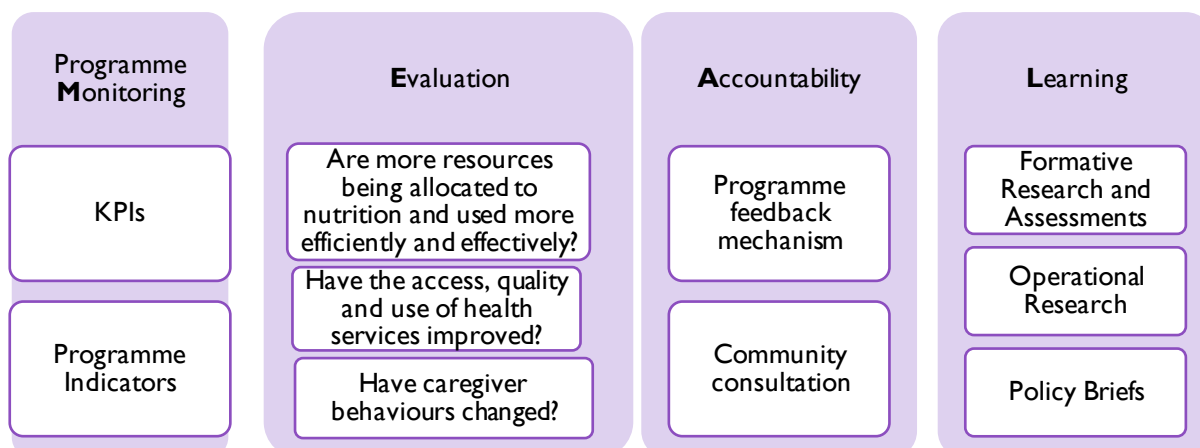
SC is also in discussions with another private sector partner and two academic partners to conduct cutting-edge research on stunting and specifically environmental enteric dysfunction (previously referred to as 'enteropathy'). Using the BISA programme as the platform for this research, the data gathered and the findings therein will contribute to the programme's learning agenda including refining of approaches, priorities for scale-up, and overall findings to share through advocacy and policy both within and beyond Indonesia. Save the Children's relationship with these partners stem from a global partnership, offering a global stage and scale through which to share these findings. As this discussion is ongoing, Save the Children is not at liberty to disclose the details of these partners but will confirm once agreement is reached.

NI will receive USD 2.5 million in co-financing for the BISA project from Global Affairs Canada (GAC). GAC will disburse the co-financing in annual payments, as part of its five-year Institutional Support Grant to NI, starting March 2019. The co-financing from GAC will be used to finance the nutrition interventions as designed in the BISA project across all targeted geographies.

RESULTS, REPORTING, AND EVALUATION

Save the Children and Nutrition International's approach to results and reporting encompasses Monitoring, Evaluation, Accountability, and Learning (MEAL). The BISA LogFrame (Annex 2) summarises the changes expected as a result of the BISA interventions. The purpose of the MEAL system is to evaluate progress towards each of these outputs, outcomes and strategic objectives; understand the drivers of these changes and identify where progress has been lagging to address

them in a timely way. A comprehensive MEAL framework will be developed during inception to describe how each indicator (from activity to SO level) will be collected, analysed and reported on.



Programme Monitoring

Programme monitoring is how SC and NI track programme progress over time and ensure that the programme is delivering what is outlined in the LogFrame. Monitoring focuses on output-level changes, resulting directly from the project activities and interventions. It will involve regular data collection to monitor progress in implementing key activities and delivering on the planned outputs. The list and source of data will be confirmed in the MEAL framework during inception and be based on a thorough analysis of existing data sources, their quality and reliability, to ensure that there is no duplication of data collection. Routine and annual sources of data are anticipated to include the annual 'mini-Riskesdas' which will be conducted by the Government; additional data will need to be collected by the programme to ensure appropriate disaggregation (demographically and geographically) and that all key indicators and activities are included. Reporting of both activities and their associated outputs, as well as higher-level targets will be included in the six-monthly reports submitted to the Power of Nutrition. BISA will also disseminate these results with key programme stakeholders.

A monitoring information system will be established during the inception phase, which will include a mobile (digital) data collection system to provide live data to BISA project managers to track progress and identify and resolve problems in a timely fashion. All data will also be disaggregated by gender. Monitoring data will be compiled and summarised by the District-level MEAL Officer, who will compile and share with the Provincial and national-level programme staff. An online dashboard will be established and utilised to track progress. BISA will engage with government stakeholders as far as possible to also contribute to their monitoring system and strengthen their sub-national mechanism. Meetings will be organised at least twice a year with district and provincial level partners to review progress.

In addition to the indicators delineated in the LogFrame, the programme also has three high-level Key Performance Indicators (KPI), see Figure 10. These KPIs reflect the top priorities and ambitions of the programme and the 'big picture' problems. BISA supports the Government of Indonesia (GoI) commitments for stunting reduction, which have set a target prevalence of 22% by 2022 (currently 31%). BISA will contribute towards that target but has an intentionally smaller impact target. The targets for these KPIs are based on national trends, partner programme experience, review of similar programmes, and reflection on programme scope and resources.

BISA will use the NIHRD for Riskesdas data. Should there be any shifts to that, there will be implications for BISA's reporting against these KPIs. The targets for these KPIs will be finalised during

the inception phase based on District-level data from RISKESDAS and in consultation with the GoI and key players, e.g. the World Bank, to ensure broad alignment with key partners.

BISA Key Performance Indicators: 2019 and 2024	
1.	% reduction of under-two stunting prevalence (total # of CU2 suffering from stunting)
2.	% reduction of under-five child mortality (total # of under-five deaths)
3.	% reduction of anaemia amongst pregnant women and adolescent girls and total number of pregnant women / adolescent girls who are anaemic

Figure 9

In addition to these high-level KPIs, to which BISA will contribute, there are indicators for the three SOs which will be monitored throughout the programme implementation (see Figure 11). These indicators will be tracked and reported against in the schedule detailed in the LogFrame (Annex 2).

BISA Key Performance Indicators: Ongoing	
1.	SO1: % 0 - <6 month old infants who are exclusively breastfed (in the last 24h)
2.	SO1: % 6-23 month old children with minimum dietary diversity score
3.	SO1: % HH with CU2 with improved handwashing behaviour
4.	SO2: % of CU5 who received Vitamin A in the last six months
5.	SO2: % of CU5 with diarrhoea who received both ORS and zinc for treatment
6.	SO2: % of pregnant women who received 90+ / 180 IFAS in their last pregnancy period
7.	SO3: % of villages with % budget expenditure for nutrition

Figure 10

Evaluation

BISA will use a mixed method approach (qualitative and quantitative) to evaluate the programme's contribution to these KPIs and outcomes. Importantly, the evaluations are not to be used to determine direct attribution or causality but rather to articulate the change and impact achieved through BISA and what contributed to those changes. Evaluation helps the programme understand how the changes occurred, striving to answer the following three main questions:

- Are more resources being allocated to nutrition and are they being used more efficiently and effectively? How have these changes occurred?
- Have health service access, quality and use improved? What improvements? How?
- Have caregiver behaviours changed? What contributed to these changes?

Quantitative data will primarily come from government reports from the national stunting reduction programme or from the existing government monitoring system at sub-national level. BISA's primary data from household, village, and District level will supplement this data. BISA may also conduct mini surveys in select villages to assess progress on specific indicators.

For the qualitative evaluation, BISA proposes to use the *Qualitative Impact assessment Protocol (QulP)*⁷³, a double blinded qualitative evaluation method developed by Bath Social & Development Research, Ltd to evaluate beneficiary and stakeholder perceived changes since the start of the programme. Gender will be one of the domains that QulP will focus on, alongside nutrition and access to services, to identify changes in gender dynamics at household and community level and drivers of these changes. The QulP also includes review and analysis of the programme and non-programme-related factors that contributed to these changes. This will allow the partners to identify which programme activities are more effective and which to prioritise for scale up. All data will be disaggregated by gender, age and population group to identify inequalities in access, use of services and adoption of behaviours.

⁷³ <http://bathsdrr.org/wp-content/uploads/2017/09/Revised-QulP-briefing-paper-July-2017.pdf>

Cost data will be routinely collected and combined with programme evaluation results to conduct impact and cost-effectiveness modelling. The modelling for this methodology as well as its role in the programme is included in Annex 9, for BISA the OMNI tool was the primary modelling tool used. It is important to note that the current results of the modelling reflect the best evidence and data available at this time. As additional data and/or evidence is generated over the course of implementation, this model may necessarily shift.

Baseline Assessment and Analysis (Y1, Inception)

The baseline process, which is mainly further analysis and inputs of data into the LogFrame, and additional data collection for any gaps in secondary data, will provide pre-programme data, against which the programmes' progress will be measured over time. The Baseline sets the starting point against which programme targets will be set and achievement will be assessed and reported. Target setting for outcome and output levels will be done in consultation with District-level partners to increase ownership and responsibility for achieving these targets.

Where possible, BISA will use the data available through secondary sources. Baseline data will come in part from the Government's (NIHRD) Riskesdas 2018 data, a nationwide household survey data assessing use of services and health and nutrition behaviours. The NIHRD Riskesdas is conducted every five years; this timing is well aligned to the BISA timeline. It is also the most comprehensive and reliable dataset available and is a core part of the new collaboration between the GoI and World Bank. Riskesdas data is disaggregated to the District level.

Mini-Riskesdas surveys, conducted annually, are also planned by the government to be conducted annually at District level, which BISA can potentially also use. Some indicators, such as village-level budgeting and spending, household cleanliness and adolescent nutrition behaviours are not included in the Riskesdas and so will require separate data collection.

Mid-line assessment (Y2, Quarter 4)

The mid-line assessment will include a review of monitoring data (e.g. output indicators), existing NIHRD Riskesdas data and a qualitative evaluation. The mid-line will focus on the process: is the partnership delivering what has been designed and to the expected standards? Are there improvements at the health system, government and village levels? Are beneficiaries responding to these improvements? Are any community members unintentionally excluded? What is working well, less well and what improvements need to be made?

The mid-line will determine the relevance, replicability and generalisability of the interventions and results as well as providing insights into improving programme performance; assessing the feasibility, effectiveness and impact of innovation, new strategies or interventions; and collecting evidence to guide policy recommendations on nutrition-specific and -sensitive interventions. This will directly inform any changes or adaptations needed to implementation, particularly as the programme scales up in Year 3. The evaluation will also examine how different groups (pregnant women, adolescents, health volunteers) have been engaged and impacted.

Endline Assessment (Y5, Q2-3)

The main purpose of the endline will be conducted externally by an independent agency. The evaluation will be to evaluate BISA's progress against the indicators and targets, including the change in stunting, behaviours, use and access to services and budget allocation and use, since baseline. The exact same assessment tools and methodologies as the mid-term evaluation will be used for the endline to ensure comparability. It, too, will include four dimensions: [1] quality; [2] outcomes; [3] impact and performance; and [4] costs to provide effective services.

The endline assessment will compile, analyse, and reflect on all the data, research, and evidence produced over the course of the programme to produce recommendations for national and local stakeholders. These recommendations will be centred around how to sustainably and cost-effectively replicate and scale up the interventions. The evaluation will also assess the achievement of the programme against the four KPIs outlined above.

The results of MT and final evaluation will be disseminated externally to key stakeholders and national platforms, including government partners, multi-lateral implementers (e.g. the World Bank), and other stakeholders. From the evaluation, additional dissemination tools may be developed, such as specific briefs, press releases, or visual aids.

Accountability

Closely related to and completed in conjunction with monitoring activities are additional measures to ensure quality and accountability. A Quality Benchmark will be developed for each output to monitor the quality of the activities and interventions. In addition, a complaint and feedback mechanism will be developed during the programme's inception phase to allow stakeholders and beneficiaries to provide feedback and input for corrective action. Information sharing especially for primary beneficiaries (mother with CU5, teachers, household members), participation, and complaint and feedback mechanism are key component of accountability.

Child safeguarding and gender integration are two priority elements of programme quality. Save the Children's child safeguarding policies and protocols are embedded throughout our approach to programme design and management. In any community or beneficiary engagement, these policies will govern and protect the child. Save the Children will also ensure that any partners or other stakeholders closely involved in the BISA programme are oriented to the rigorous child safeguarding standards of SC.

BISA will employ participatory monitoring and cross monitoring visits as well as a specifically established feedback mechanism to encourage active participation of targeted beneficiaries. This includes engaging them in the baseline and endline process to ensure their voice is heard about the impact and changes achieved through BISA.

Engagement with beneficiaries will occur through regular information sharing, including community meetings and regular reporting. At minimum, these community sessions will convey:

1. Who Save the Children and Nutrition International are and why we are in the community
2. The background and goal of BISA and expected outputs and outcomes
3. Activities and interventions in the programme (Priority groups; Quality Standard of activity)
4. Complaint and Feedback Mechanism

Because BISA is so closely linked with government systems and capacity building, these activities will also contribute to strengthening the local feedback and accountability mechanisms.

Knowledge Management and Learning (KML)

The focus of KML has two key aspects:

1. Documentation, management, and application of lessons learned and best practices from within the programme to initiatives and actors beyond the programme; and
2. Specific research in addition to routine monitoring, evaluation, and quality assessments as part of the programme learning agenda (PLA).

BISA will also actively participate in learning and sharing through national and sub-national stunting reduction forums, such as the annual stunting meeting and national meetings for innovations and best practices for stunting reduction.

One of the ambitions underpinning the delivery and design of BISA is that ultimately, this programme should be sustainable by government and local stakeholders. To achieve that requires significant evidence and sharing of knowledge learned from the programme. Figure 11, below, outlines what some of these learning dissemination and knowledge management pieces are.

Expected output	Approach
Learning document, case study, human interest story, or similar document produced	Twice yearly documents prepared following semi-annual reporting and actively shared and presented to stakeholders.
Regular policy briefs summarising key findings and recommendations	Regular sharing and engagement with key stakeholders Directly inform policy and advocacy messages
Report, Infographic, or other SBCC material produced and shared	Regular sharing and engagement with key stakeholders, including relevant technical networks and working groups Potential publication in technical journal; development of headline content
Internal/intranet system updated with the latest document	Internal/intranet system and government portal or management system (if any)

Figure 11

Learning Agenda

The second element of BISA's KML strategy is the specific programme learning agenda (PLA). As outlined throughout the programme description, BISA will generate considerable evidence which will directly inform the scale-up, phasing, and sustainability of the programme.

BISA's learning agenda includes the formative research around existing capacity, gaps, bottlenecks, and behaviours outlined in the programme description as well as operations research and quality reviews, as previously outlined. Formative research will be conducted in quarters one and two of programme year one. The research will conduct to understand current community behaviour on key nutrition and WASH practice this is including to identify barrier and influencing actors. The Cost of the Diet, Household Economy Analysis, and specific gender analysis will also be conducted to further elucidate the nuances and context for where BISA will be implemented. The findings of this research directly inform the programme content and key behaviours, notably for SBCC, as described in SO1. The findings of these studies will also contribute to the community-level planning and advocacy efforts under SO2 and SO3, as well, to ensure that the systems, capacities, and efforts are responding to the actual gaps and barriers to improved nutrition faced by households.

All learning questions will be discussed and finalised during the inception phase in consultation with District, Provincial, and National government stakeholders. This consultation is important to ensure that BISA is generating the evidence and information that will be most useful to these actors to demonstrate impact and also to guide their scale-up and delivery in future years.

Project Reporting

As outlined, BISA's MEAL framework includes regular and routine monitoring as this directly informs management and implementation and is a central part of programme quality assurance.

As agreed with the Power of Nutrition, BISA will be reported against on a six-monthly basis. The reporting schedule, as determined by the Power of Nutrition, has fixed submission dates at the end of February and end of August. Reports will include updates and details on progress against the

programme's activities and indicators as well as KPIs. The annual reports will include more detail and analysis than the interim reports as per the agreed Deed of Grant. Recognising the importance of partnership, the BISA consortium is exploring mechanisms through which to ensure optimum communication and engagement.

RISKS & MITIGATION

Annex 10 includes a comprehensive table of potential risks and the corresponding mitigation strategy. These include staffing and human resource challenges; political climate; partnership dynamics; as well as natural disasters, amongst others. As experienced implementers globally and in Indonesia, SC and NI are prepared and equipped to effectively navigate these risks should any occur to minimise effect on the programme and safeguard our impact for children.

BUDGET

The BISA Programme Budget, Annex 3 includes all anticipated costs associated with delivering this programme. These include staffing, travel, activity costs, MEAL, and technical support.

POST-APPROVAL ISSUES AND TIMING

Inception Phase

Prior to the start of activities, SC and NI propose an inception phase. This phase is proposed to be **five months**. The main objectives and deliverables are both administrative / operational and programmatic. The table below outlines the objective / activity, specific timing, and deliverable.

Level	Objective / Activity	Timing / Process	Deliverable
Administrative and Operational	Agreement with Power of Nutrition signed; Partnership Agreement between SC and NI signed		Signed, formalised agreements
	Finalise internal processes to formally initiate the award		Internal administrative process followed
	Finalise and implement Human Resources plan, procurement plan, including recruitment for all full-time BISA staff positions (National, Provincial, and District)		Job Descriptions / advertisements prepared for recruitment from start of programme
	Revision, finalisation of Terms of Reference and membership (Annex 12) for Steering Group		Terms of Reference of Steering Group
	Budget finalisation once geographies are confirmed		Revised Budget
Programmatic	Kick off meetings (internal and jointly with stakeholders)		Internal process to engage programme management team Introductory meetings and sessions with stakeholders

			to celebrate the launch of the programme
	Final consultations with Provincial leadership for geographic targeting and phasing, from within the existing District shortlist (Annex 7)		Decision on first four Districts to be targeted
	Develop and refine Detail Implementation Plan (DIP), including detailed First Year Workplan		Detailed Implementation Plan and First Year Workplan
	Finalise programme monitoring system, including establishing the digital monitoring system		Ongoing from April, system will be finished in July
	Finalise annual and cumulative targets for all indicators, determine activity indicators, and input Baseline data		Inputting data into LogFrame to establish baseline and confirm targets
	Ensure alignment with most recent policies and strategies, updating continually as needed		Following elections, ensuring consistency remains in alignment
	Finalise stakeholder mapping across National, Provincial, District, and Village levels		Following elections, ensuring consistency remains in alignment
	Development of national and sub-national advocacy strategies informed by stakeholder analysis, policy mapping, and formative research		Building on mapping to develop strategy
	Formative Research, assessments, conducted and initial development of SBCC Strategy		Ongoing from April, completed and findings available by August. Draft SBCC strategy developed.
	Finalisation of PLA		Clearly defined research objectives and questions; plans for formative and implementation research
	Initiation of developing programme beneficiary feedback mechanism	August 2019	Internal accountability systems exist but will be adjusted for BISA. BISA will gradually support the government to strengthen their accountability system and at the same time provide channels for targeted beneficiaries to provide input and feedback.

Programme Workplan

Following from the inception phase, the programme activities will commence. The Detailed Implementation Plans will be reviewed and developed on an annual basis. These reviews will contribute to the annual reporting agreed with the Power of Nutrition, as reflected in the MEAL

section. These reviews will also include stakeholder engagement. The general trajectory of the programme, reflected in the Theory of Change, is to engage stakeholders and local partners and to scale up over the five years. On a yearly basis, the programme breaks down as follows:

Year One: The first year of the programme will be comprised of the inception phase as outlined above. This year will be important to set the tone for the programme and ensure all of the key structures and processes are in place, including staffing, government engagement, and programme governance. Following inception, programme activities will phase up, as outlined in the LogFrame.

Year Two: Continuing the momentum from Year One, activities will continue to scale up. All activities will start before the end of Year 2, primarily in Q1.

Year Three: Year Three is a key year as it is the commencement of phasing, and increase in collaboration with local civil society and partners. No new activities will begin this year in the initial four Districts. The focus will be on maintaining the quality in those Districts whilst scaling up.

Year Four: Activities will continue in all Districts, with coverage at approximately 70%. The focus will increasingly be on transitioning responsibility and ownership to local stakeholders and continuing to socialise the evidence and learnings from the programme.

Year Five: The final programme year will see coverage reaching the critical mass of 80%; the final evaluation will occur this year as well to capture overarching evidence and lessons which will inform final engagements, briefs, and advocacy with stakeholders.

