



LQAS Endline report
for the Research on
Pilot Testing of Social and Behaviour Change (SBC)
Design Guide
to Enhance Child Care and Feeding Practices
in East Lombok District, Indonesia

September 2025

Acknowledgement

This endline report is jointly prepared by the Consultant team led by Andre Tanoe and the Senior Technical Advisor for Health and Nutrition from World Vision International (Esther Indriani), who is also the Principal Investigator for the research on “Pilot Testing of Social and Behavior Change (SBC) Design Guide to Enhance Child Care and Feeding Practices in East Lombok District”. The research is a collaboration of World Vision US, World Vision International and Yayasan Wahana Visi Indonesia, which was implemented from October 2024 to September 2025. This endline study is a part of research methods employed in the research.

We would like to express our sincere gratitude to everyone who contributed to the creation of this report. Firstly, we would like to thank the Area Program East Lombok team for their hard work in supporting the preparation and implementation of this endline study, and all the enumerators who helped during data collection. We thank the National Office of Wahana Visi Indonesia, especially the Health technical team and Program Evidence Accountability Research and Learning (PEARL) team for their help in reviewing the plans, survey tool, and the draft Endline report. We also thank the technical support from World Vision US Senior Technical Advisor for SBC (Joel Mercado), and funding support from World Vision US and World Vision International. Thank you also for the support and guidance from World Vision International Global Health and Nutrition team.

Lastly, we appreciate the participation of the Endline survey respondents from the six villages in East Lombok. May the result of this survey be useful for the health and nutrition of children in those villages and in East Lombok district in general.

Respectfully,

Consultant Team
Andre Tanoe, MD, MHP
Rensi Hutabarat, SKM

World Vision International
Esther Indriani, MPH (Senior Technical Advisor for Health & Nutrition, and Principal Investigator for the Research)

Executive Summary

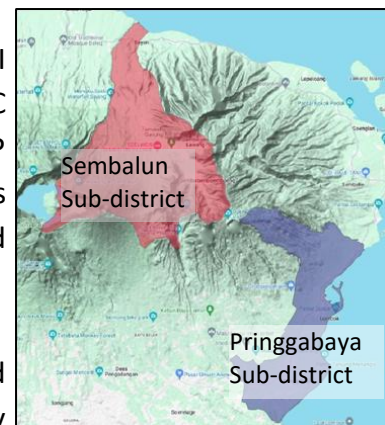
Background

In 2022, World Vision (WV) implemented and managed \$1.73 million funds for development programs, \$967 million for relief and rehabilitation programs, and \$27 million for community education and advocacy. The projects reached over 4.3 million children in 37 countries. With those massive reach, partnerships, and investments, World Vision must have a Social and Behaviour Change (SBC) Framework and Toolkit to ensure all our programs and projects are aligned to conduct innovative, scalable, and impactful SBC activities and document its implementation to generate evidence of impact for WV.

To ensure their field offices can design innovative, scalable, and impactful SBC activities, WV created its first SBC Framework and Toolkit (draft completed in December 2023). The new SBC Framework and Toolkit, rooted in current evidence, and Systems Thinking, will provide a robust guide for integrating SBC into our diverse programs.

This pilot testing of SBC framework, approach and toolkit are done through a collaboration of World Vision US, World Vision International, and Yayasan Wahana Visi Indonesia. To fill the gap from the previous existing research, this testing was conducted through a mixed-method approach.

As the location of the SBC formative research and pilot testing, WVI was selected based on its commitment to strengthen the SBC capacity and to fund the implementation of SBC pilot testing in AP East Lombok. For the purpose of this research, WVI chose 6 villages within the AP East Lombok working area (Sembalun and Pringgabaya sub-district).



These 6 villages were chosen because, based on the data collected from village leaders by the AP East Lombok prior to the survey, they have highest number of mothers with under five years old children. The 6 villages are: Sembalun Bumbung, Sembalun Timba Gading, Sembalun Lawang, Pohgading Timur, Labuhan Lombok, and Tanak Gadang villages.

Baseline was conducted in November 2024 and the final report was submitted in January 2025. This baseline was followed by planning and implementation activities by WVI. This Endline is done at the end of FY2025 to evaluate achievements of the SBC intervention.

The quantitative method for baseline and endline survey in this study used the LQAS (Lot Quality Assurance Sampling) method. LQAS method is chosen by WV for its ability to show supervision

area specific results and requires smaller sample compared to other methods, such as cluster sampling method. It is also possible to use parallel sampling in LQAS methodology, useful to measure practices in younger mother and older mothers groups. Approval for endline survey from Review Committee in the Faculty of Medicine, University of Indonesia was received on 20 June 2025.

SBC pilot testing project planning and implementation

Two activities were chosen by SBC pilot testing team: 1) crash course class on parenting and, 2) Content creator training. These interventions were implemented in the six villages as planned.

The crash course class on parenting were divided into two groups: for primary caregivers who have youngest children 3 - 23 months old and caregivers of children aged 24 – 59 months old, using two different training of facilitators modules. These two modules were developed by the SBC pilot testing team in WV and WVI. Each module was divided into 3 sessions, conducted within 3 separate days. Facilitators were Posyandu Cadres (Community Health Worker), who underwent one-day training.

Participations in Crash Course of Parenting was supposed to be fixed (participants could not come in and go). However, data shows a drop out in participation from Session 1 to Session 3. For the content creator training, the trainer was a mother, a local content creator in Lombok.

The first content creator training was done on 30 June 2025. While the first batch training for trainers of crash course class on parenting was conducted on 10 July 2025, and the first session of the crash course on parenting was conducted on 21 July 2025. The total number of primary caregivers who joined crash course on parenting between 21 July – 21 August 2025 is 722 primary caregivers.

Endline Survey

This Endline survey had two groups of samples, and parallel sampling in the LQAS method was used to cover both groups:

- Mothers of child under five years old, who are presently aged 24 years old or below (younger mothers group)
- Mothers of child under five years old, who are presently aged 28 years old or above (older mothers group)

The questionnaire used in this study was developed based on several international standard questionnaires and scales i.e., KPC (Knowledge Practice Coverage) Survey, Minimum Dietary Diversity, IYCF (Infant and Young Child Feeding), Brigance, and NOVA classification for Ultra

Processed Food groups. Discussion with the SBC pilot testing team in WV and WVI was done to decide which questions are considered suitable to measure the selected indicators.

The 6 villages became **6 Supervision Areas (SAs)**, and in each SA there are 19 samples for each group. In total, there are 228 samples in this Endline survey. The survey was conducted between 21 – 23 August 2025, with 10 enumerators and 4 supervisors.

Mothers age group	SA						Total
	SB	SL	STG	PT	TG	LL	
≤ 24 years old	19	19	19	19	19	19	114
≥ 28 years old	19	19	19	19	19	19	114
TOTAL	38	38	38	38	38	38	228

Endline Results

The endline focused on finding indicators that changed compared to baseline results, especially those that might be impacted by the SBC pilot testing project activities (content creator training and crash course on parenting classes).

- ◆ The “content creator” training program, provided by SBC project is part of the behaviour change activities. Nevertheless, many videos created by training participants were not yet posted online due to many reasons. So, endline was not able to measure the impact of this training.
- ◆ The proportion of primary caregivers from Younger Mothers group participated in crash course class on parenting is 51.8% ±10.6%. The proportion of primary caregivers from Older Mothers group participated in crash course class on parenting is 70.2% ±10.0%.
- ◆ All of primary caregivers who attended the crash course class on parenting (100%) mentioned that the classes helped them to provide child caring and feeding in their daily life.
- ◆ Brigance score was part of the endline questionnaire, consisted of 18 statements which measured the interactions between primary caregivers and the youngest child. The highest score is reached when all 18 statements are answered correctly. Only a few primary caregivers have highest score (18 points) for Brigance in both younger mothers group (0.9% ±1.3%) and older mothers group (5.3% ±4.2%).
Baseline results for this indicator are 1.7% ±1.8% for younger mothers group and 1.7% ± 4.9% for older mothers group. Since the confidence intervals are intersecting each other, it can be concluded that the situation for Brigance maximum score at Endline remains essentially the same as at Baseline.

- Brigance statement number 5 (I look at or read children's books to my child) has the lowest score for both younger (20.2% ±9.1%) and older (23.7% ±9.2%) mothers group.
- Brigance statement number 13 (primary caregivers who think their youngest child is very much fun to be with), the proportion of primary caregivers who answers correctly from older mothers group during Baseline is 62.3% ±7.8% (54.5 – 70.1%), while the result for endline is 87.7% ±6.7% (81.0 – 94.4%). Confidence intervals from baseline and endline results is not overlapping, thus the difference in score for Brigance question number 13 among the older mothers group is statistically significant.

However, comparison of confidence intervals from baseline (58.2% – 75.2%) and endline (75.0% - 91.6%) results for Brigance question number 13 for younger mothers group unfortunately is barely intersecting each other. Thus, the difference is not statistically significant for younger mothers group during endline compared to baseline.

- ◆ The proportion of youngest child ≥ 6 months old who received at least 5 food groups 24 hours prior to endline survey is 84.1% ±6.0%. Baseline result for this indicator is 72.6% ±6.5%. Comparison between the endline confidence interval (78.1% – 90.1%) and baseline confidence interval (66.1% – 79.1%), shows that the confidence intervals are still overlapping. Thus, the difference is not statistically significant.
 - However, the percentage of youngest child ≥ 6 months old who received legumes and nuts increased during endline (77.9% ±6.5%) compared to baseline (60.9% ±7.5%). The confidence intervals do not overlap. Thus, the difference between consumption of legumes and nuts at endline (71.4% - 84.4%) compared to baseline (53.4% - 68.4%) is statistically significant.
- ◆ The results for parental perceived barriers are:
 - Low percentages of child-related barriers in both younger and older mothers' groups.
 - Low percentages of parent-related barriers related to vegetables and fruits in both younger and older mothers groups.
 - Relatively high percentages of parent-related barriers concerning added sugar in both younger and older mother groups.
 - Relatively high percentages of social context-related barriers in both younger and older mothers groups.
 - Cost-related barriers, particularly for fruits, were reported by both younger and older mothers groups.
- ◆ Family is the most important source when primary caregivers from both younger mothers (92.1% ±4.6%) and older mothers (71.9% ±9.7%) groups need advice on child caring and feeding.
- ◆ More than half of primary caregivers from Younger (62.3% ±10.2%) and Older (58.8% ±9.4%) mothers groups watched videos (created by Indonesian content creator) about child caring and feeding. Moreover, all primary caregivers from Younger Mothers Group mentioned that those videos help them with ideas to better care and feed their children. All primary caregivers from Older Mothers Group mentioned the same situation, except one primary

caregiver who mentioned that she does not know whether it is helping or not. However, almost all of the indicators of child feeding and caring behaviours did not change between baseline and endline. Thus, the impact of watching the videos which were not created by the local content creator training participants is still questionable.

- ◆ Other indicators from endline did not change/improve compared to baseline.

Conclusions

This SBC pilot project relied on crash course classes on parenting and content creator training for improving communities' behaviours related to child caring and feeding. The first field activity, conducting prototyping testing for crash course on parenting class for caregivers was started on 13 June 2025. The first crash course training of facilitators for Posyandu Cadres (CHW) was done on 14 July 2025, and then followed by implementation of the crash course on parenting for the primary caregivers of children 3-23 months, and primary caregivers of children 24-59 months old, separately. Crash course on parenting was done in one round, with 1 session conducted per week, and a total of 3 sessions.

The endline survey was started on 19 August 2025 with enumerators training. At that time, all SBC interventions implementation were already completed. Therefore, the SBC pilot project only had about 1 month of intervention implementation. The coverage of crash course on parenting classes is around 51% for younger mothers group and around 70% of older mothers group. This coverage achievement is already impressive considering the short time of implementation.

All (100%) of primary caregivers who participated in crash course on parenting classes mentioned that the classes help them to provide better caring and feeding practices for their children.

Two indicators (% of youngest child \geq 6 months old receiving legumes and nuts and % of primary caregivers from older mothers group who feel that their child is fun to be with) improved from baseline to endline and the difference is statistically significant. All other indicators do not show any changes or improvement during endline compared to baseline.

Measuring the results of content creator was not yet possible at endline because many of the trained content creators had not posted their videos on social media. Since many of primary caregivers use social media as learning source (more than 70% for both younger and older mothers group), this might be promising in the future, as it would be easier for primary caregivers to find information needed for caring and feeding their children.

Recommendations

1. To continue SBC implementation

As described in SBC pilot testing background, The goal of this SBC pilot project is:

To ensure the field offices can design innovative, scalable, and impactful SBC activities, WV created its first SBC Framework and Toolkit (draft completed in December 2023). The new SBC Framework and Toolkit, rooted in current evidence, and Systems Thinking, will provide a robust guide for integrating SBC into our diverse programs.

Due to many reasons, this SBC pilot testing field activities were implemented within one month prior to the endline survey. For this short period of time, it can be seen that two minor indicators have been improved at population level (population of primary caregivers from younger and older mothers group).

Thus, based on the comparisons of endline versus baseline results, the steps in “the new SBC framework and toolkit” are able to measure impacts at outcome level of SBC projects at population level. It is strongly recommended to continue the SBC activities implementation as it already showed changes in community behaviour (% of youngest child \geq 6 months old receiving legumes and nuts and % of primary caregivers from older mothers group who feel that their child is fun to be with).

During endline, it shows that the coverage of crash course on parenting classes reached 51.8% of younger mothers group and 71.2% of older mothers group. However, 15% of primary caregivers from older mothers group and 28.8% from younger mothers group had not participated in the classes at all, thus it would be good if the AP East Lombok could continue with some classes to complete the SBC activities so that the remaining caregivers of children under five can take part in it.

Unfortunately, the effectiveness of content creator training could not be measured due to the lack of implementation time. According to the tentative results of FGDs conducted by WV and WVI, the mothers who joined content creators training faced some unforeseen challenges, such as feeling shy to upload the videos to their social media. The fact that both baseline and endline survey confirmed that caregivers of young children like to seek information from social media, training mothers as local content creators is a promising approach for behaviour change activities, provided that the project can work with the local content creators to address the technical and non-technical barriers together. If the support for local content creators, can be continued by AP East Lombok, it might help in producing social and behaviour changes in the area of child feeding and child caring.

Furthermore, there should be improvements on the prepared SBC modules for further implementation. World Vision and Yayasan Wahana Visi Indonesia, as any other NGOs, are

trying to improve the community situations. Without community and related stakeholders' behaviour change, it would be difficult, if not impossible, to improve the situation. WVI should explore the possibilities for partnership with other institutions or community groups or any other possible stakeholders to continue the activities.

2. Find more in-depth information

The quantitative data is not enough to get a complete picture of the situation, hence a qualitative data is needed to fill in the gaps from quantitative results. More data is needed to improve SBC implementation, such as:

- What crash course on parenting participants think about the classes; their suggestions for improving the classes; ideas for reducing parental perceived barriers, problems to joining the classes; and other people whom should be included (such as the husband and the grandmother).
- What crash course on parenting facilitators think about the training of facilitators provided to them; their suggestions for improving the modules; ideas for reducing parental perceived barriers; and problems to invite primary caregivers.
- What the project can do to improve video quality produced by the content creator training participants; what can be done to make sure the videos do not contain mis-information; what can be done to expand their videos viewers; ways to integrate content creator production with crash course on parenting classes.
- The project team conducted qualitative review using FGDs with the participants of the crash course on parenting and the trained content creators, separately. Once the result is ready, it can complement the LQAS endline findings.

3. Improvements on SBC modules

During this SBC pilot testing, SBC project team developed two training of facilitators modules for crash course on parenting: module for primary caregivers with children 3-23 months old, and with children 24-59 months old. These modules were still in testing phase, feedbacks from qualitative data should give more information and guidance to revise the modules or training process.

The focus of the sessions targeting caregivers of children 3-23 months old were to do education through fun activities and direct learning to promote dietary diversity such as cooking demonstration, blind testing of fruits, and to encourage child stimulation by caregivers. The focus of the sessions targeting caregivers of children 24-59 months old were to promote dietary diversity and reducing ultra processed food consumption, and to teach caregivers how to read the nutrition labels. Preliminary FGD findings show that while crash course participants from caregivers of 3-23 months old were happy with the cooking

demonstration and the games, the caregivers of 24-59 months old did not mention that they were happy with the games, suggesting the need to have more interactive and direct learning with the caregivers.

Only two indicators that were improved (% of youngest child \geq 6 months old receiving legumes and nuts and % of primary caregivers from older mothers group who feel that their child is fun to be with) at endline. This shows that the modules need improvements to be able to improve many other indicators at community level. **Moreover, the caregivers only received one round of 3-sessions, which may contribute also why many indicators did not improve as the dosage is still too low.**

One result from baseline said that primary caregivers preferred a direct method of training, which means that they preferred more direct involvements rather than receiving information only. For example, rather than informing the primary caregivers on types of healthy food for their children, they prefer a cooking class using healthy food, where they are involved in the cooking process, and can directly test the meals to their children. So, primary caregivers will know whether their children will eat the meal or not, they know exactly how to prepare the meal, they can calculate related expenses, time needed, and difficulties for preparing the same meal at home.

Both baseline and endline results show that family member is the most trusted source whenever primary caregivers need to ask information related to child caring and feeding. Their advices become primary caregivers' priority. Thus, involving them in behaviour change activities is important. **Due to the limited time, the project focused on the primary caregivers for the crash course on parenting sessions, and did not include the husbands and the grandmothers. However, key messages on important involvement of husbands and grandmothers were emphasized during Photovoice workshop, crash course on parenting sessions, and the videos produced by local content creators.**

The results of parent perceived barriers should also be considered during modules improvement process. For example, ultra processed food consumption by the youngest child will never be reduced by providing only information. Parents and their family need skills or alternatives for making the youngest child happy without giving ultra processed food.

4. Expand and extend the selected targets for SBC interventions

The new SBC framework and toolkit shows a promising path for usages in social and behaviour change related programs. It provides the possibilities for modifications,

creativities, measuring the impact of the intended results/outcome at community level, and further improvements.

It is recommended either to continue this SBC pilot testing implementation or use/test the framework and toolkit for other purposes outside health-related field. By implementing and using this SBC framework and toolkit, it will develop and improve skills for both WV and WVI staffs to implement more effective and impactful behaviour change projects in the future.

Abbreviations

AP	Area Programme
CWN	Children are Well Nourished
CHW	Community Health Worker
ELCSA	Latin American and Caribbean Food Security Scale
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
FIES	Food Insecurity Experience Scale
FIES-SM	Food Insecurity Experience Scale - Survey Module
FK-UI	Faculty of Medicine -University of Indonesia
FY	Fiscal Year
GMP	Growth Monitoring and Promotion / KMS card
HFIAS	Household Food Insecurity Access Scale
HH	Household
IYCF	Infant and Young Children Feeding
KPC	Knowledge, Practice, And Coverage
LL	Labuhan Lombok village
LQAS	Lot Quality Assurance Sampling
MUAC	Mid Upper Arm Circumference
PT	Pohgading Timur village
SA	Supervision Area
SB	Semalun Bumbung village
SBC	Social And Behaviour Change
SBCC	Social And Behaviour Change Communication
SL	Semalun Lawang village
STG	Semalun Timba Gading village
TG	Tanak Gadang village
TOR	Term Of Reference
TV	Television
U5C	Under five years old Children
UNICEF	United Nations Children's Fund
USDA	U.S. Department of Agriculture
VOH	Voices Of the Hungry
WV	World Vision
WVI	Wahana Visi Indonesia
WVUS	World Vision United States
YO	Years Old

Table of Contents

Acknowledgement	i
Executive Summary.....	ii
Abbreviations	xi
List of tables	xiv
List of figures.....	xvii
I. Background.....	1
II. Study Location	2
III. Research Design and Objectives	3
1. General Objectives.....	4
2. Research Questions and Research Objectives.....	4
3. Conceptual framework	5
4. Indicators	7
5. Data Analysis.....	10
6. Methodology for the LQAS Quantitative Endline	10
7. Minimum Dietary Diversity (MDD)	12
8. Parent-child interaction measurement using Brigance Scale.....	13
9. Ultra-processed food (UPF)	13
10. Parental Perceived Barriers to give healthy food for the children	14
11. Data Collection Tools.....	14
12. Limitations of the study.....	16
13. Ethics	16
IV. SBC Program Planning and Implementation.....	17
1. Project Planning	17
2. Project Implementation.....	21
3. Project monitoring.....	21
V. LQAS Endline Survey implementation.....	26
Enumerators training	26
4. Data collection	27
5. Data cleaning	28
VI. Results & analysis	29

1. General characteristic.....	29
a. Primary caregiver	30
b. Father’s age and highest education completed	32
c. Age and gender of the children under five years old in the survey	33
2. Child care practices	33
3. Parent & child interaction.....	37
4. Nutrition practices	41
a. Youngest child ever breastfed	41
b. Types of food given to the youngest child within the first 3 days after birth	41
c. Youngest child who already received solid food	43
d. Age when youngest child received solid food for the first time	43
e. Youngest child who meets the Minimum Dietary Diversity (MDD)	44
f. Youngest child who received ultra processed food.....	45
5. Parental perceived barriers to give healthy food for the children	46
6. Nutrition measurements	49
7. Learning on child caring and feeding practices	50
a. Past learning sources	50
b. Trusted people for advices	51
c. Social media usages	52
8. SBC Project Activities Coverage	54
VII. Summary.....	56
VIII. Conclusions.....	60
IX. Recommendations.....	61
X. Appendices	66
1. Ethical approval.....	66
2. Questionnaire	68
3. Random sample location based on population of sub-village.....	90
4. Summary of Indicators.....	92
XI. References.....	100

List of tables

Table 1: LQAS sample size.....	12
Table 2: SBC pilot testing project designed behaviour change framework.....	20
Table 3: SBC pilot testing project monitoring summary	22
Table 4: Supervision Areas locations	27
Table 5: Mother age group survey results	27
Table 6: All biological mothers' highest education completed.....	28
Table 7: All biological mothers's ages when they got married for the first time	29
Table 8: Primary caregivers' age groups	29
Table 9: Primary caregivers relationship with the youngest child.....	30
Table 10: All primary caregivers education level	30
Table 11: Primary caregivers occupations	30
Table 12: Primary caregivers number of occupations	31
Table 13: Fathers' age groups.....	31
Table 14: Fathers education level.....	31
Table 15: Youngest child age groups	32
Table 16: Youngest child gender	32
Table 17: Primary caregivers who received help taking care the youngest child.....	32
Table 18: Number of people helping primary caregivers taking care of the youngest child from younger mothers group	33
Table 19: Number of people helping primary caregivers taking care of the youngest child from older mothers group	33
Table 20: People who help primary caregivers, from younger mothers group, taking care the youngest child.....	33
Table 21: People who help primary caregivers, from older mothers group, taking care the youngest child	34
Table 22: Frequency of youngest child brought to Posyandu (Integrated Service Post) among younger mothers group	34
Table 23: Frequency of youngest child brought to Posyandu (Integrated Service Post) among older mothers group	34
Table 24: Youngest child ever received immunization	35

Table 25: youngest child > 11 months old received deworming medication	35
Table 26: GMP card ownership of youngest child for younger mothers group	35
Table 27: GMP card ownership of youngest child for older mothers group	36
Table 28: Youngest child brought to Posyandu (Integrated Service Post) in the last 3 months, based on card shown.....	36
Table 29: Brigance maximum score (18).....	36
Table 30: Details of Brigance results comparisons in younger mothers group	37
Table 31: Details of Brigance results comparisons in older mothers group	38
Table 32: Primary caregivers who gave toys to youngest child	39
Table 33: Primary caregivers from younger mothers group, who think youngest child place to play have safe and clean place to play.....	39
Table 34: Primary caregivers older mothers group, who think youngest child place to play have safe and clean place to play	40
Table 35: Youngest child who ever breastfed.....	40
Table 36: Food given to youngest child during the first 3 days from younger mothers group	41
Table 37: Food given to youngest child during the first 3 days from older mothers group	41
Table 38: Youngest child who already received solid food.....	41
Table 39: Age when youngest child when s/he first received solid food from younger mothers group ...	42
Table 40: Age when youngest child when s/he first received solid food from older mothers group	42
Table 41: Youngest child who received at least 5 food groups 24 hours prior to survey.....	43
Table 42: Detail comparisons of food group for youngest children \geq 6 months old during Endline and Baseline	43
Table 43: Youngest child who received ultra processed food from younger mothers group	44
Table 44: Youngest child who received ultra processed food from older mothers group	45
Table 45: Parental perceived barriers for biological mothers aged \leq 24 yo group	46
Table 46: Parental perceived barriers for biological mothers aged \geq 28 yo group	47
Table 47: Youngest children who are \geq 6 months old from both younger and older mothers groups	48
Table 48: MUAC status for youngest children 6 months old.....	48
Table 49: Learning sources for primary caregivers from younger mothers group.....	49
Table 50: Learning sources for primary caregivers from older Mothers group	49

Table 51: Primary caregivers from younger mothers group seek for advice on child caring and feeding .	50
Table 52: Primary caregivers from older mothers group seek for advice on child caring and feeding.....	50
Table 53: Primary caregivers from younger mothers group who used social media to learn child caring and feeding	51
Table 54: Primary caregivers from biological mothers aged ≤ 24 yo group who watch videos from indonesian content creator to learn child caring and feeding	51
Table 55: Crash course class on parenting coverage for younger mothers group	52
Table 56: Crash course class on parenting coverage for older mothers group	53
Table 57: Number of times of primary caregivers from younger mothers group participating in crash course class on parenting	53
Table 58: Number of times of primary caregivers from older mothers group participating in crash course class on parenting	54

List of figures

Figure 1: Map of SBC area.....	3
Figure 2: UNICEF Conceptual framework on determinants of Maternal & Child Nutrition, 2020	6
Figure 3: Conceptual framework for SBC pilot testing in Indonesia	7
Figure 4: Number of primary caregivers who joined crash course on parenting	23
Figure 5: Means of pre-post test score of crash course on parenting.....	23
Figure 6: Beliefs of primary caregiver who supports her in giving diverse food to their child.....	24
Figure 7: Age when the youngest child received solid food for the first time.....	57

LQAS Endline report for the Research on Pilot Testing of Social and Behaviour Change Design Guide to Enhance Child Care and Feeding Practices in East Lombok District, Indonesia

I. Background

In 2022, World Vision (WV) implemented and managed \$1.73 million funds for development programs, \$967 million for relief and rehabilitation programs, and \$27 million for community education and advocacy. The projects reached over 4.3 million children in 37 countries. With those massive reach, partnerships, and investments, World Vision must have a Social and Behaviour Change (SBC) Framework and Toolkit to ensure all our programs and projects are aligned to conduct innovative, scalable, and impactful SBC activities and document its implementation to generate evidence of impact for WV.

To ensure their field offices can design innovative, scalable, and impactful SBC activities, WV created its first SBC Framework and Toolkit (draft completed in December 2023). The new SBC Framework and Toolkit, rooted in current evidence, and Systems Thinking, will provide a robust guide for integrating SBC into our diverse programs.

Using the combined efforts and funding from WVUS' Accelerator Funding, WVUS Health Research & Development, and WV International Advocacy & External Engagement, funding was generated to support the formative research and pilot-testing of the SBC Toolkit and interventions, as a collaboration of WVUS, WV Global Centre Health & Nutrition team, and WVI.

The pilot testing of SBC framework, approach and toolkit are done through a collaboration of World Vision US, World Vision International, and Yayasan Wahana Visi Indonesia. Funding for the 18-months testing will be co-shared amongst these entities.

This study used a mixed method design and will fill the gaps of previous studies done in East Lombok, such as on early marriage among girls and feeding practices among children. Most of those studies were conducted in Mataram, the capital of West Nusa Tenggara province. Their chosen scope was narrow and in the limited timeframe, notably during the COVID-19 pandemic, and used qualitative methods (2–4).

To fill the gap from the previous existing research, this testing was conducted through a mixed-method approach which preceded by a baseline survey (quantitative), Photovoice

method (qualitative) which includes in-depth interviews and focus group discussion (FGD) with the Photovoice participants, and the process of discerning the results from quantitative baseline and Photovoice to develop an SBC intervention targeting caregivers of children 0-59 months old, and the intervention in 6 villages, and a quantitative endline survey. This report covers only the quantitative, LQAS endline survey, whereas the Photovoice data collection was reported separately.

A mixed-methods design will give the comprehensive understanding of the subject matter by incorporating insights from observations and interviews with the population's prevalence of particular qualities, which is derived via surveys (Wasti et al., 2022).

Baseline was conducted in November 2024 and the final report was submitted in January 2025. This baseline was followed by planning and implementation activities by WVI. Endline is done at the end of FY2025 to evaluate achievements of the SBC intervention.

II. Study Location

As the location of the SBC formative research and pilot testing, WVI was selected based on its commitment to strengthen the SBC capacity and to fund the implementation of SBC pilot testing in the six villages in AP East Lombok. This cost sharing was the most important positive point of the proposal for Accelerator Funding.

For the purpose of this research, WVI chose 6 villages within the AP east Lombok working area (Sembalun and Pringgabaya sub-districts). These 6 villages were chosen because, based on the data collected from village leaders by the AP East Lombok prior to the survey, they have highest number of mothers with under five years old children. The 6 villages are:

Sembalun sub-district:

1. Sembalun Bumbung village
2. Sembalun Lawang village
3. Sembalun Timba Gading village

Pringgabaya sub-district:

4. Pohgading Timur village
5. Tanak Gadang village
6. Labuhan Lombok village

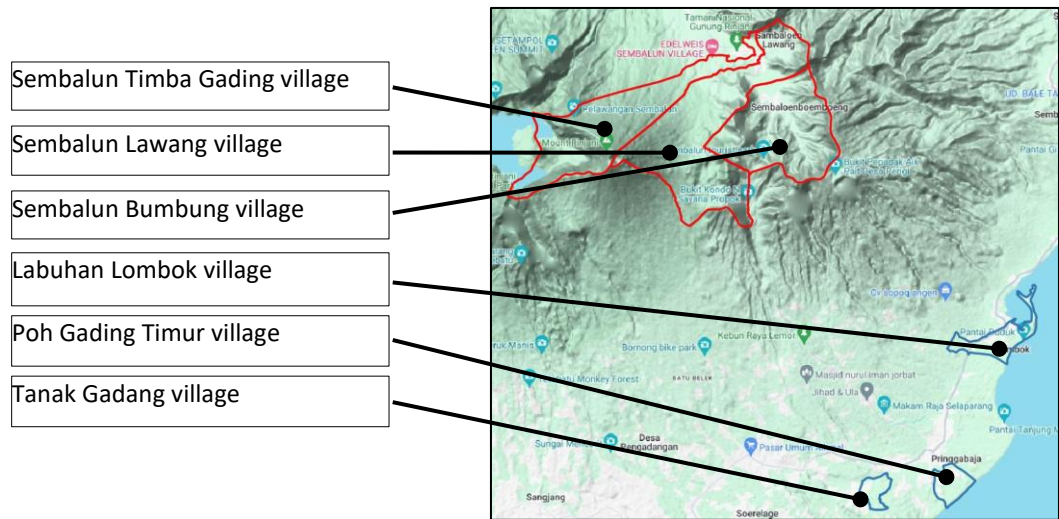


Figure 1: Map of SBC area

III. Research Design and Objectives

In order to be able to compare baseline and endline, the overall endline research design and objectives were following the baseline.

To increase the likelihood that the research team would be able to find young and adolescent mothers who married at the age of 10 to 18 years old, this study set the age group of “younger mothers” as those mothers of children under five years old who are presently aged 24 years old or below.

In both baseline and endline survey, the “older mothers” was defined as mothers of children under five years old who are 28 years old or older presently. This means that they were married or pregnant when they were 23 years or older in the last five years. However, it is also possible that the child under five is not their first child, and these older mothers also married young.

Inclusion Criteria: Young Mothers aged (≤ 24 years old) or older mothers aged (≥ 28 years old) with U5C (Under five years old children) or the primary caregivers responsible for the U5C’s caring and nutritional needs; child is still alive; child can be boy or girl; can be breastfeeding or non-breastfeeding; any education level of the primary caregiver; any marital status of the caregiver; primary caregiver presently resides in one of the 6 villages; primary caregiver is willing to participate.

Exclusion Criteria: Mothers or primary caregivers of U5C with severe mental health condition; Primary caregivers with significant language or communication barriers that

prevent effective participation in the study; Primary caregivers who plan to relocate from the study area soon (within one month) or just relocate to the study area, which could affect data continuity; Primary caregivers with U5C who have health conditions requiring special dietary or nutritional interventions that do not reflect the general population's situation; Primary caregivers who refuse to participate; Primary caregivers who live in other village than the selected 6 villages.

The younger and older mothers of the child 0-59 months are the primary target of this study. The research team has decided that if the biological mothers were away due to migration or not living in the same house with the child 0-59 months, then the research team would replace the respondents with the primary caregiver of the child 0-59 months, either the father, grandmother, grandfather, or older sister or brother.

1. General Objectives

The aim of this study is to explore differences of nutrition and caring practices of younger mothers aged ≤ 24 years old and older mothers aged ≥ 28 years old and explore the effectiveness of World Vision's SBC Intervention Design Guide in designing participatory SBC intervention to teach primary caregivers of children under five years old in East Lombok District.

2. Research Questions and Research Objectives

During baseline there were four research questions with the corresponding research objectives, but since the SBC implementation is limited, thus SBC pilot project team decided to remove couple of the research questions because these are not relevant anymore.

The remaining of research questions are still applicable to endline, these are:

Research Question 1 : What are the different nutrition and caring practices of younger mothers (≤ 24 years old) and older mothers (≥ 28 years old) in Sembalun and Pringgabaya sub-districts, East Lombok District?

Research Objective 1.1: To describe the child caregiving practices of the respondent.

Research Objective 1.2: To describe parent-child interaction of the respondent.

Research Objective 1.3: To describe nutrition practices of the respondent.

Research Objective 1.4: To identify and compare caring and feeding practices among households with children under five years old born of younger mothers (≤ 24 years old) and households with children under five years old born of older mothers (≥ 28 years old) (Quantitative)

Research Objective 1.5: To compare the caring and feeding practices among households with children under five years old born of younger mothers (≤ 24 years old) at baseline

versus endline in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

Research Objective 1.6: To compare the caring and feeding practices among households with children under five years old born of older mothers (≥ 28 years old) at baseline versus endline in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

Research Objective 1.7: To identify proportion of children under five years old being taken care of by their own mother in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

Research Objective 1.8: To identify barriers and enablers of good dietary diversity among children under five in the 6 villages include food insecurity, household economy. (Quantitative and Qualitative)

Research Objective 1.9: To identify barriers and enablers of good dietary diversity among children under five in Sembalun and Pringgabaya sub-district, East Lombok District include food insecurity, household economy. (Quantitative and Qualitative)

Research Objective 1.10: To identify barriers and enablers of frequent interactions and stimulations between primary caregivers and the children under five in Sembalun and Pringgabaya sub-district, East Lombok District (Qualitative)

Research Objective 1.11: To identify barriers and enablers for primary caregivers to stop feeding their child under five ultra-processed food in Sembalun and Pringgabaya sub-district, East Lombok District (Qualitative)

Research Question 2 : Do younger mothers prefer different social and behaviour change communication (SBCC) interventions, compared to the traditional SBCC interventions in the area e.g., Posyandu (Integrated Service Post) health awareness session in Sembalun and Pringgabaya sub-districts, East Lombok District?

Research Objective 2.1: To describe the social behaviour change communication channel, information and preferred method to learn about child caring and feeding practices.

Research Objective 2.2: To gather insights on preferred method of learning about child caring and feeding practices from the younger mothers and the older mothers in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

3. Conceptual framework

For this study, the research team uses the 2020 UNICEF Conceptual Framework for Maternal and Child Nutrition, which describes the various determinants of maternal and child nutrition (6). The 2020 Conceptual Framework on Maternal and Child Nutrition builds on UNICEF's 1990 conceptual work, acknowledging the increasing triple burdens

of malnutrition – undernutrition, micronutrient deficiencies, and overweight – and highlights the role of diets and care as immediate determinants of maternal and child nutrition.

There are immediate determinants which include diets and care; underlying determinants which include food, practices, and services; and enabling determinants which include resources, norms and governance. Mother’s education, employment, stability of income, and social and cultural norms are the enabling determinants and will determine the nutritional status of the child.

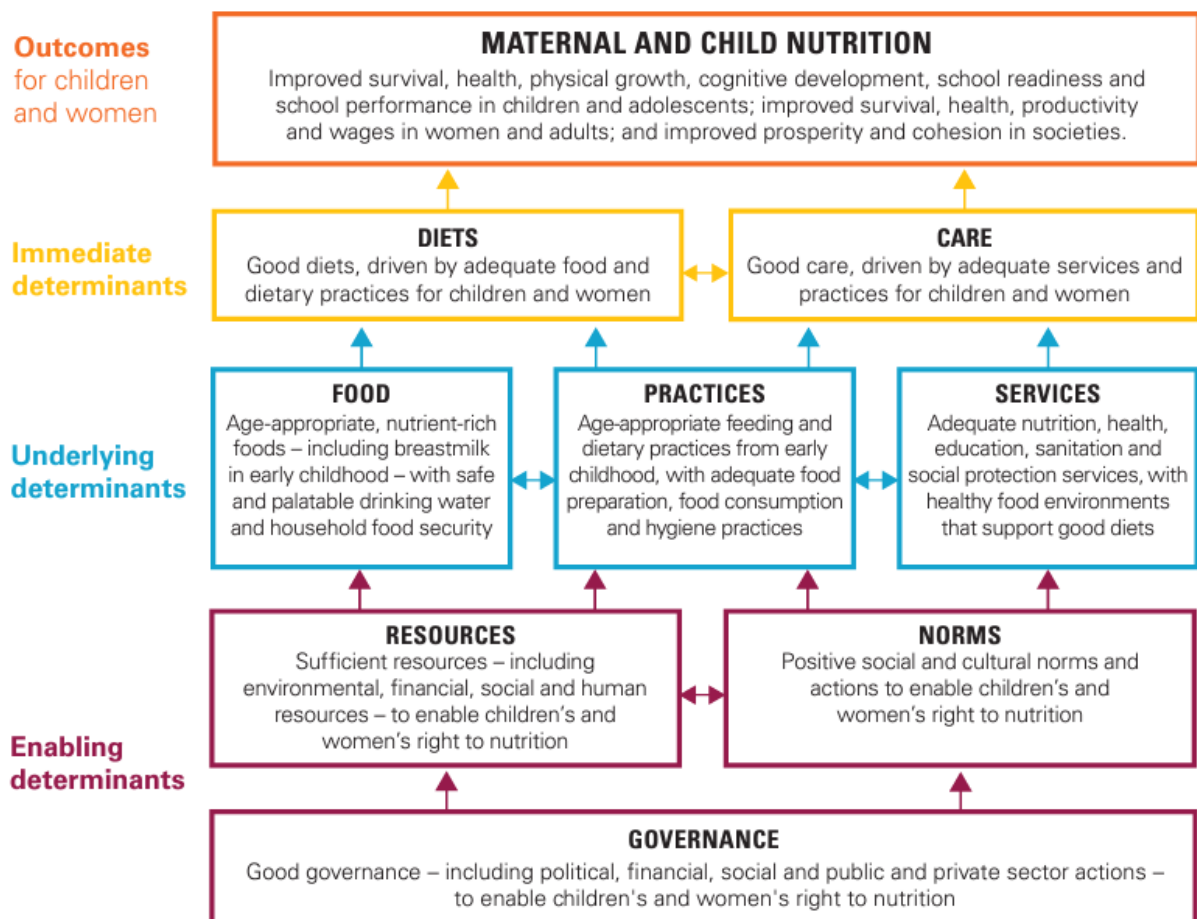


Figure 2: UNICEF Conceptual framework on determinants of Maternal & Child Nutrition, 2020

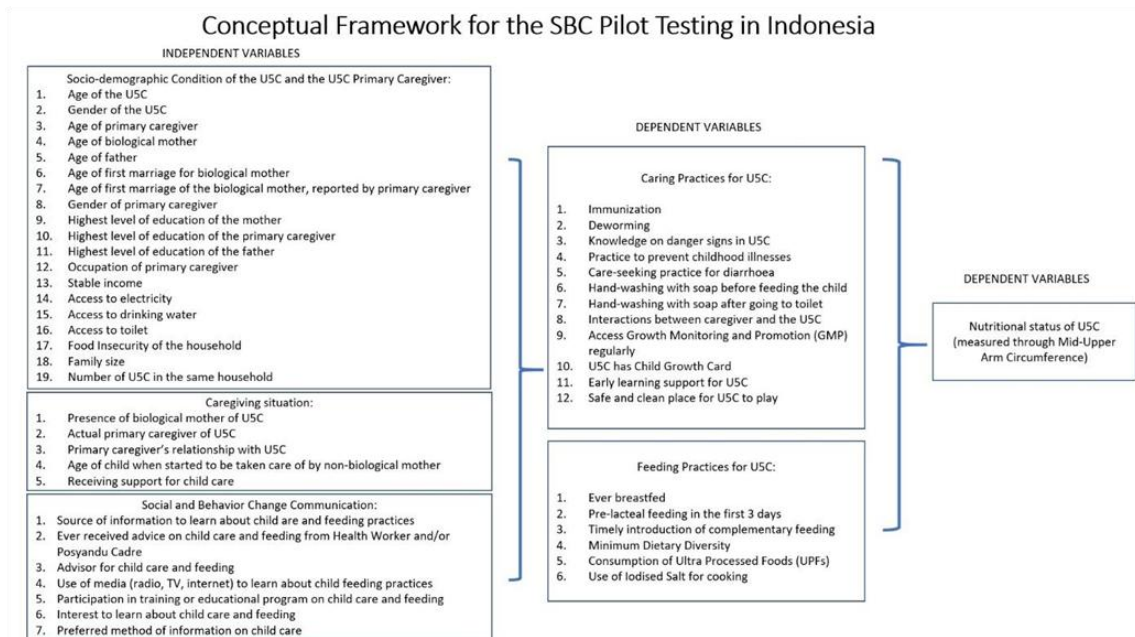


Figure 3: Conceptual framework for SBC pilot testing in Indonesia

In this study, the research team adapted the UNICEF Conceptual Framework as shown in Figure 3. The conceptual framework of this study shows the independent and dependent variables in this study.

4. Indicators

Based on the research objectives mentioned above, to answer the research questions the following indicators were chosen. These indicators would be collected at baseline and endline, and the differences would be compared during endline to measure the changes.

Research Objective 1:

To describe the social, economy, demography, assets and living condition of the households with children under-five years old including age, gender, education level, occupation, numbers of household member, electricity ownership, toilet facility type, source of drinking water, and regular income.

- % of Households based on gender of Primary caregiver
- Primary caregiver age distribution

- Youngest child age distribution
- Distribution of Primary caregiver status to youngest child
- Distribution of time since primary caregiver took care the youngest child
- Youngest child's mother age when she got married the first time
- Distribution of youngest child's mother current location
- Distribution of youngest child's mother education
- Distribution of primary caregiver education
- Age distribution of youngest child's father
- Distribution of youngest child's father education
- Distribution of primary caregiver occupation

Research Objective 1.1: To describe the child caregiving practices of the respondent.

- % of primary caregiver who received help taking care youngest child
- Distribution of people who helped primary caregiver taking care youngest child
- % of primary caregiver who can show youngest child's growth chart
- % of youngest child who ever received vaccination
- % of youngest child who received deworming medication in the last 6 months

Research Objective 1.2: To describe parent-child interaction of the respondent.

- % of primary caregiver responding correctly to all 18 brigance questions
- % of primary caregiver who gave toys to youngest child
- % of caregiver who think youngest child have safe and clean place to play

Research Objective 1.3: To describe nutrition practices of the respondent.

- % of youngest child ever been breastfed
- % of youngest child who only receive breast milk during the first 3 days
- % of youngest child received solid/semi solid food > 6 months old
- % of youngest child age >6 months old who received at least 5 food groups in the last 24 hours (Minimum Dietary Diversity)
- % of youngest child age > 6 months old who did not eat junk food in the last 24 hours
- % of youngest child age > 6 months old whose MUAC is between > 125mm

Research Objective 1.4: To identify and compare caring and feeding practices among households with children under five years old born of younger mothers (≤ 24 years old) and households with children under five years old born of older mothers (≥ 28 years old) (Quantitative)

Comparisons of above indicators results divided by biological mothers aged ≤ 24 years old and ≥ 28 years old – please see section 5. Data Analysis.

Research Objective 1.5: To compare the caring and feeding practices among households with children under five years old born of younger mothers (≤ 24 years old) at baseline versus endline in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

- Comparisons of above indicators for biological mothers ≤ 24 years old results during baseline versus endline

Research Objective 1.6: To compare the caring and feeding practices among households with children under five years old born of older mothers (≥ 28 years old) at baseline versus endline in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

- Comparisons of above indicators for biological mothers ≥ 28 years old results during baseline and endline

Research Objective 1.7: To identify proportion of children under five years old being taken care of by their own mother in Sembalun and Pringgabaya sub-district, East Lombok District (Quantitative)

- % of primary caregiver who is also the biological mother of the youngest child

Research Objective 1.8: To identify barriers and enablers of good dietary diversity among children under five in the 6 villages include food insecurity, household economy. (Quantitative and Qualitative)

- % of children under 5 received ≥ 5 food groups from the 8 food groups in MDD questions

Research Objective 2.1: To describe the social behaviour change communication channel, information and preferred method to learn about child caring and feeding practices.

- Distribution of primary caregiver' current learning sources
- % of primary caregiver who received health education from health workers
- % of primary caregiver who received health education from Community Health Workers
- Distribution of people whom primary caregiver trust and use as information sources for child caring and feeding
- % of primary caregiver who use media (TV, internet, radio) as information source for child feeding knowledge

- % of primary caregiver who attended training or other educational program for child feeding and caring practices.

5. Data Analysis

The analysis of this endline Survey result uses descriptive analysis for all the variables (socio demographic condition, caregiving situation, social and behaviour change communication, caring practices and feeding practices for children under five, and nutritional status measured using mid-upper arm circumference or Wasting).

This endline survey focused on finding indicators' changes between baseline and endline. Confidence intervals play a big role in comparing baseline and endline results. A significant change cannot be concluded when both confidence intervals are intersecting each other.

Samples from some indicators need to be combined in order to have enough sample size, in order to have a low confidence limit, for example the child's nutritional status measured using MUAC (Wasting) and the child's Minimum Dietary Diversity (MDD) score were only measured among children ≥ 6 months old, hence the total number of samples for each Supervision Area (SA) is less than 19.

One of the benefits of using LQAS method is that it can show which SAs are significantly lower than the average results for each indicator by using LQAS decision rule table. This means that when the decision rule is not met, it is evidence that the target has not been achieved in certain SA (this will be true 90% or more of the time).¹ The SAs which below the LQAS decision rule, for each indicator, will be coloured orange in the results section. This could be useful for project managers to have guidance on which SA s/he should give more attention to.

6. Methodology for the LQAS Quantitative Endline

The quantitative method for baseline and endline survey in this study used the LQAS (Lot Quality Assurance Sampling) method (1). LQAS method is chosen by WV for its ability to show supervision area specific results and requires smaller sample compared to other methods, such as cluster sampling method. It is also possible to use parallel sampling in

¹Assessing Community Health Programs Using LQAS for Baseline Surveys and Regular Monitoring (Participants manual and workbook and the trainer's guide) by Joseph J. Valadez, William Weiss, Corey Leburg, and Robb Davis http://www.coregroup.org/working_groups/lqas_train.html and http://www.coregroup.org/working_groups/LQAS_Participant_Manual_L.pdf

LQAS methodology, useful to measure practices in younger mother and older mothers groups. In LQAS, a minimum of 5 supervision areas is needed, and from each SA 19 samples is required (1,7).

Since LQAS methodology uses a small number of sample, the limitation of the method would be on how precise the result is. In the LQAS Planning and Implementation Guide from World Vision and the Liverpool School of Tropical Medicine (14), the proposed sample size of 19 x 5 Supervision Areas will have a Confidence Interval that will always be less than ± 0.10 , which is a level of precision accepted by most donor organizations and government ministries. In this Baseline survey, the team even used 6 Supervision Areas, which means the Confidence Interval has decreased further.

During survey planning, there were no known statistically significant differences in community groups within the population in 6 villages chosen for SBC testing area.

Since there was no new population list by sub-village (dusun), the endline LQAS survey used the population list from baseline. This population list was used to calculate random samples needed in each sub-village. Endline survey did not ask for a list of mothers with under five children from each Posyandu (Integrated Service Post) because the Posyandu list may not contain all children and mothers in the area, and some mothers may have never brought her child to Posyandu at all. In Indonesia, Posyandu attendance is not mandatory, and even though the Posyandu Cadres (Community Health Workers) conduct community mobilization and try to encourage mothers to come and bring their child to Posyandu for growth monitoring every month, it is up to the family's decision whether they will avail the service in Posyandu or not.

Overall, LQAS as a quantitative method has limitation related to the small number of samples, that analysis of the subset of the population is not possible. The research team must ensure that the 19 samples selection from each age group of mothers was done as random as possible to minimize bias. The research team ensured that the enumerators conducted random sampling directly on the spot in each selected village.

This endline survey had two groups of samples, and parallel sampling in the LQAS method (8) was used to cover both groups:

- Mothers of child under five years old, who are presently aged 24 years old or below
- Mothers of child under five years old, who are presently aged 28 years old or above

The 6 villages became **6 Supervision Areas (SAs)**, and in each SA there are 19 samples for each group. In total, there are 228 samples in this endline survey.

Villages	Samples of Mother ≤ 24 years old with < 5 yo child	Samples of Mother ≥ 28 years old with < 5 yo child
SA1	19	19
SA2	19	19
SA3	19	19
SA4	19	19
SA5	19	19
SA6	19	19
Total	114	114

Table 1: LQAS sample size

The number of populations for each sub-village (dusun) within the 6 SAs was collected by AP East Lombok and used for random sampling selection process. Following the LQAS standard procedure for random sampling, the locations of respondents were distributed within the dusun (sub-village).

The endline survey was conducted after the SBC intervention. enumerators went to each dusun (sub-village) to select respondents randomly in each dusun (sub-village) and not only those caregivers who attended the Crash Course on parenting classes. The complete table of sample locations is available in appendix 3, page 90.

7. Minimum Dietary Diversity (MDD)

In this study, Minimum Dietary Diversity is measured using the guideline on measuring Minimum Dietary Diversity (MDD) for 6 to 23 years old from WHO and UNICEF (9), but in this research, it was used to ask the caregivers of children 6 to 59 months. There are eight food groups in MDD:

1. Breastmilk
2. Grains, white/pale starchy roots, tubers and plantains
3. Beans, peas, lentils, nuts and seeds
4. Dairy products (milk, infant formula, yoghurt, cheese)
5. Flesh foods (meat, fish, poultry, organ meats)
6. Eggs
7. Vitamin-A rich fruits and vegetables

8. Other fruits and vegetables

The analysis for MDD was done using this formula:

Numerator: children 6–59 months of age who consumed foods and beverages from at least five out of eight defined food groups during the previous day. The eight food groups used for tabulation of this indicator are: 1. Breast milk; 2. Grains, roots, tubers and plantains; 3. Pulses (beans, peas, lentils), nuts and seeds; 4. Dairy products (milk, infant formula, yogurt, cheese); 5. Flesh foods (meat, fish, poultry, organ meats); 6. Eggs; 7. Vitamin-A rich fruits and vegetables; and 8. Other fruits and vegetables. Denominator: children 6–59 months of age.

8. Parent-child interaction measurement using Brigance Scale

The Brigance parent – child interaction scale has 18 questions and is used for measuring parent – child interaction (10). These questions were integrated into the questionnaire. Some Brigance questions use negative phrases, during data analyses the correct answers for this type of questions are those who answers against the negative phrases.

9. Ultra-processed food (UPF)

The ingredients of ultra-processed products make them fatty, sugary or salty, often high in saturated fats or trans-fats, and depleted in dietary fibre and various micronutrients and other bioactive compounds. Higher consumption of these products is associated with unhealthy dietary nutrient profiles and several diet-related non-communicable diseases (12). Processes and ingredients used for the manufacture of ultra-processed foods are designed to create highly profitable products (low-cost ingredients, long shelf-life, branded products).

In ultra-processed food, Monteiro et al. proposed the use of NOVA classification. NOVA is the food classification that categorises foods according to the extent and purpose of food processing, rather than in terms of nutrients (12). NOVA (a name, not an acronym) classifies all foods and food products into four clearly distinct and meaningful groups (12,13). It specifies which foods belong in which group and provides precise definitions of the types of processing underlying each group.

NOVA is now recognised as a valid tool for nutrition and public health research, policy and action, in reports from the Food and Agriculture Organization of the United Nations and the Pan American Health Organization.

This study used 13 types of ultra-processed food from Monteiro et al., which are:

- 1) Breakfast cereals, cake mixes, 'energy' bars; wafer, biscuit
- 2) Instant packaged soups and noodles;
- 3) many types of sweetened breads and buns, cakes, pastries and desserts;
- 4) chips (crisps), many other types of sweet, fatty or salty snack products;
- 5) Sugared milk and fruit drinks, soft cola and 'energy' drinks.
- 6) Pre-prepared meat, fish, vegetable or cheese dishes, pizza and pasta dishes, burgers and hot dogs, French fries (chips), poultry and fish 'nuggets' or 'sticks' ('fingers');
- 7) Bread and other cereal products, animal products made from flour and salt with scraps or remnants of meat;
- 8) cookies (biscuits), preserves (jams);
- 9) sauces, meat, yeast, other extracts;
- 10) ice cream, chocolates, candies (confectionery);
- 11) margarines;
- 12) canned or dehydrated soups;
- 13) Infant formula, follow on milks, baby products.

The survey questionnaire included local and relevant examples of ultra-processed foods in the above 13 categories, and enumerator asked the respondents whether their youngest child consume any of the food in these 13 categories in the last 24 hours.

10. Parental Perceived Barriers to give healthy food for the children

Most parents have reasonable knowledge about what healthy diet is; they want their children to eat healthy and nutritious foods, regularly eat vegetables, or restrict their added sugar intake. However, parents' intention to promote healthy eating or change unhealthy food choices and behaviours is often hindered by several objective or subjective barriers to performing the relevant practices or behaviours.

Gomez et al. developed questionnaire for assessing parental perceived barriers when promoting healthy eating habits in 2023.² The questionnaire uses five scales: Child-Related Barriers, Parent-Related Barriers—Vegetables and Fruit, Parent-Related Barriers—Added Sugars, Social Context-Related Barriers, and Cost-Related Barriers. These five scales are included in the questionnaire.

11. Data Collection Tools

The questionnaire used in this study was developed based on several international standard questionnaires and scales i.e., KPC (Knowledge Practice Coverage) Survey,

²Indicators for assessing infant and young child feeding practices: definitions and measurement methods. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2021. Licence: CC BY-NC-SA 3.0 IGO;

Minimum Dietary Diversity, Infant and Young Child Feeding practices (IYCF)³, Brigance, and NOVA classification for Ultra-processed Food groups. Discussion with the SBC pilot testing team in WV and WVI was done to decide which questions considered suitable to measure the selected indicators.

Questions were selected from the KPC module, especially from the modules of Child Nutrition. The 18 questions from the Parent – Child interaction from Brigance were added. Questions related to the 13 types of processed food groups were added. Fifteen questions related to perceived parent barriers were added, along with two new questions on local content creator videos on child caring and feeding. The final questionnaire was translated into Bahasa Indonesia language. The final questionnaire for endline is available in appendix 2, page 68.

The research team did not conduct any validity and reliability test for the survey instrument, as the survey questionnaire was developed from the internationally tested questions and scales, which have undergone separate validity and reliability test by the respective researchers.

The questionnaire which was used for baseline becomes the basic questionnaire for endline data collection. However, some questions from baseline were removed for the endline questionnaire. These questions are not appropriate for measuring changes because they are not related to SBC program implementation. The removed questions are:

- Question for mobile phone number, because it is not useful for measuring changes
- All questions from “Household assets and living condition” section
- All questions from “Food insecurity experience scale”
- Some questions from “Child care practices” section:
 - ✓ “hand washing with soap”, because SBC project activities were not trying to change this behaviour.
 - ✓ “sick child prevention and home treatment”
 - ✓ “Home treatment for child with diarrhoea”
- Some questions from “Learning about child caring and feeding practices” section:
 - ✓ Past preferred information channel
- Iodine test for salt

³From Design For Behaviour Change Framework – In The Social And Behaviour Change Testing Project, Area Programme East Lombok, WVI In Collaboration With WV US And WV International (May 2025)

For easy data collection process, the team decided to do paperless survey and used Kobocollect for data collection. Kobocollect questionnaire version was developed after the final questionnaire was available and approved by WV and WVI.

12. Limitations of the study

Initially, the research team would like to use formal Kartu Keluarga (Family Card) as a means of verification for the age of mothers and children. However, during baseline survey the team found out that not all Family Cards contained accurate data such as name and correct date of births, due to many reasons. The date of birth of the mother and of the child mentioned by the primary caregivers are generally considered more reliable and used for the analysis in this study.

Since LQAS methodology uses a small number of sample, the limitation of the method would be on how precise the result is. In the LQAS Planning and Implementation Guide from World Vision and the Liverpool School of Tropical Medicine (14), the proposed sample size of 19 x 5 Supervision Areas will have a Confidence Interval that will always be less than ± 0.10 , which is a level of precision accepted by most donor organizations and government ministries. In this Baseline survey, the team even used 6 Supervision Areas, which means the Confidence Interval has decreased further.

13. Ethics

As in the Baseline survey, care was taken to ensure that all primary caregivers encountered during the LQAS endline survey, especially those who were married as minors, provided informed consent. All respondents received explanation about the survey purpose and explanation about Informed Consent and Informed Assent, as relevant. The research team trained the enumerators to get informed consent and informed assent from the respective respondent, and to respect the autonomy of the adolescent mothers.

Participation in this LQAS endline survey was voluntary and respondents received explanation from the enumerators that they could withdraw at any time without negative consequences.

Due to the sensitivity around child marriage, the research team maintained strict confidentiality and protect the identities of the respondents. Hence, as in baseline, throughout the endline study preparation, training, and data collection, the research team and enumerators used the broader term of “younger mothers” instead of

adolescent mothers. The same care will be taken during sharing of endline findings to government officials.

The research team engaged community leaders and local stakeholders through the assistance of AP East Lombok team to ensure that the research is culturally appropriate. The research team deployed research assistants and enumerators from the local area to ensure that they understand local cultures and appropriate communication and engagement with the respondents.

The research design, research protocol and all the research instruments, including the quantitative questionnaire and the Informed Consent and Informed Assent forms were submitted to the Ethics Review Committee in the Faculty of Medicine, University of Indonesia in early September 2024. There was a minor revision suggested by the Ethics Review Committee, i.e., to add into the Informed Consent and Informed Assent forms the phone number of local staff in East Lombok Area Programme, and the information of monetary compensation for the respondents. The Principal Investigator (GC Senior Technical Advisor for Health & Nutrition) submitted the revised proposal on 30 September 2024.

Since there were some baseline questions removed and some new questions were added to endline questionnaire, amendment was submitted to Review Committee in the Faculty of Medicine, University of Indonesia on 16 June 2025. Approval from the committee was received on 20 June 2025. The approval can be found in Appendix 1, page 66.

To ensure data privacy and confidentiality, the Consultant team will send the raw data of the LQAS endline survey to WV and WVI with the respondents' identity (names of primary caregiver, father, and child, and phone number of primary caregiver) removed.

IV. SBC Program Planning and Implementation

1. Project Planning

Based on the Baseline survey results and the qualitative Photovoice findings, the SBC pilot testing team designed the Social and Behaviour Change (SBC) interventions targeting several behaviours⁴, as shown in Table 2:

⁴From SBC pilot testing project monthly monitoring reports

Target behaviour	Target audience	Planned Activities
<p>1. Timely introduction of complementary feeding</p>	<p>Priority group: Caregivers of children below 6 months old.</p> <p>Supporting groups: Their husband and mother or mother-in-law</p>	<ul style="list-style-type: none"> • “Kelas Kilat Pengasuhan”, a 3-session class focusing on practical and tactile demonstration on complementary feeding and child stimulation. Includes cooking demonstration of healthy and quick recipes, blind test games to guess the name of the food, toy-making workshop, practice playing to the child using guidance for age-specific play, and other games. • Develop small booklets for easy and quick reading about “myths & facts on breastfeeding” and “myths & facts on complementary feeding” • Develop small booklet on how to deal with and prevent picky eaters, how to properly start a successful journey in complementary feeding. Ask experts to produce short videos as well that can be shared with the target audience. • Engage local content creators to produce short videos on myths & facts and share it to the caregivers in project area and upload in social media for wider reach <p>Engage local content creators to promote the use of local fruits and vegetables for MPASI and their benefit for child’s health</p>
<p>2. Providing a variety of age-appropriate foods (plant protein, vegetables, eggs)</p>	<p>Priority group: Caregivers of children 6-59 months.</p> <p>Supporting groups: Their husband and mother or mother-in-law</p>	<ul style="list-style-type: none"> • A three-session Crash Course on Parenting • Develop small booklets on key messages • Develop small recipe books based on recipes from the Ministry of Health and local Positive Deviance Hearth recipes in Lombok • Engage local creators to promote the use of local fruits and vegetables for MPASI and their benefit for child’s health Will be addressed through: <ul style="list-style-type: none"> • “Kelas Kilat Pengasuhan”, a 3-session class focusing on practical and tactile demonstration on complementary feeding and child stimulation. Includes cooking demonstration of healthy and quick recipes, blind test games to guess the name of the food, toy-making workshop, practice playing to the child using guidance for age-specific play, and other games. • Develop small booklets for easy and quick

Target behaviour	Target audience	Planned Activities
		<p>reading about “myths & facts on breastfeeding” and “myths & facts on complementary feeding”</p> <ul style="list-style-type: none"> • Develop small booklet on how to deal with and prevent picky eaters, how to properly start a successful journey in complementary feeding. Ask experts to produce short videos as well that can be shared with the target audience. • Engage local content creators to produce short videos on myths & facts and share it to the caregivers in project area and upload in social media for wider reach • Engage local content creators to promote the use of local fruits and vegetables for MPASI and their benefit for child’s health
<p>3. Stopping ultra-processed food consumption for young children</p>	<p>Priority group: Caregivers of children 6-59 months old</p> <p>Supporting groups: Their husband and mother or mother-in-law, Child’s older sibling, Close neighbours</p>	<p>Will be addressed through:</p> <ul style="list-style-type: none"> • “Kelas Kilat Pengasuhan”, a 3-session class focusing on practical and tactile demonstration on complementary feeding and child stimulation. Includes cooking demonstration of healthy and quick recipes, blind test games to guess the name of the food, toy-making workshop, practice playing to the child using guidance for age-specific play, and other games. • Develop small booklets for easy and quick reading about “danger of junk food and drinks for our children”. Ask experts to produce short videos on this topic as well that can be shared with the target audience. • Engage local content creators to produce short videos on danger of junk foods and drinks for young children, how to recognize healthy food versus junk food from the label, etc. • Engage local content creators to promote the use of local fruits and vegetables for MPASI and their benefit for child’s health • Local level advocacy to Health Workers and District Health Office to have a stricter control on the marketing and selling of food and drinks for children without proper label • Collaborate with Health Workers and District Health Office to do proactive education to community on the danger of junk food, and food

Target behaviour	Target audience	Planned Activities
		<p>high in additives, colourings, and preservatives for children</p> <ul style="list-style-type: none"> • Encourage local food vendors not to let young children shop without their parent’s permission – engage village chiefs for this initiative, and involve health workers • Helps produce and sharing SBCC materials on the danger of junk foods
<p>4. Daily child stimulation (play, talk, hug, sing, show, storytelling)</p>	<p>Priority group: Caregivers of children 0-59 months old.</p> <p>Supporting groups: Their husband and mother or mother-in-law, Child’s older sibling, Close neighbours</p>	<p>Will be addressed through:</p> <ul style="list-style-type: none"> • “Kelas Kilat Pengasuhan”, a 3-session class focusing on practical and tactile demonstration on complementary feeding and child stimulation. Includes cooking demonstration of healthy and quick recipes, blind test games to guess the name of the food, toy-making workshop, practice playing to the child using guidance for age-specific play, and other games. • Develop small booklets for easy and quick reading about “how to play and stimulate your child every day – integrating simple activities into daily life”. Ask experts to produce short videos on this topic as well that can be shared with the target audience. <p>Engage local content creators to produce short videos on child care and child stimulation</p>

Table 2: SBC pilot testing project designed behaviour change framework

2. Project Implementation

Two activities were chosen by SBC pilot testing team: 1) Crash Course class on parenting and, 2) Content creator training. These interventions were implemented in the six villages as planned.

The crash course class on parenting were divided into two groups: for primary caregivers who have youngest children 3 - 23 months old and caregivers of children aged 24 – 59 months old, using two different training of facilitators modules. These two modules were developed by the SBC pilot testing team in WV and WVI. Each module was divided into 3 sessions, conducted in 3 separate days. Facilitators were Posyandu Cadres (Community Health Worker), who underwent one-day training. Participations in Crash Course of Parenting was supposed to be fixed (participants could not come in and go). However, data shows a drop out in participation from Session 1 to Session 3.

For the content creator training, the trainer was a mother, a local content creator in Lombok. She was engaged as external consultant. Based on the design above, SBC pilot testing project implemented field activities.

3. Project monitoring

Based on the project’s monitoring reports, the fields activities were as follow⁵:

Date	Activities	Location	Participants
30 June 2025	Content Creator training	Lesehan Taman Langit Pringgabaya	17 adult women from Batuyang Health Center, Labuhan Lombok Cealth Center, Posyandu cadres (CHW), and mothers
10 July 2025	FGD to review the first testing of crash course on parenting with facilitators that was conducted in June 2025, facilitated by Field Assistant	3 villages in Sembalun	7 facilitators

⁵From Pre-Post Score Analysis of Crash Course on Parenting, SBC project monitoring

Date	Activities	Location	Participants
10 July 2025	FGD to review the first testing of crash course on parenting with facilitators that was conducted in June 2025, facilitated by Field Assistant	Batuyang Health Center auditorium in Pringgabaya	13 facilitators (12 women and 1 male), health staffs from Batuyang & Labuhan Lombok Health Centers, Posyandu cadres (CHW) from Tanak Gadang and Pohgading Timur sub-villages
15 July 2025	Training for facilitators of crash course on parenting for under two years old children, facilitated by World Vision	Sembalun sub-district office auditorium	9 Posyandu cadres (CHW)
	Training for facilitators of crash course on parenting for children between 2 – 5 years old, facilitated by WV Indonesia	Sembalun Health Center auditorium	10 Posyandu cadres (CHW)
17 July 2025	Training for facilitators of crash course on parenting for under two years old children, facilitated by World Vision	Batuyang Community Health Center auditorium, Pringgabaya	10 Posyandu cadres (CHW)
	Training for facilitators of crash course on parenting for children between 2 – 5 years old, facilitated by WV Indonesia	Pringgabaya sub-district office auditorium	11 Posyandu cadres (CHW)
21 - 25 Juli 2025	First batch of crash course on parenting for children 2 – 5 years old	Sembalun Bumbung village (Jorong Timur, Jorong Tengah, Bebante Induk, Daya Rurung Barat, Batu Jalik, Otak Desa, Lauk Rurung Timuk sub-villages) Sembalun Lawang village (Lebak Benjor, Baret Desa, Telaga, Mapakin, Dasan Kodrat sub-villages) Sembalun Timba Gading village (Dasan Tengah Timuk, Bantek I sub-villages)	198 mothers
21 - 25 July 2025	First batch of Crash course on parenting for children under 2 years old	Sembalun Bumbung village (Jorong Induk, Jorong Utara, Bebante Timur, Bedurik, Benyer, Daya Rurung Timuk, Lauk Rurung Barat sub-villages) Sembalun Lawang village (Lebak Daya, Baret Desa, Telaga, Mapakin, Lebak Lauk sub-villages)	178 mothers

Date	Activities	Location	Participants
		Semalun Timba Gading village (Dasan Tengah Timuk, Bantek II sub-villages)	
21 - 25 July 2025	First batch of crash course on parenting for children under 2 years old (introducing simple recipe book and cooking demo)	Labuhan Lombok, Tanak Gadang and Pohgading Timur villages	13 facilitators with 164 mothers
21 - 25 July 2025	First batch of crash course on parenting for children 2 – 5 years old (food variations and their benefits)	Labuhan Lombok, Tanak Gadang and Pohgading Timur villages	13 facilitators with 166 mothers
	Monitoring on content creator training participants		17 people who participated in content creator training
July – August 2025	Video content contest	5 persons from Semalun sib-district and 8 persons from Pringgabaya sub-district. A total of 23 videos were submitted for the competition	–

Table 3: SBC pilot testing project monitoring summary

As described in table 3, the first content creator training was done on 30 June 2025. While the first batch training for trainers of crash course class on parenting was conducted on 10 July 2025, and the first session of the crash course on parenting was conducted on 21 July 2025.

The SBC pilot testing project also conducted a pre-test during first session of the crash course on parenting class, and a post-test after the crash course on parenting third session ended. Below are the results of the pre-post-test⁶:

⁶Baseline report, page 45

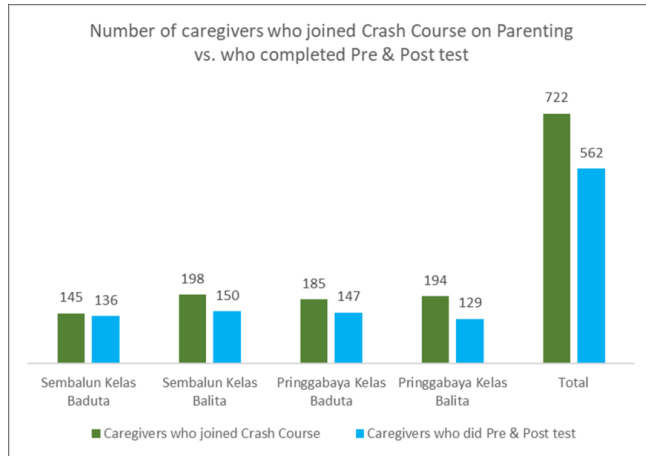
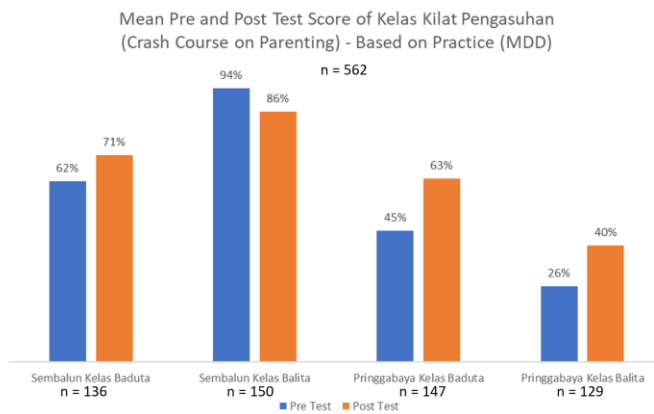


Figure 4: Number of primary caregivers who joined crash course on parenting

As seen in figure 4, the total number of primary caregivers who joined crash course on parenting is 722 people, with only 562 people completed both pre- and post-test.



All are significant change

Figure 5: Means of pre-post test score of crash course on parenting

As seen in figure 5, in Sembalun, the crash course on parenting for children under 2 years old started from average moderate score (62%) in Minimum Dietary Diversity (MDD) practice, and then improved significantly (71%). The crash course on parenting for children 2 years old and above, on the other hand, started with relatively good MDD (94%), but then decreased significantly (86%), although still better than the caregivers in the crash course on parenting for children under 2 years old Class.

In Pringgabaya, the crash course on parenting for children under 2 years old class started with low practice of MDD (45%), but then improved significantly (63%). Crash course on parenting for children 2 years old and above class, started with very low MDD score (26%) and then improved significantly (40%). However, after improvement, the MDD

score in crash course on parenting for children 2 years old and above class in Pringgabaya is still quite low.

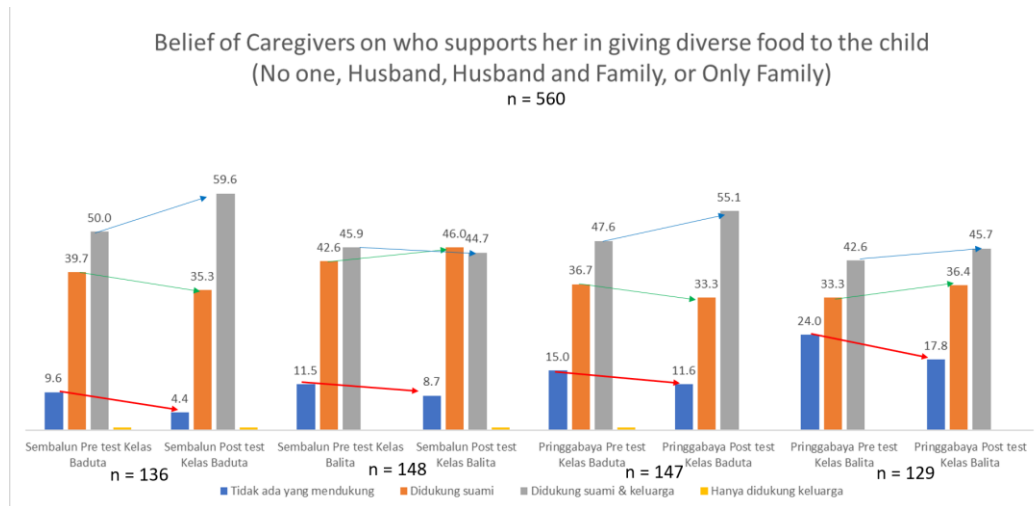


Figure 6: Beliefs of primary caregiver who supports her in giving diverse food to their child

Across four groups, there are change in Belief, but change in Sembalun crash course on parenting for children 2 years old and above class is the least, shown by the very small decrease in believing that “no one help” the caregiver to provide diverse food for her child. In the other three groups, this belief has changed by improvement in belief that the husband, or husband & family support the primary caregiver.

However, in Sembalun crash course on parenting for children 2 years old and above class and Pringgabaya crash course on parenting for children 2 years old and above class, belief that husband helps caregiver in providing diverse food for the child improved. This was not seen in the crash course on parenting for children under 2 years old classes in Sembalun and Pringgabaya.

Belief in the support of husband & family increased sharply in the crash course on parenting for children under 2 years old class in Sembalun and Pringgabaya. It improves slightly in crash course on parenting for children 2 years old and above class in Pringgabaya. Note: There are 2 missing responses from Sembalun crash course on parenting for children 2 years old and above Pre-Test.

V.LQAS Endline Survey implementation

Enumerators training

The enumerator training was conducted to ensure enumerators have the same understanding of the questionnaire so that they could get accurate data, to avoid bias, and to ensure that they have enough skills to conduct interviews.

The training for enumerators and supervisors was conducted in two days, on 19 – 20 August 2025, before the survey started. Ten enumerators attended the training, along with East Lombok AP Monitoring, Evaluation & Learning coordinator, two field assistants, and several AP staff who helped coordination process. The training was conducted in the meeting room of Puskesmas (Community Health Center) Sembalun. The enumerators had previous experiences in conducting survey with other organizations.

Day 1 of enumerators training

- Introduction of Yayasan Wahana Visi Indonesia by East Lombok AP Monitoring, Evaluation & Learning coordinator.
- Purpose of endline survey and the connection to the SBC Pilot Testing Research by Senior Technical Advisor for Health and Nutrition from WV International.
- Explanation on survey questionnaire, target samples, informed consent and ascent forms, use of Kobocollect mobile data collection application, and on the procedure to measure Mid Upper Arm Circumference (MUAC) in children using MUAC tape by the Consultant team.
- How to do random selection of the respondents in the field by the Consultant team. Emphasize was given to not only search for caregivers who joined the crash course on parenting classes.
- Practice using Kobocollect application in enumerator's mobile phone and role-played interviews with each other. Each enumerator tried to interview using Kobocollect once. The enumerators' simulation interview results were sent to Kobocollect server and analysed by consultant to find mistakes.
- Refresh on the procedure for MUAC measurement by Senior Technical Advisor for Health and Nutrition from WV International and Consultant team.
- Safeguarding policy and explanation on enumerator's contract by East Lombok AP Monitoring, Evaluation & Learning coordinator.
- Enumerators signed their contract and Safeguarding policy at the end of the first training day.

Day 2 of enumerators training

- Brief explanation by consultant
- Short discussion on minor mistakes made during yesterday's simulation
- Practice using MUAC tape to measure children
- Field visit to the selected sub-village for field testing (Lendang Luar sub-village), coordinated and led by two AP field staffs.
- Consultant analysed the field testing results.
- Lunch break
- Consultant discussed the field test results.
- Explanation and clarifications on several questions by the Senior Technical Advisor for health and nutrition from World Vision International, to ensure enumerators understand the purpose of the questions, and to avoid misunderstanding.
- AP East Lombok staff coordinated the strategy for data collection, and distributed survey logistics to all enumerators.

Process of field testing

Purpose of the field testing was to train enumerators to find samples randomly, conduct interview and to get the approximate duration for each interview. The sub-village for field testing (Lendang Luar sub-village in Sembalun village) was chosen by AP East Lombok and is not located in the six selected villages for SBC pilot testing area and endline survey. Each enumerator interviewed one primary caregivers with children 0 – 59 months old from younger mothers group and another one from older mothers group, so the total were 20 respondents interviewed. Each interview was completed within 35 – 40 minutes. The results were sent to Kobocollect server, then analysed by consultant.

4. Data collection

The endline survey data collection was conducted on 21 – 23 August 2025, with 10 enumerators, using Kobocollect version 2025.2.3.

The survey did not face any problem. The two East Lombok AP field assistants coordinated and lead the survey flawlessly. On 21 – 22 August 2025, East Lombok AP Monitoring, Evaluation & Learning coordinator and Senior technical advisor for health and nutrition, from WV International supervised the data collection in Sembalun sub-district, while two consultants supervised data collection in Pringgabaya sub-district.

On 23 August 2025, all supervisors were helping Senior technical advisor for health and nutrition, from world vision international to conduct FGD with Parent Support Group – an SBC intervention implemented by the AP East Lombok for caregivers of children with disability. This FGD will be reported in a different report.

At the end of each data collection day, consultant reviewed all incoming data and clarifications were done with enumerators. All survey data were already completed at the end of 23 August 2025, sent to Kobocollect server, and cleaned.

The results are divided into six Supervision Areas (SAs), which are:

SA	Village
SA1:	Semalun Bumbung village or SB
SA2:	Semalun Lawang village or SL
SA3:	Semalun Timba Gading village or STG
SA4:	Pohgading Timur village or PT
SA5:	Tanak Gadang village or TG
SA6:	Labuhan Lombok village or LL

Table 4: Supervision Areas locations

SA 1, SA 2 and SA 3 are in Semalun sub-district, while SA 4, SA 5, and SA 6 are in Pringgabaya sub-district. SAs description in Table 4 is used for the analysis of the whole survey results.

The final number of respondents interviewed are:

Mothers age group	SA						Total
	SB	SL	STG	PT	TG	LL	
≤ 24 years old	19	19	19	19	19	19	114
≥ 28 years old	19	19	19	19	19	19	114
TOTAL	38	38	38	38	38	38	228

Table 5: Mother age group survey results

5. Data cleaning

Data cleaning process was conducted by the consultant team, first by checking the completeness of records from Kobocollect form. The questionnaire in this survey used mandatory format for questions that are mandatory for the respondents. Hence, this helped ensuring completeness of the data for all the questions.

For optional questions, skip function was used in Kobocollect, thus preventing the mistake due to human error. Questions related to numeric have been set to include the upper value and lower value and the number of digits allowed.

After all the data from 228 respondents have been checked for completeness and clarity of texts, the survey records are considered ready for data analysis. All 228 data was collected and no data was excluded. Epiinfo 7 version 7.2.7.0 was used to check and clean the data. Every day of the data collection, the consultant team confirmed the number of interviews completed and clarified ambiguous responses with the enumerators.

VI. Results & analysis

Overall, the analysis in this section will be based on the two groups of sampling: Households with biological mother aged ≤ 24 years old and ≥ 28 years old. They will be referred to as “Household of younger mothers group” and “Household of older mothers group”. The 95% Confidence Limit shown in the results tables are weighted for SA population sizes (1).

The SAs which below the LQAS decision rule, for each indicator, will be coloured orange in the results section. In LQAS method, this information is useful for project managers to have guidance on which SA s/he should give more attention to. This information would also be useful for AP managers as well as WV and WVI to follow up on which SAs need more attention.

1. General characteristic

Biological mother’s age, highest education completed, and age at first marriage

All Biological mothers’ education level completed	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Did not go to school	0	1	0	0	0	0	1	0.4%	$\pm 0.4\%$
Elementary school but did not finish	1	2	2	3	1	6	15	6.6%	$\pm 3.7\%$
Graduated from elementary school	4	4	6	4	4	8	30	13.2%	$\pm 4.8\%$
Graduated from junior high school	10	12	13	15	19	11	80	35.0%	$\pm 7.3\%$
Graduated from senior high school	21	15	15	12	14	13	90	39.5%	$\pm 7.2\%$
Graduated from university	2	4	2	4	0	0	12	5.3%	$\pm 3.9\%$
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 6: All biological mothers' highest education completed

As seen in table 6, more than 60% biological mothers graduated from Junior High School (35.0% $\pm 7.3\%$) and Senior High School (39.5% $\pm 7.2\%$).

	Supervision Area	Total	%	95%
--	------------------	-------	---	-----

Biological mothers's ages when they got married for the first time	SB	SL	STG	PT	TG	LL			confidence limit
≤ 18th	16	18	20	10	11	16	91	39.9%	± 6.9%
> 18th	21	20	18	26	25	20	130	57.0%	± 7.2%
Dont know	1	0	0	2	2	2	7	3.1%	
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 7: All biological mothers's ages when they got married for the first time

Table 7 shows that 39.9% of biological mothers were married for the first time at age 18 years old or younger. The age of first marriage ranges from 10 to 27 years old. The means for the age of first marriage is 19.3 years old.

Seven biological mothers were not present at the time of survey, and primary caregivers were not able to mention mothers' age when they got married for the first time. Biological mothers' current age varies between 15 and 50 years old.

a. Primary caregiver

Primary Caregivers' Age	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
≤ 18 years old	1	3	1	2	0	2	9	4.0%	± 2.9%
19 – 24 years old	18	16	18	16	18	16	102	44.7%	± 7.5%
25 – 30 years old	2	5	7	2	6	7	29	12.7%	± 4.4%
31 – 36 years old	13	8	7	8	6	8	50	21.9%	± 6.1%
37 – 42 years old	4	5	5	7	5	3	29	12.7%	± 5.5%
43 – 48 years old	0	1	0	2	1	0	4	1.8%	± 2.7%
49 – 54 years old	0	0	0	1	1	0	2	0.9%	± 2.0%
55 – 60 years old	0	0	0	0	1	1	2	0.9%	± 0.9%
61 – 66 years old	0	0	0	0	0	0	0	0%	
67 – 72 years old	0	0	0	0	0	1	1	0.4%	± 0.3%
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 8: Primary caregivers' age groups

Table 8 shows that almost half of the primary caregivers are in the age group of 19.24 years old. All primary caregivers during endline are female. The means of primary caregivers' age is 28.4 years old.

Primary caregivers relationship with the youngest child	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			

Biological mother	38	37	38	37	37	34	221	96.9%	± 2.1%
Grandmother	0	0	0	1	1	3	5	2.2%	± 2.1%
Aunt	0	1	0	0	0	1	2	0.9%	± 0.5%
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 9: Primary caregivers relationship with the youngest child

Table 9 shows that almost all primary caregivers (96.9% ±2.1%) are also the biological mothers. Thus, data of primary caregivers and biological mothers are almost identical.

Primary Caregivers Education Level	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Did not go to school	0	1	0	1	0	2	4	1.8%	± 1.9%
Elementary school but did not finish	1	2	2	3	1	6	15	6.6%	± 3.7%
Graduated from elementary school	4	4	6	4	5	8	31	13.6%	± 4.9%
Graduated from junior high school	10	13	13	15	19	10	80	35.0%	± 7.3%
Graduated from senior high school	21	14	15	11	13	12	86	37.7%	± 7.1%
Graduated from university	2	4	2	4	0	0	12	5.3%	± 3.9%
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 10: All primary caregivers education level

Table 10 shows that 78% of primary caregivers' highest education was junior high school or higher.

Primary caregivers' occupations	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Housewife	38	37	36	38	38	38	225	98.7%	± 1.5%
Farmer	10	24	6	2	2	0	44	19.3%	± 4.3%
Food vendor	1	2	2	0	2	2	9	3.9%	± 2.1%
Labour farming	3	6	13	1	1	1	25	11.0%	± 4.0%
Teacher	0	1	1	1	0	0	3	1.3%	± 2.1%
Civil Servant	0	0	0	1	0	0	1	0.4%	± 1.8%
Small business	5	1	5	2	0	2	15	6.6%	± 3.7%
Others	0	1	0	1	2	5	9	3.9%	± 2.3%

Table 11: Primary caregivers occupations

Biological mothers group	Number of PC Occupations			Total
	1	2	3	

Younger Mothers group	79	32	3	114
Older Mothers group	58	47	9	114
TOTAL	137	79	12	228

Table 12: Primary caregivers number of occupations

Table 11 shows that 98.7% ±1.5% primary caregivers are housewife, but they also have other roles. Table 12 shows that most of the primary caregivers who are biological mothers in younger mothers group have fewer roles.

b. Father's age and highest education completed

Fathers Age groups	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
≤ 18 years old	1	0	0	2	0	0	3	1.3%	± 2.6%
19 - 24 years old	8	7	10	6	2	8	41	18.0%	± 5.6%
25 - 30 years old	7	8	11	7	14	9	56	24.6%	± 6.3%
31 - 36 years old	11	14	7	8	8	13	61	26.8%	± 6.2%
37 - 42 years old	5	3	6	5	10	5	34	14.9%	± 5.4%
43 - 48 years old	2	6	3	5	1	2	19	8.3%	± 4.5%
49 - 54 years old	4	0	1	3	2	0	10	4.4%	± 3.7%
55 - 60 years old	0	0	0	1	0	0	1	0.4%	± 1.8%
Dont know	0	0	0	1	1	1	3	1.3%	± 2.0%
TOTAL	38	38	38	38	38	38	228	100.0 %	

Table 13: Fathers' age groups

Table 13 shows that 51.4% of fathers are between 25 – 36 years old..

Fathers' Education Level	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Did not go to school	0	0	1	0	0	0	1	0.4%	± 1.1%
Elementary school but did not finish	1	4	3	4	5	4	21	9.2%	± 4.5%
Graduated from elementary school	6	5	4	6	8	8	37	16.2%	± 5.4%
Graduated from junior high school	10	11	11	12	15	13	72	31.6%	± 7.0%
Graduated from senior high school	17	13	13	14	9	9	75	32.9%	± 7.1%
Graduated from university	4	5	6	2	1	3	21	9.2%	± 3.9%
Dont know	0	0	0	0	0	1	1	0.4%	± 0.3%
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 14: Fathers education level

Fathers' education levels are similar to primary caregivers' education level. Table14 shows that more 73.7% of the fathers were graduated from junior high school or higher.

c. Age and gender of the children under five years old in the survey

Youngest Childs' Age Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
0-5 months	7	6	6	3	3	8	33	14.5%	± 4.6%
6 - 11 months	6	3	5	12	5	3	34	14.9%	± 6.2%
12 - 23 months	8	14	13	10	11	12	68	29.8%	± 6.8%
24 - 35 months	11	8	6	5	9	7	46	20.2%	± 5.5%
36 - 47 months	4	7	5	5	6	5	32	14.0%	± 5.1%
48 - 59 months	2	0	3	3	4	3	15	6.6%	± 4.1%
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 15: Youngest child age groups

Youngest Child Gender	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Girl	21	19	20	20	20	24	124	54.4%	± 7.5%
Boy	17	19	18	18	18	14	104	45.6%	± 7.5%
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 16: Youngest child gender

Table 15 shows that 50% of the children under five years old surveyed are in the age group of 12-35 months old. The means for child age is 22.1 months old. Table 16 shows that more than half of the youngest children are girls (54.4%).

2. Child care practices

Primary Caregivers Receiving Help Taking Care Youngest Child	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger Mothers Group	17	19	17	14	17	17	101	88.6%	± 8.2%
Older Mothers group	14	15	16	12	7	12	76	66.7%	± 9.8%

Table 17: Primary caregivers who received help taking care the youngest child

Table 17 shows that Primary caregivers from younger mothers group (88.6% ±8.2%) received help for taking care the youngest children, more than the older mothers group (66.7% ±9.8%).

Number of People Who Helped Primary Caregivers Taking Care Youngest Child From Younger Mothers Group	Supervision Area						Total	%
	S B	SL	STG	PT	TG	LL		
1	3	8	10	8	11	10	50	49.5%
2	11	4	5	6	3	7	36	35.6%

Number of People Who Helped Primary Caregivers Taking Care Youngest Child From Younger Mothers Group	Supervision Area						Total	%
	S B	SL	STG	PT	TG	LL		
3	2	6	2	0	3	0	13	12.9%
4	1	1	0	0	0	0	2	2.0%
TOTAL	17	19	17	14	17	17	101	100.0%

Table 18: Number of people helping primary caregivers taking care of the youngest child from younger mothers group

Number of People Who Helped Primary Caregivers Taking Care Youngest Child From Older Mothers Group	Supervision Area						Total	%
	SB	SL	STG	PT	TG	LL		
1	6	6	12	9	5	7	45	59.2%
2	4	3	2	3	2	5	19	25.0%
3	2	3	2	0	0	0	7	9.2%
4	2	3	0	0	0	0	5	6.6%
TOTAL	14	15	16	12	7	12	76	100.0%

Table 19: Number of people helping primary caregivers taking care of the youngest child from older mothers group

Table 18 shows that all of the primary caregivers from younger mothers group received help to take care of their youngest child. Half of them received help from one person, while the rest received help from more than 1 person.

Similarly, table 19 shows that all of the primary caregivers from older mothers group received help to take care of their youngest child, with 59.2% received help from one person while the rest received help from 2-4 persons.

People Who Helps Primary Caregivers from Younger Mothers group	Supervision Area						Total	%
	SB	SL	STG	PT	TG	LL		
Grandmother	11	16	12	7	11	13	70	69.3%
Respondent's Spouse	15	13	10	9	7	7	61	60.4%
Other relatives	6	2	1	2	5	1	17	16.8%
Grandfather	2	7	3	1	1	1	15	14.8%
Older Siblings	0	0	0	1	1	2	4	4.0%
Others	1	0	0	0	1	0	2	2.0%

Table 20: People who help primary caregivers, from younger mothers group, taking care the youngest child

Table 20 shows that grandmother (69.3%) and primary caregiver's spouse (60.4%) are the two most common people to provide help in taking care of the youngest children in younger mothers group.

People Who Helps Primary Caregivers from Older Mothers group	Supervision Area						Total	%
	SB	SL	STG	PT	TG	LL		

Respondent's Spouse	12	12	10	6	4	7	51	67.1%
Grand mother	5	11	6	6	4	5	37	48.7%
Other relatives	4	5	1	2	1	2	15	19.7%
Grand father	4	5	3	0	0	0	12	15.8%
Older Siblings	2	0	0	1	0	2	5	6.6%
Others	1	0	2	0	0	1	4	5.3%

Table 21: People who help primary caregivers, from older mothers group, taking care the youngest child

Table 21 shows similar situation in older mothers group, that respondent's spouse (67.1%) and grandmother (48.7%) are the two common people to provide help in taking care the youngest children.

Frequency of Youngest Child Brought to Posyandu (Integrated Service Post)	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Always	17	16	18	19	19	16	105	92.1%	± 3.2%
Sometimes	2	2	1	0	0	1	6	5.3%	± 3.0%
Never	0	1	0	0	0	2	3	2.6%	± 1.1%
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 22: Frequency of youngest child brought to Posyandu (Integrated Service Post) among younger mothers group

Frequency of Youngest Child Brought to Posyandu (Integrated Service Post)	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Always	17	19	19	16	19	19	109	95.6%	± 6.1%
Sometimes	2	0	0	2	0	0	4	3.5%	± 5.2%
Never	0	0	0	1	0	0	1	0.9%	± 3.6%
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 23: Frequency of youngest child brought to Posyandu (Integrated Service Post) among older mothers group

Table 22 and 23 shows that almost all of the youngest children surveyed were consistently brought to the Posyandu, both in the younger mothers group (92.1% ±3.2%) and the older mothers group (95.6% ±6.1%).

Youngest Child Ever Received Immunization	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger Mothers Group	18	18	18	19	19	14	106	93.0%	± 2.8%

Older Mothers Group	19	19	19	19	19	17	112	98.2%	± 0.8%
----------------------------	----	----	----	----	----	----	-----	-------	--------

Table 24: Youngest child ever received immunization

Table 24 shows that almost all youngest child had ever received immunization, both in the younger mothers group (93.0% ±2.8%) and the older mothers group (98.2% ±0.8%). At baseline, the results for this indicators⁷ were 97.4% ±4.3% for the younger mothers group and 98.2% ±1.0% for the older mothers group. Since the confidence intervals are overlapping, the situation at endline remains essentially the same as at baseline.

All children age ≥ 12 months old	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Received deworming medication in the last 6 months	25	25	22	21	26	23	142	88.2%	± 5.7%
Did not received deworming medication	0	4	4	2	4	3	17	10.6%	
Don't Know	0	0	1	0	0	1	2	1.2%	
TOTAL	25	29	27	23	30	27	161	100.0%	

Table 25: youngest child > 11 months old received deworming medication

Table 25 shows that a large portion (88.2% ±5.7%) of the youngest children ≥ 12 months old received deworming medication in the last 6 months. Baseline results for this indicator⁸ was 83.0% ±6.4%. Since the confidence intervals overlap, the situation at endline remains essentially the same as at baseline.

GMP Card Ownership For Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Yes, shown to enumerator	12	13	16	18	18	15	92	80.7%	± 6.2%
Yes, not shown	6	6	3	1	1	3	20	17.5%	
Don't have	1	0	0	0	0	1	2	1.8%	
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 26: GMP card ownership of youngest child for younger mothers group

GMP Card Ownership For Older	Supervision Area						Total	%	95% confidence
------------------------------	------------------	--	--	--	--	--	-------	---	----------------

⁷ Baseline report, page 45

⁸ Baseline report, page 45-46

Mothers Group	SB	SL	STG	PT	TG	LL			limit
Yes, shown to enumerator	14	14	16	18	18	15	95	83.3%	± 6.1%
Yes, not shown	5	5	3	1	1	4	19	16.7%	
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 27: GMP card ownership of youngest child for older mothers group

Table 26 and 27 shows a high percentage of respondents who were able to show the growth monitoring card in the younger mothers group (80.7% ±6.2%) and the older mothers group (83.3% ±6.1%). At Baseline, the results for this indicator⁹ were 84.2% ±8.1% for the younger mothers group and 83.3% ±5.6% for the older mothers group. Since the confidence intervals overlap, the situation at endline remains essentially the same as at baseline.

Youngest Child Brought to Posyandu in The Last 3 Months	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Yes	25	27	32	35	36	30	185	98.9%	± 2.1%
No	1	0	0	1	0	0	2		
TOTAL	26	27	32	36	36	30	187	100.0%	

Table 28: Youngest child brought to Posyandu (Integrated Service Post) in the last 3 months, based on card shown

Table 28 shows that almost all youngest children were brought to Posyandu, based on card (98.9% ± 2.1%), within the last 3 months. Baseline result for this indicator¹⁰ is 96.2% ± 2.3%. Since the confidence intervals overlap, the situation at endline remains essentially the same as at baseline.

3. Parent & child interaction

Brigance score = 18	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger mothers group	1	0	0	0	0	0	1	0.9%	± 1.3%
Older mothers group	2	3	0	1	0	0	6	5.3%	± 4.2%

Table 29: Brigance maximum score (18)

Brigance tool was used to measure the interaction between caregiver and the child, consisting of 18 statements. Table 29 shows that only a few primary caregivers have highest score (18 points) for Brigance in both younger mothers group (0.9% ±1.3%) and older mothers group (5.3% ±4.2%). Baseline results for this indicator¹¹ are 1.7% ±1.8% for younger mothers group and 1.7% ± 4.9% for older mothers group. Since the

⁹Baseline report, page 47

¹⁰ Baseline report page, 48

¹¹Baseline report, page 49-50

confidence intervals are intersecting each other, it can be concluded the situation for Brigance maximum score at endline remains essentially the same as at Baseline.

No	Younger Mothers Group	Baseline		Endline	
	Brigance questions	%	95% confidence limit	%	95% confidence limit
1	I play with my child and show him or her things about toys.	83.3%	± 7.5%	75.4%	± 8.9%
2	I hug and kiss my child.	99.1%	± 0.6%	93.0%	± 5.3%
3	I mostly talk to my child when he is crying.	79.8%	± 8.9%	67.5%	± 9.7%
4	I help my child learn by talking and showing him or her new things	82.5%	± 9.1%	69.3%	± 8.9%
5	I look at or read children’s books to my child.	24.6%	± 9.1%	20.2%	± 9.1%
6	My child does not calm down or seem very interested when I talk to him (correct=not very true)	87.7%	± 6.4%	84.2%	± 7.4%
7	I make up games or songs for my child.	61.4%	± 10.2%	60.5%	± 10.3%
8	When my child looks at or touches a toy, I talk to him about the toy	57.0%	± 10.6%	57.0%	± 10.2%
9	When my child is looking at me, I talk or make sounds with him.	71.9%	± 9.5%	70.2%	± 9.8%
10	My child doesn’t seem to like me. (correct=not very true)	93.0%	± 4.3%	94.7%	± 4.9%
11	I enjoy feeding my child or eating with him.	87.7%	± 7.3%	89.5%	± 6.4%
12	I talk to my child in a special way.	75.4%	± 8.7%	65.8%	± 10.3%
13	My child is not very much fun to be with. (correct=not very true)	66.7%	± 8.5%	83.3%	± 8.3%
14	I can make my child feel better when he or she is upset.	80.7%	± 9.1%	79.8%	± 8.9%
15	When my child looks at or touches something, the first thing I say is “no”. (correct=not very true)	36.8%	± 9.6%	46.5%	± 10.1%
16	Most of the time I like my child.	94.7%	± 2.9%	96.5%	± 5.2%
17	My child does not need my help learning new things (correct=not very true)	53.5%	± 10.5%	64.0%	± 9.9%
18	I talk with my child when feeding or eating with him or her.	66.7%	± 10.2%	78.1%	± 8.3%

Table 30: Details of Brigance results comparisons in younger mothers group

No	Older Mothers Group	Baseline		Endline	
	Brigance questions	%	95% confidence limit	%	95% confidence limit
1	I play with my child and show him or her things about toys.	89.5%	± 5.3%	81.6%	± 7.9%
2	I hug and kiss my child.	95.6%	± 3.1%	99.1%	± 2.1%
3	I mostly talk to my child when he is crying.	76.3%	± 9.1%	64.9%	± 9.2%
4	I help my child learn by talking and showing him or her new things	86.8%	± 8.4%	71.9%	± 9.2%
5	I look at or read children’s books to my child.	28.1%	± 9.5%	23.7%	± 9.2%
6	My child does not calm down or seem very interested when I talk to him (correct=not very true)	88.6%	± 4.9%	91.2%	± 7.0%
7	I make up games or songs for my child.	74.6%	± 9.3%	64.9%	± 10.2%
8	When my child looks at or touches a toy, I talk to him about the toy	64.9%	± 10.3%	64.0%	± 10.2%
9	When my child is looking at me, I talk or make sounds with him.	74.6%	± 8.5%	74.6%	± 9.4%
10	My child doesn’t seem to like me. (correct=not very true)	97.4%	± 2.7%	97.4%	± 4.0%
11	I enjoy feeding my child or eating with him.	96.5%	± 5.4%	94.7%	± 5.7%
12	I talk to my child in a special way.	77.2%	± 6.9%	64.0%	± 9.7%
13	My child is not very much fun to be with. (correct=not very true)	62.3%	± 7.8%	87.7%	± 6.7%
14	I can make my child feel better when he or she is upset.	88.6%	± 7.7%	89.5%	± 6.5%
15	When my child looks at or touches something, the first thing I say is “no”. (correct=not very true)	37.7%	± 10.0%	41.2%	± 10.4%
16	Most of the time I like my child.	97.4%	± 4.0%	98.3%	± 1.4%
17	My child does not need my help learning new things (correct=not very true)	53.5%	± 10.5%	60.5%	± 9.8%
18	I talk with my child when feeding or eating with him or her.	75.4%	± 9.7%	83.3%	± 9.2%

Table 31: Details of Brigance results comparisons in older mothers group

Table 30 and 31 shows more details of Brigance score. It can be seen that Brigance statement number 5 (I look at or read children’s books to my child) has the lowest score for both younger and older mothers group.

The comparisons of each Brigance statement between baseline and endline, in both younger and older mothers groups, show no change, except for one question in older mothers group. Table 31 shows a change in Brigance statement number 13 (My child

is not very much fun to be with) for older mothers group. As described above, this statement uses a negative phrase, so the calculated result is “percentage of primary caregivers who think their youngest child is very much fun to be with”.

Baseline result¹² for this statement for older mothers group is 62.3% ±7.8% (54.5 – 70.1%), while the result for endline is 87.7% ±6.7% (81.0 – 94.4%). **Confidence intervals from baseline and endline results is not overlap, thus the difference in score for Brigance question number 13 among the older mothers group is statistically significant.**

Table 30 also shows that comparison of Brigance statement number 13 for younger mothers group is barely intersecting each other. Confidence intervals from baseline (58.2% - 75.2%) and endline (75.0% - 91.6%) results are overlapping, thus the difference is not statistically significant.

Primary caregivers who gave toys to youngest child	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger Mothers Group	17	18	18	17	18	14	102	89.5%	± 6.1%
Older Mothers Group	19	19	16	17	17	15	103	90.4%	± 6.5%

Table 32: Primary caregivers who gave toys to youngest child

Table 32 shows that 89.5% ±5.1% of primary caregivers from younger mothers group and 90.4% ±6.5% from older mothers group gave toys to the youngest child. These results are similar to the Baseline data¹³, which is 89.5% ±6.0% for younger biological mothers group and 90.3% ±5.4% for older mothers group. Confidence intervals from baseline and endline results are overlapping, thus the difference is not statistically significant.

Younger Mothers group Primary caregivers who think the youngest child have safe and clean space to play	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Really safe and clean place	4	2	1	2	8	3	20	17.5%	± 7.1%
Enough safe and clean	14	17	17	17	10	15	90	78.9%	± 7.5%
Not safe and clean	1	0	1	0	0	0	2	1.8%	± 2.4%
Don't know	0	0	0	0	1	1	2	1.8%	± 1.8%
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 33: Primary caregivers from younger mothers group, who think youngest child place to play have safe and clean place to play

¹²Calculated from Baseline raw data

¹³Baseline report, page 50 – 51

Older Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Primary caregivers who think the youngest child have safe and clean space to play									
Really safe and clean place	2	2	5	2	9	1	21	18.4%	± 7.8%
Enough safe and clean	17	17	14	17	10	18	93	81.6%	± 7.8%
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 34: Primary caregivers older mothers group, who think youngest child place to play have safe and clean place to play

Table 33 shows that 17.5% ±7.1% of primary caregivers from younger mothers group think that the youngest child has a safe and clean place to play. During baseline, the result was 18.4% ±8.6%¹⁴. Since the confidence intervals are overlapping, it is concluded that there is no change in endline result compared to baseline.

Table 34 shows that 18.4% ±7.8% of primary caregivers from biological mothers aged 28 yo think that the youngest child has a safe and clean space to play. During baseline, the result was 29.0% ±9.5%¹⁵. Confidence intervals from baseline and endline results overlap, thus the difference is not statistically significant.

4. Nutrition practices

a. Youngest child ever breastfed

Youngest child ever breastfed	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger Mothers Group	19	19	19	19	19	18	113	99.1%	± 0.6%
Older Mothers Group	17	19	19	18	19	16	108	94.7%	± 4.1%

Table 35: Youngest child who ever breastfed

Table 35 shows that 99.1% ±0.6% of youngest child from younger mothers group were ever breastfed, and 94.7% ±4.1% from older mothers group. Baseline results¹⁶ show that 97.4% ±2.2% youngest child from biological mothers aged 24 yo group and 95.6% ±3.0% from older mothers group were ever breastfed. Confidence intervals from baseline and endline results are overlapping, thus the difference is not statistically significant.

b. Types of food given to the youngest child within the first 3 days after birth

¹⁴ Baseline report, page 51 – 52

¹⁵ Baseline report, page 51 – 52

¹⁶ Baseline report, page 52 – 53

Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Types of food given to youngest child during her/his first 3 days									
Breastmilk only	18	15	19	11	13	9	85	74.6%	± 9.0%
Breastmilk	19	17	19	14	17	12	98	86.0%	± 7.6%
Infant formula	1	3	0	8	5	9	26	22.8%	± 8.9%
Honey	0	1	0	0	0	0	1	0.9%	± 0.7%
Other (sugar solution, dates/kurma)	0	0	0	0	1	1	2	1.8%	± 1.8%

Table 36: Food given to youngest child during the first 3 days from younger mothers group

Table 36 shows that 74.6% ±9.0% of youngest child received only breast milk in the first 3 days and 86.0% ±7.6% received breast milk along with other prelacteal feeds in their first 3 days from younger mothers group. Baseline results¹⁷ shows that 60.5% ±10.2% of youngest child received only breast milk and 86.0 ±6.6% received breast milk along with other prelacteal feeds from biological mothers aged ≤24 yo group. Confidence intervals from baseline and endline results overlap, thus the difference is not statistically significant.

Older Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Types of food given to youngest child during her/his first 3 days									
Breast milk only	16	18	12	16	15	1	95	83.3%	± 8.8%
Breast milk	17	19	16	16	18	1	105	92.1%	± 6.8%
Infant Formula	3	1	1	6	3	3	17	14.9%	± 8.6%
Honey	0	0	0	0	0	1	1	0.9%	± 0.6%
Other (soft coconut)	0	0	0	1	0	0	1	0.9%	± 3.6%

Table 37: Food given to youngest child during the first 3 days from older mothers group

Table 37 shows that 83.3% ±8.8% of youngest child received breast milk only in the first 3 days and 92.1% ±6.8% received breast milk along with others in their first 3 days, from older mothers group. Baseline shows¹⁸ that 72.8% 8.7% of youngest child received breast milk only and 88.6% 4.7% received breast milk along with others, from older mothers group. Confidence intervals from baseline and endline results overlap, thus the difference is not statistically significant.

¹⁷ Baseline report, page 53 – 54

¹⁸ Baseline report, page 53 – 54

c. Youngest child who already received solid food

Youngest Child Who Already Received Solid Food	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger Mothers Group	17	15	17	19	17	17	102	89.5%	± 4.4%
Older Mothers Group	15	17	16	17	18	14	97	85.1%	± 6.8%

Table 38: Youngest child who already received solid food

Table 38 shows that 102 (89.5% ±4.4%) youngest child from younger mothers group and 97 (85.1% ±6.8%) youngest child from older mothers group already received solid food. During Baseline¹⁹, 92.1% ±5.4% youngest child from younger mothers group and 91.2% ±5.4% for youngest child from older mothers group already received solid food. As it can be seen, the confidence intervals for baseline and endline are still intersecting each other for both younger and older mothers group. Thus, the situation between baseline and endline did not change.

d. Age when youngest child received solid food for the first time

Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Youngest child age when s/he received solid food for the first time									
< 6 months old	1	5	3	9	8	12	38	37.3%	± 10.1%
≥ 6 months old	16	10	14	10	9	5	64	62.7%	± 10.1%
TOTAL	17	15	17	19	17	17	102	100.0%	

Table 39: Age when youngest child when s/he first received solid food from younger mothers group

Table 39 shows that 62.7% ±10.1% of youngest child already received solid food after they were 6 months old, from younger mothers group. The baseline result²⁰ show that 59.0% ±10.6% of youngest child already received solid food after they reached 6 months old. Confidence intervals from baseline and endline results overlap, thus the difference is not statistically significant.

Older Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Youngest child age when s/he received solid food for the first time									
< 6 months old	2	0	0	6	2	2	12	12.4%	± 8.8%
≥ 6 months old	13	17	16	11	16	12	85	87.6%	± 8.8%
TOTAL	15	17	16	17	18	14	97	100.0%	

Table 40: Age when youngest child when s/he first received solid food from older mothers group

¹⁹ Baseline report, page 55

²⁰ Baseline report, page 55

Table 40 shows that 87.6% \pm 8.8% of youngest child already received solid food after they were 6 months old, from older mothers group. The baseline result²¹ show 72.1% \pm 10.1% of youngest child from older mothers group already received solid food after they reached 6 months old. Confidence intervals from baseline and endline results overlap, thus the difference is not statistically significant.

e. Youngest child who meets the Minimum Dietary Diversity (MDD)

Youngest child \geq 6 months old, who received \geq 5 food groups	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Yes	26	29	29	28	27	25	164	84.1%	\pm 6.0%
No	5	3	3	7	8	5	31	15.9%	\pm 6.0%
TOTAL	31	32	32	35	35	30	195	100.0%	

Table 41: Youngest child who received at least 5 food groups 24 hours prior to survey

Table 41

shows that 84.1% \pm 6.0% of youngest child who is \geq 6 months old, who received at least 5 food groups 24 hours prior to survey. Baseline result²² is 72.6% \pm 6.5% for the same indicator. Comparison between the endline confidence interval (78.1 – 90.1%) and baseline confidence interval (66.1 – 79.1%), shows that the confidence intervals are still overlapping. Thus, the difference is not statistically significant.

No	Food group	BL	95% confidence limit	EL	95% confidence limit
1	Breastmilk	50.0%	\pm 8.0%	47.1%	\pm 7.8%
2	Grains, roots, and tubers	96.0%	\pm 2.5%	96.9%	\pm 4.0%
3	Legumes and nuts	60.9%	\pm 7.5%	77.9%	\pm 6.5%
4	Dairy products (milk, yoghurt, cheese)	23.8%	\pm 7.0%	30.3%	\pm 6.5%
5	Flesh foods (meat, fish, poultry, liver/organ meats, insects, reptiles)	61.9%	\pm 7.7%	72.3%	\pm 7.3%
6	Eggs	79.7%	\pm 6.1%	76.4%	\pm 7.1%
7	Vitamin A-rich fruits and vegetables	77.7%	\pm 5.7%	84.1%	\pm 5.4%
8	Other fruits and vegetables	74.8%	\pm 7.0%	86.7%	\pm 5.9%

Table 42: Detail comparisons of food group for youngest children \geq 6 months old during Endline and Baseline

²¹ Baseline report, page 55

²² Baseline report, page 56

Table 42 shows that dairy products (milk, yoghurt, cheese) have the lowest percentage during baseline and endline. Only 30.3% \pm 6.5% of the youngest child received dairy products in the last 24 hours prior to endline survey.

Table 42 also shows that the percentage of youngest child \geq 6 months old who received legumes and nuts is increased during endline (77.9% \pm 6.5%) compared to baseline²³ (60.9% \pm 7.5%). **The confidence intervals do not overlap. Thus, the difference between consumption of legumes and nuts at endline compared to baseline is statistically significant.**

The denominator for this indicator is the number of the youngest child \geq 6 months old. Since the denominator became smaller after selecting only the children \geq 6 months old, the two mothers groups result had to be combined. Thus, the results cannot be differentiated between younger and older mothers groups.

f. Youngest child who received ultra processed food

Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Breakfast Cereals	7	7	4	5	9	8	40	35.1%	\pm 9.6%
Instant Package	6	3	8	2	8	4	31	27.2%	\pm 8.4%
Sweetened Bread	11	5	6	6	4	4	36	31.6%	\pm 9.8%
Chips	6	6	9	6	11	5	43	37.7%	\pm 10.1%
Sugared Milk	3	3	4	1	2	0	13	11.4%	\pm 6.2%
Prepared Meat	8	3	4	4	2	3	24	21.1%	\pm 8.6%
Bread Cereals	8	2	6	5	8	4	33	28.9%	\pm 9.7%
Cookies	7	3	5	6	3	5	29	25.4%	\pm 9.5%
Sauces	2	2	6	1	2	0	13	11.4%	\pm 6.4%
Ice Cream	8	6	8	6	10	4	42	36.8%	\pm 10.2%
Infant Formula	7	5	8	7	3	3	33	28.9%	\pm 10.0%
Did Not Consume	3	5	3	2	4	4	21	18.4%	\pm 7.3%

Table 43: Youngest child who received ultra processed food from younger mothers group

Table 43 shows that 18.4% \pm 7.3% of youngest children from younger mothers group did not receive any ultra processed food during endline, compared to 20.2% \pm 9.2% during baseline²⁴. The confidence intervals are intersecting each other, thus there is no change during endline compared to baseline.

²³ Calculated from baseline raw data

²⁴ Baseline report, page 57 – 58

Older Mothers Group Types of Ultra Processed Food Consumed	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Breakfast Cereals	9	9	3	6	7	5	39	34.2%	± 9.7%
Instant Packaged	5	4	3	5	7	2	26	22.8%	± 9.2%
Sweetened Bread	7	13	5	7	11	5	48	42.1%	± 10.1%
Chips	10	9	8	7	11	8	53	46.5%	± 10.4%
Sugared Milk	1	1	0	2	4	4	12	10.5%	± 6.1%
Prepared Meat	9	3	4	4	7	4	31	27.2%	± 9.1%
Bread Cereals	9	5	1	4	10	7	36	31.6%	± 8.6%
Cookies	6	8	5	3	5	5	32	28.1%	± 8.6%
Sauces	5	3	0	1	1	0	10	8.8%	± 4.9%
Ice Cream	11	11	4	9	7	4	46	40.4%	± 10.2%
Margarines	0	1	0	0	1	0	2	1.8%	± 1.9%
Infant Formula	10	2	5	4	7	3	31	27.2%	± 9.2%
Did Not Consume	4	4	5	3	1	5	22	19.3%	± 7.9%

Table 44: Youngest child who received ultra processed food from older mothers group

Table 44 shows that 19.3% ±7.9% of youngest child from older mothers group did not consume any ultra processed food, compared to 19.3% ±8.5% during baseline.²⁵ Confidence intervals from baseline and endline results overlap, thus the difference is not statistically significant.

5. Parental perceived barriers to give healthy food for the children

The results of parental perceived barriers are divided into several groups:

- a. Child related barriers (questions number 1 – 5)
- b. Parent related barriers – vegetables and fruits (questions number 6 – 11)
- c. Parent related barriers – added sugar (question number 12)
- d. Social context related barriers (question number 13)
- e. Cost related barriers (question number 14 – 15)

These results could explain possible barriers related to youngest child eating behaviour.

No	Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
		SB	SL	STG	PT	TG	LL			
1	My child does not like to try new vegetables	3	0	7	1	1	3	15	13.2%	± 6.4
2	Getting my child to eat vegetables	4	1	5	4	2	2	18	15.8%	± 8.5

²⁵ Baseline report, page 57 – 58

No	Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
		SB	SL	STG	PT	TG	LL			
	at meals is difficult									
3	My child doesn't like the taste of vegetables	3	1	3	2	0	1	10	8.8%	± 6.4
4	My child is a picky eater	5	3	6	4	2	2	22	19.3%	± 8.7
5	The child does not like to try new fruits	1	1	4	3	0	2	11	9.6%	± 7.2
6	I don't like fruits myself	0	0	0	0	0	0	0	0%	
7	I don't know how to cook vegetables	0	0	0	0	0	0	0	0%	
8	I don't like vegetables myself	0	0	0	1	0	1	2	1.8%	± 3.6
9	It is difficult to find recipes for vegetables	0	0	1	0	0	0	1	0.9%	± 2.1
10	Preparing the fruit to eat (peeling, cutting) is much work	2	0	0	0	1	0	3	2.6%	± 2.5
11	Preparing vegetables the child likes takes much time	0	2	2	0	1	1	6	5.3%	± 3.5
12	I like to make the child happy by buying him a cake, candy, or a treat when we go out	5	8	8	9	11	6	47	41.2%	± 10.5
13	Grandparents, other family members, or friends often offer you cakes, sweets, or treats.	11	12	14	9	7	6	59	51.8%	± 10.4
14	Fruit is expensive	11	6	9	8	7	6	47	41.2%	± 10.5
15	Vegetables are expensive	1	0	0	1	2	3	7	6.1%	± 4.6

Table 45: Parental perceived barriers for biological mothers aged ≤ 24 yo group

No	Older Mothers Group	Supervision Area						Total	%	95% confidence limit
		SB	SL	STG	PT	TG	LL			
1	My child does not like to try new vegetables	1	3	2	2	0	0	8	7.0%	± 5.9
2	Getting my child to eat vegetables at meals is difficult	2	2	3	2	1	2	12	10.5%	± 6.6
3	My child doesn't like the taste of vegetables	2	2	2	1	1	0	8	7.0%	± 5.3
4	My child is a picky eater	5	5	5	1	1	1	18	15.8%	± 6.4

No	Older Mothers Group	Supervision Area						Total	%	95% confidence limit
		SB	SL	STG	PT	TG	LL			
5	The child does not like to try new fruits	1	1	1	2	0	0	5	4.4%	± 5.5
6	I don't like fruits myself	0	0	1	0	3	3	7	6.1%	± 3.7
7	I don't know how to cook vegetables	0	0	0	0	0	1	1	0.9%	± 0.6
8	I don't like vegetables myself	0	0	0	0	0	2	2	1.8%	± 0.8
9	It is difficult to find recipes for vegetables	0	0	0	0	0	3	3	2.6%	± 1.0
10	Preparing the fruit to eat (peeling, cutting) is much work	0	0	0	0	1	1	2	1.8%	± 1.8
11	Preparing vegetables the child likes takes much time	0	0	0	0	2	1	3	2.6%	± 2.5
12	I like to make the child happy by buying him a cake, candy, or a treat when we go out	6	10	9	8	10	7	50	43.9%	± 10.5
13	Grandparents, other family members, or friends often offer you cakes, sweets, or treats.	10	11	12	9	6	6	54	47.4%	± 10.5
14	Fruit is expensive	6	6	7	6	8	6	39	34.2%	± 10.1
15	Vegetables are expensive	0	0	0	1	1	3	5	4.4%	± 4.1

Table 46: Parental perceived barriers for biological mothers aged ≥ 28 yo group

Table 45 and 46 show that there are child-related barriers, although the percentage is not high but these barriers play some roles in affecting the MDD achievements in table 41 and 42. Primary caregivers' skills play a big role on how to deal with situation when their youngest child is a picky eater, or does not like the food taste, and these skills are recommended to be included in the crash course of parenting classes.

Table 45 and 46 show that primary caregivers are also part of the barriers, such as some primary caregivers who do not like vegetables, or lacking skills to cook vegetables as the youngest child like, or having difficulties to find recipes. Cooking skills and various recipes included in the crash course on parenting might help to reduce these barriers.

Based on table 45 and 46, reducing ultra processed food given to youngest child would be more difficult since the primary caregivers and family members often gave such

food to youngest child to make the child happy. Education to family members might help to reduce the barriers, but skills to handle the youngest child should help them more to make the youngest child happy without providing ultra processed food.

Table 45 and 46 show that a big portion of primary caregivers considered fruits to be expensive, while vegetables are more affordable.

In summary, the parental perceived barriers include:

- a. Low percentages of child-related barriers in both younger and older mothers' group.
- b. Low percentages of parent-related barriers related to vegetables and fruits in both groups.
- c. Relatively high percentages of parent-related barriers concerning added sugar in both groups.
- d. Relatively high percentages of social context-related barriers in both groups.
- e. Cost-related barriers, particularly for fruits, reported by both groups.

These barriers should be considered for the future behaviour change activities.

6. Nutrition measurements

Youngest Child ≥ 6 Months Old	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Yes	31	32	32	35	35	30	195	85.5%	± 4.6%
No	7	6	6	3	3	8	33	14.5%	
TOTAL	38	38	38	38	38	38	228	100.0%	

Table 47: Youngest children who are ≥ 6 months old from both younger and older mothers groups

MUAC Status For Youngest Child ≥ 6 Months Old	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Moderate Acute Malnutrition	3	1	0	1	0	1	6	3.1%	2.4%
Normal Nutritional status	28	31	32	34	35	29	189	96.9%	2.4%
TOTAL	31	32	32	35	35	30	195	100.0%	

Table 48: MUAC status for youngest children 6 months old

Table 47 shows the number of youngest children who were measured during survey, while table 48 shows the nutritional status of children based on their MUAC measurements. As many as 3.1% ±2.4% of youngest children are in Moderate Acute Malnutrition (MAM) status, while 96.9% ±2.4% are in Normal Nutritional status. No child was found to be in Severe Acute Malnutrition (SAM) status.

During baseline²⁶ there were 2.5% \pm 3.7% youngest children who are in Moderate Acute Malnutrition (MAM) status, so, the confidence intervals between endline and baseline overlap. Thus, it is concluded that the difference between endline and baseline of youngest children nutritional status measured using MUAC is not statistically significant.

7. Learning on child caring and feeding practices

a. Past learning sources

Younger Mothers Group Learning Sources	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Family	11	8	7	16	16	14	72	63.2%	\pm 8.6%
Social Media	15	16	11	8	7	10	67	58.8%	\pm 10.3%
Community Health Worker	15	11	10	1	5	3	45	39.5%	\pm 7.4%
Health workers	13	9	8	1	7	2	40	35.1%	\pm 7.7%
Elders	6	7	8	2	1	2	26	22.8%	\pm 7.7%
Neighbours	1	4	6	1	2	0	14	12.3%	\pm 6.4%
Others	0	0	1	3	0	1	5	4.4%	\pm 6.2%
Comm events	3	0	0	0	0	0	3	2.6%	\pm 2.1%
Dont know	0	1	1	0	0	1	3	2.6%	\pm 2.3%

Table 49: Learning sources for primary caregivers from younger mothers group

Table 49 shows that the most important learning source for primary caregivers from younger mothers group is the family (63.2% \pm 8.6%). Social media is also being used extensively (58.8% \pm 10.3%). The baseline²⁷ also showed family is the main source (52.6% \pm 9.9%), followed by social media (47.4% \pm 10.1%). Thus, the situation is not changing during endline compared to baseline.

Older Mothers Group Learning Sources	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Community Health Worker	19	17	15	7	8	4	70	61.4%	\pm 9.5%
Health workers	19	14	13	3	7	4	60	52.6%	\pm 8.4%
Social Media	12	12	13	2	9	3	51	44.7%	\pm 8.3%
Family	7	7	6	10	10	10	50	43.9%	\pm 10.5%
Elders	6	6	6	2	4	2	26	22.8%	\pm 7.9%
Community events	2	5	3	1	0	0	11	9.6%	\pm 5.4%
Neighbours	1	4	4	0	1	0	10	8.8%	\pm 4.6%

²⁶ Baseline report, page 59

²⁷ Baseline report, page 61 – 62

Older Mothers Group	Supervision Area						Total	%	95% confidence limit
Learning Sources	SB	SL	STG	PT	TG	LL			
Others	1	2	1	1	3	6	14	12.3%	± 5.4%

Table 50: Learning sources for primary caregivers from older Mothers group

Table 50 shows that for primary caregivers from older mothers group the main learning source are Community Health Workers or Posyandu cadres (61.4% ±9.5%) and health workers (52.6% ±8.4%). The next important learning sources are social media (44.7% ±8.3%) and family (43.9% ±10.5%) as learning sources.

b. Trusted people for advices

Baseline²⁸ result shows that Community Health Workers (45.6% ±10.6%) and health workers (44.7% ±10.3%) are the main learning sources for primary caregivers from biological mothers aged ≥28 yo group, followed by family (36.0% ±10.0%) and social media (32.5% ±10.2%). Table 49 and 50 show that there are differences for learning sources for different groups of primary caregivers, but the situation is still the same between endline and baseline.

Younger Mothers Group	Supervision Area						Total	%	95% confidence limit
People Whom the Primary Caregivers Asked for Advice on Child Caring and Feeding	SB	SL	STG	PT	TG	LL			
Family	18	17	18	18	19	15	105	92.1%	± 4.6%
Neighbours	13	7	7	4	8	3	42	36.8%	± 9.4%
Community Health Workers	11	8	10	2	3	1	35	30.7%	± 8.1%
Health workers	8	5	6	2	7	3	31	27.2%	± 8.3%
Friends	6	3	4	2	2	0	17	14.9%	± 7.3%
No one	0	1	0	1	0	3	5	4.4%	± 3.8%
Others	0	1	1	1	1	2	6	5.3%	± 4.6%

Table 51: Primary caregivers from younger mothers group seek for advice on child caring and feeding

Older Mothers Group	Supervision Area						Total	%	95% confidence limit
People Whom the Primary Caregivers Asked for Advice on Child Caring and Feeding	SB	SL	STG	PT	TG	LL			
Family	14	13	13	13	15	14	82	71.9%	± 9.7%
Community Health Workers	16	10	12	7	6	5	56	49.1%	± 10.1%
Health workers	12	8	7	6	8	3	44	38.6%	± 10.1%
Neighbours	11	10	8	6	4	2	41	36.0%	± 9.9%

²⁸ Baseline report, page 61 – 62

Older Mothers Group People Whom the Primary Caregivers Asked for Advice on Child Caring and Feeding	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Friends	5	7	5	2	1	1	21	18.4%	± 7.3%
No one	0	3	2	0	0	1	6	5.3%	± 3.2%
Others	0	0	1	0	0	0	1	0.9%	± 2.1%

Table 52: Primary caregivers from older mothers group seek for advice on child caring and feeding

Table 51 and 52 show that family is the most important source when primary caregivers, from both younger mothers (92.1% ±4.6%) and older mothers (71.9% ±9.7%) groups need advices on child caring and feeding. Thus, in order to change primary caregivers' behaviour in child feeding and caring, family should be included in the activities.

c. Social media usages

Use Social Media for learning child feeding & caring	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Younger Mothers Group	17	16	15	15	12	16	91	79.8%	± 8.8%
Older Mothers Group	15	14	15	8	15	14	81	71.1%	± 9.8%

Table 53: Primary caregivers from younger mothers group who used social media to learn child caring and feeding

Tables 53 shows that large portion of primary caregivers from Younger Mothers Group (79.8% ±8.8%) and Older Mothers group (71.1% ±9.8%) are using social media as a learning source for child caring and feeding.

Baseline results²⁹ show that 71.9% ±9.4% of primary caregivers from Younger Mothers Group and 51.7% ±10.6% of primary caregivers from Older Mothers Group use social media to learn about child caring and feeding. Even though the usage of social media in Older Mothers Group tends to increase, but the confidence intervals for both younger and older mothers groups still overlap, thus the difference is not statistically significant.

Primary caregivers who watch videos from Indonesian content creator to learn child caring and feeding	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			

²⁹ Baseline report, page 65

Younger Mothers Group	12	13	14	11	7	14	71	62.3%	± 10.2%
Older Mothers Group	11	13	16	5	11	11	67	58.8%	± 9.4%

Table 54: Primary caregivers from biological mothers aged ≤ 24 yo group who watch videos from Indonesian content creator to learn child caring and feeding

Indicator shown in table 54 was originally created to capture the results of “content creator” training program, provided by SBC project as part of the behaviour change activities. Nevertheless, many videos created by training participants were not yet posted online due to many reasons. So, this indicator was modified to capture videos from Indonesian content creators about child caring and feeding.

Table 54 shows that more than half of primary caregivers, from Younger (62.3% ±10.2%) and Older (58.8% ±9.4%) Mothers groups, watch videos about child caring and feeding.

All primary caregivers from Younger Mothers Group mentioned that those videos help them to provide ideas to better care and feed their children. All primary caregivers from Older Mothers Group mentioned the same situation, except one primary caregiver who mentioned that she does not know whether it is helping or not. However, almost all of the indicators of child feeding and caring behaviours are not changed between baseline and endline. Thus, the impact of watching the videos created by Indonesian content creator (not trained by SBC pilot testing project) to behaviour change is still questionable.

The similar situation was also shown in baseline results³⁰, and SBC pilot testing team believed that social media was one of the best ways for promoting behaviour change. That was the reason for the SBC pilot testing team prepared a content creator training for community, as described above in SBC program implementation section. This training was planned to improve child feeding and caring behaviours.

Unfortunately, up until endline survey, most of the videos created by the training participants were not yet posted and shared online. Thus, endline was not able to analyse the effectiveness of promoting local content creator for influencing child caring and feeding behaviour by using videos.

³⁰ Baseline report, page 65

8. SBC Project Activities Coverage

One of two main SBC project activities were the crash course class on parenting. Below is the coverage:

Younger Mothers Group Primary Caregivers Who Attended Training on Child Feeding and Caring	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Attended Crash Course on Parenting	9	8	9	9	12	12	59	51.8%	± 10.6%
Attended Training at Posyandu (Integrated Service Post)	2	3	2	0	0	0	7	6.1%	± 3.6%
Never attended training	8	8	8	10	7	7	48	42.1%	± 10.6%
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 55: Crash course class on parenting coverage for younger mothers group

Older Mothers Group Primary Caregivers Who Attended Training on Child Feeding and Caring	Supervision Area						Total	%	95% confidence limit
	SB	SL	STG	PT	TG	LL			
Attended Crash Course on Parenting	11	14	13	12	15	15	80	70.2%	± 10.0%
Attended Training at Posyandu (Integrated Service Post)	3	1	5	0	0	0	9	7.9%	± 4.7%
Attended Training from other program	0	0	0	1	0	0	1	0.9%	± 3.6%
Never attended training	5	4	1	6	4	4	24	21.0%	± 8.9%
TOTAL	19	19	19	19	19	19	114	100.0%	

Table 56: Crash course class on parenting coverage for older mothers group

Table 55 shows that only 51.8% ±10.6% primary caregivers from Younger Mothers group participated in crash course class on parenting, and 42.1% ±10.6% of them never participated in any training related to child caring and feeding.

Table 56 shows that 70.2% ±10.0% primary caregivers from Older Mothers group participated in crash course class on parenting, and 21.1% ±8.9% of them never participated in any training related to child caring and feeding.

Tables 55 and 56 are also in line with the results in table 30 and 31. Table 55 and 56 show higher coverage of crash course on parenting participation in older mothers group. While table 30 and 31 show that the percentage of primary caregivers who

think their youngest child “is very much fun to be with” in older mothers group during endline has changed compared to baseline.

Younger Mothers Group	Supervision Area						Total	%
Number of Times Primary Caregivers participating in crash course class on parenting	SB	SL	STG	PT	TG	LL		
1 time	1	0	0	2	1	1	5	8.5%
2 times	0	2	2	4	2	2	12	20.3%
3 times	7	6	7	3	7	9	39	66.1%
4 times	1	0	0	0	1	0	2	3.4%
5 times	0	0	0	0	1	0	1	1.7%
TOTAL	9	8	9	9	12	12	59	100.0%

Table 57: Number of times of primary caregivers from younger mothers group participating in crash course class on parenting

Older Mothers Group	Supervision Area						Total	%
Number of Times Primary Caregivers participating in crash course class on parenting	SB	SL	STG	PT	TG	LL		
1 time	0	2	1	0	0	0	3	3.7%
2 times	1	1	0	3	1	3	9	11.3%
3 times	10	9	11	7	13	12	62	77.5%
4 times	0	0	1	1	1	0	3	3.7%
5 times	0	0	0	1	0	0	1	1.3%
6 times	0	2	0	0	0	0	2	2.5%
TOTAL	11	14	13	12	15	15	80	100.0%

Table 58: Number of times of primary caregivers from older mothers group participating in crash course class on parenting

SBC pilot project started the crash course class on parenting by testing the prototype for the Caregivers of children 3-23 months (for under two years old children) in June 2025, and then the training of facilitator’s module was revised based on feedback received during the testing. Then, the crash course on parenting for caregivers of children 3-23 months and the caregivers of children 24-59 months (new training of facilitator module was developed in June 2025) was implemented with 3 sessions each in 6 villages.

Table 57 and 58 shows that some primary caregivers from both younger (28.8%) and older mothers (15.0%) groups, did not participate in the full 3 sessions, and some participated in both prototyping testing and the implementation phase in July –

August 2025, thus the number of sessions participated is more than 3 sessions. A large portion of the primary caregivers attended all 3 sessions for Younger Mothers (66.1%) and Older Mothers (77.5%) groups.

During the endline survey, all of primary caregivers who attended the crash course class on parenting (100%) mentioned that the classes helped them to provide child caring and feeding in their daily life.

VII. Summary

Summary of the endline results are as follow:

For Research Objective 1:

What are the different nutrition and caring practices of younger mothers (≤ 24 years old) and older mothers (≥ 28 years old) in Sembalun and Pringgabaya sub-districts, East Lombok District?

All primary caregivers are 100% female, almost all of them (96.9%) are also biological mothers. More than 60% of them are in the age groups of 19-24 years old and 31 – 36 years old. Their age ranges between 15 and 70 years old. The mean of primary caregivers' age is 28.4 years old. More than 60% of primary caregivers graduated from junior high school (35.1%) and senior high school (37.7%). Most of the primary caregivers are housewife (98.7%), but they also have other roles or occupations. Primary caregivers from younger biological mothers group tend to have fewer roles.

The proportion of biological mothers were married for the first time at 18 years old or younger is 39.9%. The age of first marriage ranges from 10 to 27 years old. More than 60% biological mothers were graduated from junior high (35.0%) and senior high (39.5%) school.

More than half of the fathers are in the age groups of 25-30 years old and 31-36 years old (26.8% \pm 6.2%), and more than half of them graduated from junior high school and senior high school.

Almost half of the youngest children are in the age groups of 12-23 months old (29.8% \pm 6.8%) and 24-35 months old (20.2% \pm 5.5%). More than half of the youngest children are girls (54.4% \pm 7.5%). Half of the children under five years old surveyed are in the age group of 12-35 months old. The mean for child age is 22.1 months old.

Research Objective 1.1: To describe the child caregiving practices of the respondent.

Primary caregivers from younger mothers group (88.6%) received help for taking care the youngest children more than older mothers group (66.7%). Grandmother and primary

caregiver's spouse are the two most common people to provide helps for taking care the youngest children.

A large percentage of respondents were able to show the growth monitoring card for younger mothers group (80.7%) and older mothers group (83.3%). Almost all youngest child ever received immunization for both younger mothers group (93.0%) and older mothers group (98.2%). 88.2% of the youngest children \geq 12 months old received deworming medication in the last 6 months.

Research Objective 1.2: To describe parent-child interaction of the respondent.

Only a few primary caregivers have maximum score (18 points) for Brigance from both younger mothers group (0.9%) and older mothers group (5.3%). In giving toys to the youngest child, 89.5% of primary caregivers from younger mothers group reported so, not too different with 90.4% of primary caregivers from older mothers group. The proportion of primary caregivers who think that the youngest child has a safe and clean place to play is 17.5% in the younger mothers group, similar to 18.4% in the older mothers group.

Research Objective 1.3: To describe nutrition practices of the respondent.

The proportion of youngest child who were ever breastfed is 99.1% in the younger mothers group and 94.7% for older mothers group.

The proportion of youngest child who received only breast milk in the first 3 days from is 74.6% in younger mothers group, and 83.3% in the older mothers group.

The proportion of youngest child who already received solid food after they are 6 months old is 62.7% in the younger mothers group, whereas it was 87.6% for older mothers group.

The proportion of youngest child who is \geq 6 months old who received at least 5 food groups in 24 hours prior to survey is 84.1% \pm 6.0%.

The proportion of youngest children who did not receive any ultra-processed food is 18.4% \pm 7.3% in the younger mothers group, whereas 19.3% \pm 7.9% of youngest child from older mothers group did not consume any ultra-processed food.

The proportion of youngest children are in Moderate Acute Malnutrition status measured using MUAC is 3.1% \pm 2.4%, while 96.9% \pm 2.4% are in normal nutritional status

Research Objective 1.4: To identify and compare caring and feeding practices among households with children under five years old born of younger mothers (≤ 24 years old) and households with children under five years old born of older mothers (≥ 28 years old)

Primary caregivers from younger mothers group (88.6%) received help for taking care the youngest children more than older mothers group (66.7%). About half of the primary caregivers from younger mothers group received help taking care the youngest child from one person (49.5%), while the rest are receiving help from more than one person. More than half of primary caregivers from older mothers group received help for taking care youngest children from one person (59.2%). Grandmother and primary caregiver's spouse are two most common people to provide helps for taking care the youngest children.

Based on mother's recall, almost all youngest children were always brought to Posyandu (Integrated Service Post), either from younger mothers group (92.1%) and older mothers group (95.6%). Almost all youngest child ever received immunization for both younger mothers group (93.0%) and older mothers group (98.2%). As many as 88.2% of the youngest children ≥ 12 months old received deworming medication in the last 6 months according to the primary caregivers.

A large percentage of respondents who were able to show the growth monitoring card, with 80.7% in the younger mothers group and 83.3% in older mothers group. The majority of the youngest children (98.9%) were brought to Posyandu (Integrated Service Post) within the last 3 months, based on card.

The proportion of youngest child already received solid food after they are 6 months old is 62.7% $\pm 10.1\%$ in younger mothers group, and 87.6% $\pm 8.8\%$ in the older mothers group.

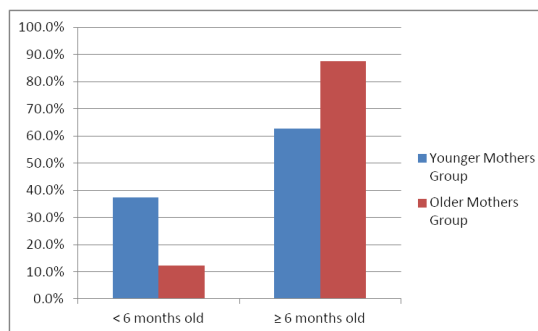


Figure 7: Age when the youngest child received solid food for the first time

Research Objective 1.5 and 1.6: To compare the caring and feeding practices among households with children under five years old born of younger mothers (≤ 24 years old) and older mothers (≥ 28 years old) at baseline versus endline in Sembalun and Pringgabaya sub-district, East Lombok District

The results of comparison of all indicators between baseline and endline show no change since all the confidence intervals still overlap. However, there are two indicators which the confidence intervals do not overlap, which shows that the difference between baseline and endline is statistically significant.

There is a change in Brigrance statement number 13 (My child is very much fun to be with) for older mothers group. Baseline result for this question is 62.3% \pm 7.8% (54.5 – 70.1%), while the result for endline is 87.7% \pm 6.7% (81.0 – 94.4%). The confidence intervals from both results are not overlapping, and therefore it is concluded that **there is a statistically significant difference for brigrance question number 13 during endline compared to baseline.**

The percentage of youngest child \geq 6 months old who received legumes and nuts increased during endline (77.9% \pm 6.5%) compared to baseline (60.9% \pm 7.5%). It can be seen that the confidence intervals are not overlapping. Thus, it is concluded that **the difference in the percentage of youngest child who received legumes and nuts during endline compared to Baseline is statistically significant.**

Research Objective 1.7: To identify proportion of children under five years old being taken care of by their own mother in Sembalun and Pringgabaya sub-district, East Lombok District

Almost all primary caregivers (96.9% \pm 2.1%) are the biological mothers.

Research Objective 1.8: To identify barriers and enablers of good dietary diversity among children under five in the 6 villages

The proportion of youngest child who is \geq 6 months old received at least 5 food groups 24 hours prior to survey for meeting the minimum dietary diversity is 84.1%.

The parental perceived barriers found during endline are:

- Low percentages of child-related barriers in both younger and older mothers' group.
- Low percentages of parent-related barriers related to vegetables and fruits in both groups.
- Relatively high percentages of parent-related barriers concerning added sugar in both groups.
- Relatively high percentages of social context-related barriers in both groups.
- Cost-related barriers, particularly for fruits, reported by both groups.

Primary caregivers' belief on who supported them to give diverse food to their child before and after attending crash course on parenting classes:

- Across four groups, there are change in Belief, but change in Sembalun for children 24 months old and above is the least, shown by the very small decrease in believing that "no one help" the caregiver to provide diverse food for her child. In the other three groups, this belief has changed by improvement in belief that the husband, or husband & family supports caregiver.

- However, in Sembalun crash course on parenting for children 24 months old and above and Pringgabaya crash course on parenting for children 24 months old and above, belief that husband helps caregiver in providing diverse food for the child improved. This was not seen in crash course on parenting for children under 24 months class in Sembalun and Pringgabaya.
- Belief in the support of husband & family increased sharply in crash course on parenting for children under 24 months class in Sembalun and Pringgabaya. It improves slightly in crash course on parenting for children 24 months and above in Pringgabaya.

Research Objective 2.1: To describe the social behaviour change communication channel, information and preferred method to learn about child caring and feeding practices.

The most important learning source for primary caregivers from younger mothers group is the family (63.2%). Social media is also being used extensively (58.8%).

Family is the most important source of information when primary caregivers, from both Younger (92.1%) and Older Mothers (71.9%) groups need advices on child caring and feeding.

A large portion of primary caregivers from Younger Mothers Group (79.8% ±8.8%) and Older Mothers group (71.1% ±9.8%) are using social media as a learning source for child caring and feeding.

The proportion of primary caregivers from Younger Mothers group were participating in crash course class on parenting is 51.8%. 42.1% of them never participated in any training related to child caring and feeding. 70.2% primary caregivers from Older Mothers group were participating in crash course class on parenting. 21.1% of them never participated in any training related to child caring and feeding.

VIII. Conclusions

This SBC pilot project relied on crash course on parenting classes and content creator training for improving communities' behaviours related to child caring and feeding. The first field activity, conducting prototyping testing for crash course on parenting class for caregivers of children 3-23 months old was started on 13 June 2025. The first crash course training of facilitators for Posyandu Cadres (CHW) was done on 14 July 2025, and then followed by implementation of the crash course on parenting for the primary caregivers of children 3-23 months, and primary caregivers of children 24-59 months old, separately. Crash course on parenting was done in one round, with 1 session conducted per week, and a total of 3 sessions.

The endline survey was started on 19 August 2025 with enumerators training. At that time, all SBC interventions implementation were already completed. Therefore, the SBC pilot project only had about 1 month of intervention implementation. The coverage of crash course on parenting classes is around 51% for younger mothers group and around 70% of older mothers group. This coverage achievement is already impressive considering the short time of implementation.

All (100%) of primary caregivers who participated in crash course on parenting classes mentioned that the classes help them to provide better caring and feeding practices for their children.

Two indicators (% of youngest child \geq 6 months old receiving legumes and nuts and % of primary caregivers from older mothers group who feel that their child is fun to be with) improved from baseline to endline and the difference is statistically significant. All other indicators are not showing any changes or improvement during endline compared to baseline.

Measuring the results of content creator was not yet possible at endline because many of the trained content creators had not posted their videos on social media. Since many of primary caregivers use social media as learning source (more than 70% for both younger and older mothers group), this might be promising in the future, as it would be easier for primary caregivers to find information needed for caring and feeding their children.

IX. Recommendations

1. To continue SBC implementation

As described in SBC pilot testing background, The goal of this SBC pilot project is:

To ensure the field offices can design innovative, scalable, and impactful SBC activities, WV created its first SBC Framework and Toolkit (draft completed in December 2023). The new SBC Framework and Toolkit, rooted in current evidence, and Systems Thinking, will provide a robust guide for integrating SBC into our diverse programs.

Due to many reasons, this SBC pilot testing field activities were implemented within one month prior to the endline survey. For this short period of time, it can be seen that two minor indicators have been improved at population level (population of primary caregivers from younger and older mothers group).

Thus, based on the comparisons of endline versus baseline results, the steps in “the new SBC framework and toolkit” are able to measure impacts at outcome level of SBC projects at population level. It is strongly recommended to continue the SBC activities implementation as it already showed changes in community behaviour (% of youngest child \geq 6 months old receiving legumes and nuts and % of primary caregivers from older mothers group who feel that their child is fun to be with).

During endline, it shows that the coverage of crash course on parenting classes reached 51.8% of younger mothers group and 71.2% of older mothers group. However, 15% of primary caregivers from older mothers group and 28.8% from younger mothers group had not participated in the classes at all, thus it would be good if the AP East Lombok could continue with some classes to complete the SBC activities so that the remaining caregivers of children under five can take part in it.

Unfortunately, the effectiveness of content creator training could not be measured due to the lack of implementation time. According to the tentative results of FGDs conducted by WV and WVI, the mothers who joined content creators training faced some unforeseen challenges, such as feeling shy to upload the videos to their social media. The fact that both baseline and endline survey confirmed that caregivers of young children like to seek information from social media, training mothers as local content creators is a promising approach for behaviour change activities, provided that the project can work with the local content creators to address the technical and non-technical barriers together. If the support for local content creators, can be continued by AP East Lombok, it might help in producing social and behaviour changes in the area of child feeding and child caring.

Furthermore, there should be improvements on the prepared SBC modules for further implementation. World Vision and Yayasan Wahana Visi Indonesia, as any other NGOs, are trying to improve the community situations. Without community and related stakeholders’ behaviour change, it would be difficult, if not impossible, to improve the situation. WVI should explore the possibilities for partnership with other institutions or community groups or any other possible stakeholders to continue the activities.

2. Find more in-depth information

The quantitative data is not enough to get a complete picture of the situation, hence a qualitative data is needed to fill in the gaps from quantitative results. More data is needed to improve SBC implementation, such as:

- What crash course on parenting participants think about the classes; their suggestions for improving the classes; ideas for reducing parental perceived barriers, problems to joining the classes; and other people whom should be included (such as the husband and the grandmother).
- What crash course on parenting facilitators think about the training of facilitators provided to them; their suggestions for improving the modules; ideas for reducing parental perceived barriers; and problems to invite primary caregivers.
- What the project can do to improve video quality produced by the content creator training participants; what can be done to make sure the videos do not contain mis-information; what can be done to expand their videos viewers; ways to integrate content creator production with crash course on parenting classes.

The project team conducted qualitative review using FGDs with the participants of the crash course on parenting and the trained content creators, separately. Once the result is ready, it can complement the LQAS endline findings.

3. Improvements on SBC modules

During this SBC pilot testing, SBC project team developed two training of facilitators modules for crash course on parenting: module for primary caregivers with children 3-23 months old, and with children 24-59 months old. These modules were still in testing phase, feedbacks from qualitative data should give more information and guidance to revise the modules or training process.

The focus of the sessions targeting caregivers of children 3-23 months old were to do education through fun activities and direct learning to promote dietary diversity such as cooking demonstration, blind testing of fruits, and to encourage child stimulation by caregivers. The focus of the sessions targeting caregivers of children 24-59 months old were to promote dietary diversity and reducing ultra processed food consumption, and to teach caregivers how to read the nutrition labels. Preliminary FGD findings show that while crash course participants from caregivers of 3-23 months old were happy with the cooking demonstration and the games, the caregivers of 24-59 months old did not mention that they were happy with the games, suggesting the need to have more interactive and direct learning with the caregivers.

Only two indicators that were improved (% of youngest child \geq 6 months old receiving legumes and nuts and % of primary caregivers from older mothers group who feel that their child is fun to be with) at endline. This shows that the modules need improvements to be able to improve many other indicators at community level.

Moreover, the caregivers only received one round of 3-sessions, which may contribute also why many indicators did not improve as the dosage is still too low.

One result from baseline³¹ said that primary caregivers preferred a direct method of training, which means that they preferred more direct involvements rather than receiving information only. For example, rather than informing the primary caregivers on types of healthy food for their children, they prefer a cooking class using healthy food, where they are involved in the cooking process, and can directly test the meals to their children. So, primary caregivers will know whether their children will eat the meal or not, they know exactly how to prepare the meal, they can calculate related expenses, time needed, and difficulties for preparing the same meal at home.

Both baseline and endline results show that family member is the most trusted source whenever primary caregivers need to ask information related to child caring and feeding. Their advices become primary caregivers' priority. Thus, involving them in behaviour change activities is important. **Due to the limited time, the project focused on the primary caregivers for the crash course on parenting sessions, and did not include the husbands and the grandmothers. However, key messages on important involvement of husbands and grandmothers were emphasized during Photovoice workshop, crash course on parenting sessions, and the videos produced by local content creators.**

The results of parent perceived barriers should also be considered during modules improvement process. For example, ultra processed food consumption by the youngest child will never be reduced by providing only information. Parents and their family need skills or alternatives for making the youngest child happy without giving ultra processed food.

4. Expand and extend the selected targets for SBC interventions

The new SBC framework and toolkit shows a promising path for usages in social and behaviour change related programs. It provides the possibilities for modifications, creativities, measuring the impact of the intended results/outcome at community level, and further improvements.


It is recommended either to continue this SBC pilot testing implementation or use/test the framework and toolkit for other purposes outside health-related field. By

³¹ Baseline report, page 66 – 67


implementing and using this SBC framework and toolkit, it will develop and improve skills for both WV and WVI staffs to implement more effective and impactful behaviour change projects in the future.

X. Appendices

1. Ethical approval



KOMITE ETIK PENELITIAN KESEHATAN
RSUP NASIONAL DR. CIPTO MANGUNKUSUMO
FAKULTAS KEDOKTERAN UNIVERSITAS INDONESIA
 Gedung H Fakultas Kedokteran UI, Jalan Salemba Raya No. 6 Jakarta 10430 PO. Box 1358
 Telp: (021) 3157008, website: <https://komite-etik.fk.ui.ac.id/>



UNIVERSITAS
INDONESIA
Sate Pahlawan Utama

FAKULTAS
KEDOKTERAN

Nomor : S- *432* /UN2.F1/ETIK/PPM.00.02/2025 20 Juni 2025
 Lampiran :
 Perihal : Amandemen Protokol Penelitian

Yth. Esther Indriani, MPH1
 Peneliti Utama
 World Vision International
 Jakarta



Sehubungan dengan protokol penelitian berikut:
 Judul : "Pilot Testing of Social and Behaviour Change Design Guide to Enhance Child Care and Feeding Practices in East Lombok District."
 Peneliti Utama : Esther Indriani, MPH
 No. Protokol Etik : 24-09-1397
 No. Surat Lolos Etik : KET-1487/UN2.F1/ETIK/PPM.00.02/2024, tanggal 18 Oktober 2024

Komite Etik Penelitian Kesehatan FKUI-RSCM telah menerima dan meninjau surat Sejawat:

Tanggal	No. Surat	Perihal	Dokumen
16 Juni 2025	01/06/2025	Permohonan Pengkajian dan Persetujuan lolos kaji etik	1. Formulir Amandemen 2. Formulir Etik Versi Amandemen 3. Protokol <i>Version 01</i> , tanggal 16 Juni 2025 4. Kuesioner Versi 02, tanggal 16 Juni 2025 5. Surat <i>Ethical Approval</i>

Isi Amandemen:

No.	Bab/Hal	<i>Version 01</i> (07 September 2024)	<i>Version 03</i> (16 Juni 2025)
1	Kuesioner untuk pengumpulan data akhir (Endline) Perubahan ini direfleksikan di Proposal Versi Amendemen halaman 34 Dan Kuesioner versi Amendemen di lampiran terpisah "Kuesioner Survey Akhir LQAS SBC Lombok Timur - (Versi Amendemen 02 - 16 Juni 2025)	Memasukkan pertanyaan-pertanyaan mengenai: a) asset rumah tangga (akses ke sumber listrik, jenis toilet, jenis sumber air-minum, pendapatan tetap), b) kerawanan pangan, c) cuci tangan pakai sabun, d) pencegahan anak sakit dan tanda anak sakit, e) pengobatan diare untuk anak, f) nomor telepon responden, g) minat untuk belajar mengenai pengasuhan, h) metode yang diminati untuk belajar mengenai pengasuhan, i) tes yodium untuk sample garam	Menghapus pertanyaan-pertanyaan mengenai: a) asset rumah tangga (akses ke sumber listrik, jenis toilet, jenis sumber air minum, pendapatan tetap), b) kerawanan pangan, c) cuci tangan pakai sabun, d) pencegahan anak sakit dan tanda anak sakit, e) pengobatan diare untuk anak, f) nomor telepon responden, g) minat untuk belajar mengenai pengasuhan, h) metode yang diminati untuk belajar mengenai pengasuhan, i) tes yodium untuk sample garam Menambahkan pertanyaan-pertanyaan mengenai: a) persepsi pengasuh mengenai hambatan untuk keragaman pangan makanan balita, b) manfaat dari Kelas Kilat Pengasuhan, c) manfaat video mitos & fakta ASI
2	Pelaksanaan Survey Akhir Perubahan ini direfleksikan di Proposal Versi	September 2025	Agustus 2025

" Menolong, memberikan yang terbaik "

JCI
CN.3494.1



**KOMITE ETIK PENELITIAN KESEHATAN
RSUP NASIONAL DR. CIPTO MANGUNKUSUMO
FAKULTAS KEDOKTERAN UNIVERSITAS INDONESIA**

Gedung H Fakultas Kedokteran UI, Jalan Salemba Raya No. 6 Jakarta 10430 PO. Box 1358
Telp: (021) 3157008, website: <https://komite-etik.fk.ui.ac.id/>



UNIVERSITAS
INDONESIA

FAKULTAS

KEDOKTERAN

	Amendemen halaman 31		
--	-------------------------	--	--

Komite Etik Penelitian Kesehatan FKUI-RSCM menyetujui amandemen pada protokol penelitian tersebut.

Atas laporan dan kerjasamanya, kami ucapkan terima kasih.

Ketua KEPK FKUI-RSCM



Prof. Dr. dr. Ratna Dwi Restuti, Sp.TITBKL(K), M.P.H

“Menolong, memberikan yang terbaik”



JCI
CN.3494.1



2. Questionnaire

Questionnaire for Endline

Respondent: Caregiver of Children Under Five in East Lombok AP

Field Information Informasi Lapangan	
Enumerator's name/code Nama/kode enumerator	_____/_____
Date of Survey: Tanggal survey	[DD/MM/YYYY] automatic (Tanggal/Bulan/Tahun)
Sub-district name/code: Nama / kode Kecamatan	_____/_____
Village name/code: Nama/kode desa	_____/_____
Sub-Village name/code: Nama/kode dusun	_____/_____
Group code Kode grup	1. ≤ 24 years old mother 2. ≥ 28 years old mother

SCRIPT: Hello, my name is _____ and this is my colleague _____. We are from Wahana Visi Indonesia East Lombok AP (Area Program). We are doing a survey about nutrition and childcaring in Sembalun and Pringgabaya Sub-district. As part of this survey, we are talking with the caregiver in the community who helps care for children under 5 years old about the nutrition and care of these children. We would like to ask you a few questions about your household to see if your household is eligible. If your household is eligible then we will request permission to talk with the mother or primary caregiver in the household about social, economy, demography; household assets, and living condition; food security; child caring practices, parent-child interaction; nutrition practices; learning about child caring and feeding Practices. Besides the interview, we will ask permission to conduct the MUAC (Mid upper arm circumference) measurement for the youngest children aged under-five in your house. This step aims for early detection of the malnourished wasting. The estimated time for survey will take no more than 1 hour. Do you mind if we ask you a few questions to see if you are eligible being the respondent:

Halo, nama saya dan ini adalah teman saya Kami dari Wahana Visi Indonesia Program Area Lombok Timur. Kami sedang melakukan survey tentang gizi dan pengasuhan anak di Kecamatan Sembalun dan Prigabaya. Sebagai bagian dari survey ini, kami akan berbincang dengan pengasuh di masyarakat yang mengasuh anak balita tentang gizi dan pengasuhan anak-anak ini. Kami ingin mengajukan beberapa pertanyaan kepada anda tentang

keluarga anda untuk melihat apakah keluarga anda memenuhi syarat. Apabila keluarga anda memenuhi syarat, maka kami meminta ijin untuk berbincang dengan ibu atau pengasuh anak di rumah ini tentang sosial, ekonomi, demografi; aset rumah tangga, dan kondisi hidup; ketahanan pangan; praktik pengasuhan anak, interaksi anak-orangtua; praktik gizi; pembelajaran tentang Praktik Perawatan dan Pemberian Makan Anak. Selain wawancara, kami akan meminta izin untuk melakukan pengukuran LILA (Lingkar Lengan Atas) untuk anak-anak termuda berusia di bawah lima tahun di rumah Anda. Langkah ini bertujuan untuk deteksi dini masalah gizi-wasting. Estimasi survei ini ialah tidak akan lebih dari 1 jam. Apakah kami dapat bertanya beberapa pertanyaan untuk melihat kesesuaian anda menjadi responden:

Bila terdapat lebih dari 1 anak balita, pilih yang paling muda.

FORM A. SCREENING RESPONDENT ELIGIBILITY

A. IDENTIFIER/ SCREENING RESPONDENT ELIGIBILITY (ASKED TO ALL CAREGIVERS OF 0-59 MONTHS) IDENTIFIKASI/SKRINING KELAYAKAN RESPONDEN (DITANYAKAN KEPADA SELURUH PENGASUH 0-59 BULAN) Pilih salah satu opsi dan isi jawaban berdasarkan pertanyaan yang ada!	
Is there a child under 5 years of age (0-59 months) living in this household? Apakah ada anak usia di bawah 5 tahun di dalam rumah tangga ini?	1. Yes Ya 2. No Tidak → Stop, pindah ke rumah lain
What is the mother's age of the youngest child currently? Berapa umur ibu kandung anak balita termuda tersebut saat ini? If the mother's age does not match the group code, move to other household Bila usia ibunya tidak sesuai dengan kode grup, pindah ke rumah lain.years oldtahun
Do you take care of the youngest child every day? Apakah Anda sehari-sehari mengurus anak ini?	1. Yes Ya 2. No → wait or come back to meet the primary caregiver and start from the beginning. Tidak. → tunggu atau kembali lagi hingga bertemu dengan orang yang biasa mengurus anak. Bila sudah bertemu, ulangi pertanyaan dari awal
B. RESPONDENT'S SOCIAL, AND ECONOMY SOSIAL, DAN EKONOMI RESPONDEN Pilih salah satu opsi dari jawaban responden/menyesuaikan dari petunjuk pertanyaan, dan isi jawaban berdasarkan pertanyaan yang ada!	
1.	What is your name? [Text]

	Siapa nama anda?	
2.	How old are you now? Usia anda sekarang?	[... years old]tahun
3.	Gender of Primary caregiver Jenis kelamin pengasuh utama	1. Laki 2. Perempuan
4.	What is the name of the youngest child? Siapa nama anak paling muda?	[text]
5.	What is the youngest child gender? Apa jenis kelamin anak termuda?	1. Male Laki-laki 2. Female Perempuan
6.	Date of birth of the youngest child: Tanggal lahir anak paling muda: IF RESPONDENT DOESN'T KNOW OR DOESN'T REMEMBER, ASK: BILA TIDAK TAHU, GANTI DENGAN PERTANYAAN: How old is the youngest child now? Berapa usia anak ini?	[DD/MM/YYYY] (Tanggal/Bulan/Tahun) Don't remember/don't know Tidak Ingat/tidak tahu [... Months]
7.	What is your relationship with this youngest child? Apa hubungan Anda dengan anak termuda ini?	1. Biological Mother Ibu kandung 2. Adopted Mother 3. Father Ayah 4. Older sibling Kakak 5. Grandmother Nenek 6. Grandfather Kakek 7. Aunt Bibi 8. Uncle Paman 9. Other relative Kerabat/saudara lain 10. Somebody paid to help Seseorang yang dibayar untuk membantu/Pengasuh/babysitter 11. Etc. Lainnya...
8.	<u>If the respondent is the biological mother, ask:</u> <u>Bila responden adalah ibu kandung, tanyakan:</u> When did you get married for the first time? Kapan tanggal pertama kali ibu menikah?	[DD/MM/YYYY] (Tanggal/Bulan/Tahun)

	<p>IF RESPONDENT DOESN'T REMEMBER, ASK: JIKA RESPONDEN TIDAK INGAT TANGGALNYA, TANYAKAN:</p> <p>How old were you when you first got married? Berapa usia ibu ketika pertama kali menikah?</p>	<p>999 Don't remember Tidak Ingat</p> <p>888 Never marry Tidak pernah menikah</p> <p>[... Tahun] lalu</p>
9.	<p><u>If the respondent is NOT the biological mother, ask:</u> <u>Bila responden adalah BUKAN ibu kandung, tanyakan:</u></p> <p>Since when have you been taking care of this youngest child? (Child's age in months)? Sejak kapan anak termuda ini diasuh oleh Anda? (umur anak dalam bulan)</p>	<p>[... Months]</p>
10.	<p><u>If the respondent is NOT the biological mother, ask:</u> <u>Bila responden adalah BUKAN ibu kandung, tanyakan:</u></p> <p>When did the mother of this child get married for the first time? Kapan tanggal pertama kali ibu dari anak ini menikah?</p> <p>IF RESPONDENT DOESN'T REMEMBER, ASK: JIKA RESPONDEN TIDAK INGAT TANGGALNYA, TANYAKAN:</p> <p>How old was the mother when she first got married? Berapa usia ibu anak ini ketika pertama kali menikah?</p>	<p>[DD/MM/YYYY] (Tanggal/Bulan/Tahun)</p> <p>999 Don't remember Tidak Ingat</p> <p>888 Never marry Tidak pernah menikah</p> <p>[... Tahun]</p>
11.	<p><u>If the respondent is NOT the biological mother, ask:</u> <u>Bila responden adalah BUKAN ibu kandung, tanyakan:</u></p> <p>Where is the biological mother of this youngest child? Dimana keberadaan ibu kandung dari anak termuda ini?</p>	<ol style="list-style-type: none"> 1. Passed away Meninggal dunia 2. Work in different city Bekerja di kota lain 3. Work in other country Bekerja di negara lain 4. Moved to different location due to marriage Pindah ke lokasi lain karena menikah lagi 5. Unknown Tidak diketahui keberadaannya 6. Don't know Tidak tahu

		7. Other, specify..... Lainnya, jelaskan....
12.	<p><u>If the respondent is NOT the biological mother, ask:</u> <u>Bila responden adalah BUKAN ibu kandung, tanyakan:</u></p> <p>What is the mother's highest level of education? Apa tingkat Pendidikan terakhir ibu kandung si anak?</p>	<ol style="list-style-type: none"> 1. Never attended school Tidak sekolah 2. Elementary school/equivalent but not completed SD/ sederajat tetapi tidak selesai 3. Completed elementary school /equivalent Lulus SD/ sederajat 4. Completed junior high school /equivalent Lulus SMP/ sederajat 5. Completed senior high school /equivalent Lulus SMA/ sederajat 6. Graduated from college/equivalent Lulus perguruan tinggi/ sederajat 7. Others, please specify... Lainnya, jelaskan..... 8. Don't know Tidak tahu
13.	<p>What is your highest level of education? Apa tingkat Pendidikan terakhir anda?</p>	<ol style="list-style-type: none"> 1. Never attended school Tidak sekolah 2. Elementary school/equivalent but not completed SD/ sederajat tetapi tidak selesai 3. Completed elementary school /equivalent Lulus SD/ sederajat 4. Completed junior high school /equivalent Lulus SMP/ sederajat 5. Completed senior high school /equivalent Lulus SMA/ sederajat 6. Graduated from college/equivalent Lulus perguruan tinggi/ sederajat 7. Others, please specify... Lainnya, jelaskan.....
14.	<p>What is the name of the youngest child's father? Siapa nama ayah dari anak termuda ini?</p>	<p>[Text] 999 bila tidak tahu → skip to no 14</p>
15.	<p>What is the date of birth of the youngest child's father? Berapa tanggal lahir ayah dari anak termuda ini?</p>	<p>[DD/MM/YYYY] (Tanggal/Bulan/Tahun)</p>

	<p>IF RESPONDENT DOESN'T KNOW, ASK: BILA RESPONDEN TIDAK TAHU, GANTI DENGAN PERTANYAAN:</p> <p>How old is the father now? Berapa usia ayah dari anak termuda saat ini?</p>	<p>Don't know Tidak tahu</p> <p>[... tahun] 999 bila tidak tahu</p>
16.	<p>What is father's highest level of education? Apa tingkat pendidikan terakhir ayah?</p>	<ol style="list-style-type: none"> 1. Never attended school Tidak sekolah 2. Elementary school/equivalent but not completed SD/ sederajat tetapi tidak selesai 3. Completed elementary school /equivalent Lulus SD/ sederajat 4. Completed junior high school /equivalent Lulus SMP/ sederajat 5. Completed senior high school /equivalent Lulus SMA/ sederajat 6. Graduated from college/equivalent Lulus perguruan tinggi/ sederajat 7. Others, please specify... Lainnya, Jelaskan..... 8. Don't know Tidak tahu
17.	<p>What is your occupation? Apa pekerjaan anda?</p> <p>DO NOT READ OPTIONS. RECORD ALL RESPONSES. RESPONDENT CAN HAVE MORE THAN ONE ANSWER PILIHAN JAWABAN JANGAN DIBACA. PILIH JAWABAN YANG DISEBUTKAN. PILIHAN BOLEH LEBIH DARI SATU</p>	<ol style="list-style-type: none"> a. Housewife Ibu Rumah Tangga b. Farmer Petani c. Fisherwoman Nelayan d. Food vendor Penjual makanan e. Day labourer in construction Buruh harian konstruksi f. Day labourer in farming or fisheries Buruh harian petani atau nelayan g. Teacher Guru h. Civil servant (PNS) Pegawai Negeri Sipil (PNS) i. Small business such as warung or toko

		Usaha kecil seperti warung atau toko j. Motorbike driver Ojek k. Etc. Lainnya...
--	--	--

C. DEMOGRAPHIC AND HOUSEHOLD ASSETS AND LIVING CONDITIONS
 DEMOGRAFI, ASSET RUMAH TANGGA, DAN KONDISI KEHIDUPAN

C1. Demographic situation.		
Pilih salah satu opsi dari jawaban responden, dan isi jawaban berdasarkan pertanyaan yang ada!		
18.	How many people currently live in your household? Berapa banyak anggota keluarga di rumah ini?	[Numeric]
19.	How many children aged 0-5 years old are in this household? Berapa banyak anak usia 0-5 tahun di rumah ini?	[Numeric]

FORM D. CHILD CARE PRACTICES		
D. CHILD CARE PRACTICES		
Pilih salah satu opsi dari jawaban responden berdasarkan pertanyaan yang ada, dan ikuti panduan pertanyaan dari masing-masing soal!		
20.	Did you get any help in taking care of this youngest child? Apakah ada yang membantu Anda untuk mengasuh anak termuda ini?	1. Yes, Ya 2. No, → to 25 Tidak
21.	Who helps you to take care of this youngest child? Siapa yang membantu anda untuk mengasuh anak ini?	a. Respondent's spouse Pasangan dari responden (suami/istri) b. The youngest child's grandfather Kakek dari anak termuda c. The youngest child's grandmother Nenek dari anak termuda d. Older sibling of the youngest child Kakak dari anak termuda e. Other relatives of the youngest child (for example uncle or aunt of the youngest child) Kerabat/saudara lain dari anak termuda (misalnya paman atau bibi) f. Somebody paid to help

		Seseorang yang dibayar untuk membantu/Pengasuh/babysitter g. Etc. Lainnya...
22.	Do you bring the youngest child to the Posyandu (Integrated service post) every month? Apakah Anda membawa anak termuda ini ke Posyandu setiap bulan ?	1. Always Selalu 2. Never Tidak pernah 3. Not always Tidak selalu 4. Dont know Tidak tahu 5. Etc, specify... Lainnya, lebih spesifik...
23.	Do you have the growth chart of the youngest child? Apakah anak termuda ini punya kartu KMS atau Buku Kesehatan Ibu dan Anak (Buku KIA)?	1. Yes (able to show the card) Ya (dapat menunjukkan kartu) 2. Yes (not able to show the card) – > 25 Ya (tidak dapat menunjukkan kartu) → 25 3. No → 25 Tidak → 25 4. Don't know → 25 Tidak tahu → 25
24.	Record child's date of birth Catat tanggal lahir anak Record child's last visit to Posyandu (Integrated service post) Catat tanggal terakhir kunjungan anak ke posyandu Select the 1st of the month, if there is no date in the KMS Bila tidak tercatat tanggal di KMS , pilih tanggal 1 pada bulan tersebut Record child's mother name Catat nama ibu si anak	[DD/MM/YYYY] (Tanggal/Bulan/Tahun) [DD/MM/YYYY] (Tanggal/Bulan/Tahun) [Text]
25.	Has your child been immunized? Apakah anak termuda ini sudah pernah mendapat imunisasi?	1. Yes Ya 2. No Tidak 3. Don't know Tidak tahu

26.	In the past 6 months, did the youngest child receive any deworming medication? Dalam 6 bulan terakhir, apakah anak termuda ini pernah mendapatkan obat cacing?	1. Yes Ya 2. No Tidak 3. Don't know Tidak tahu
E. PARENT-CHILD INTERACTION will assess the care with the Brigance Score: READ OUT: "Now, I would like to ask you about your activity with the youngest child" BACAKAN: "Sekarang, saya akan bertanya mengenai kegiatan yang Anda lakukan bersama si anak yang termuda"		
27.	How often do you play with your child and show him or her things about toys? Berapa sering anda bermain dengan anak termuda ini dan menunjukkan padanya hal – hal tentang mainan?	1. Not very often Jarang 2. Sometimes Kadang – kadang 3. Often Sering
28.	How often do you hug and kiss your child? Berapa sering anda memeluk dan mencium anak termuda ini?	1. Not very often Jarang 2. Sometimes Kadang – kadang 3. Often Sering
29.	Do you mostly talk to your child when he/she is crying? Apakah Anda hanya berbicara/mengobrol dengan anak termuda ini sewaktu dia menangis?	1. Not very true, I talk to my child anytime, not only when s/he is crying only Tidak benar, saya mengobrol dengan anak ini kapan saja, bukan hanya ketika dia menangis 2. Sometimes true Kadang – kadang 3. Mostly true, I talk to my child when s/he is crying only Hampir selalu, saya hanya berbicara/mengobrol dengan anak ini sewaktu dia menangis
30.	How often do you help your child learn by talking and showing him or her new things? Berapa sering Anda membantu anak termuda ini belajar dengan cara berbicara dan menunjukkannya benda – benda baru?	1. Not true, I do not help my child learning that way Tidak pernah, saya tidak membantu anak ini belajar dengan cara itu 2. Sometimes true Kadang – kadang 3. Mostly true. I help my child learning by talking and showing new things

		Hampir selalu. Saya membantu anak ini belajar dengan mengobrol dan menunjukkannya benda – benda baru
31.	How often do you look at or read children’s books to your child? Berapa sering anda menunjukkan atau membacakan buku – buku cerita anak kepada anak termuda ini?	1. Not very often Jarang 2. Sometimes Kadang – kadang 3. Often Sering
32.	Does your child seem very interested when you talk to him or her? Apakah anak termuda ini terlihat sangat tertarik waktu Anda berbicara kepadanya?	1. Not very true. My child does not seem very interested to me Tidak benar. Anak ini tidak terlihat sangat tertarik 2. Sometimes true Kadang – kadang 3. Mostly true. My child always seem very interested when I talk to him/her Hampir selalu. Anak ini selalu terlihat sangat tertarik ketika saya berbicara dengannya
33.	How often do you make up games or songs for your child? Berapa sering Anda membuat permainan atau lagu untuk anak termuda ini?	1. Not very often Jarang 2. Sometimes Kadang – kadang 3. Often Sering
34.	When your child looks at or touches a toy, do you talk to him/her about the toy? Ketika anak termuda ini melihat atau menyentuh sebuah mainan, apakah Anda menjelaskan kepadanya tentang mainan tersebut?	1. Not very often Jarang 2. Sometimes Kadang – kadang 3. Often Sering
35.	When your child is looking at you, do you talk to him/her or make sounds? Ketika anak termuda ini melihat Anda, apakah Anda berbicara atau membuat suara – suara kepadanya?	1. Not very often Jarang 2. Sometimes Kadang – kadang 2. Often Sering
36.	Does your child seem to like you? Apakah anak termuda ini tampak menyukai Anda?	1. Not very true. My child does not seem to like me Tidak benar. Anak ini kelihatannya tidak menyukai saya 2. Sometimes true

		<p>Kadang – kadang</p> <p>3. Mostly true. My child seems to like me</p> <p>Hampir selalu. Anak ini kelihatannya menyukai saya</p>
37.	<p>Do you enjoy feeding your child or eating with him/her? Apakah anda merasa senang ketika memberi makan anak termuda ini atau makan bersamanya?</p>	<p>1. Not very often Jarang</p> <p>2. Sometimes Kadang – kadang</p> <p>2. Often Sering</p>
38.	<p>Do you talk to your child in a special way (ex. With loving care, differently than other kids or other people)? Apakah Anda berbicara kepada anak termuda ini dengan cara yang spesial atau khusus? (Misalnya, dengan penuh kasih sayang, berbeda dari cara Anda berbicara kepada anak lain atau orang lain)</p>	<p>1. Not very often Jarang</p> <p>2. Sometimes Kadang – kadang</p> <p>3. Often Sering</p>
39.	<p>Is your child not very much fun to be with? Apakah anak termuda ini <u>tidak</u> begitu menyenangkan (asik)?</p>	<p>1. Not very true. My child is fun to be with Tidak benar. Anak ini menyenangkan (asyik)</p> <p>2. Sometimes true Kadang – kadang</p> <p>3. Mostly true. My child is not very much fun to be with Hampir selalu. Anak ini tidak terlalu menyenangkan (asyik)</p>
40.	<p>Can you make your child feel better when s/he is upset? Apakah Anda dapat membuat anak termuda ini merasa lebih baik sewaktu dia sedang merajuk/ngambek?</p>	<p>1. Not very often Jarang</p> <p>2. Sometimes Kadang – kadang</p> <p>3. Often, I can make my child feel better when s/he is upset Sering, saya dapat membuat anak ini merasa lebih baik saat dia sedang merajuk/ngambek</p>
41.	<p>When your child looks at or touches something, is the first thing you say “don’t” or “no”? Apakah ketika anak termuda ini melihat atau menyentuh sesuatu, kata pertama yang anda ucapkan adalah “jangan atau tidak”?</p>	<p>1. Not very true, when my child looks or touch something, I do not directly say don’t or no Tidak benar, ketika anak ini melihat atau menyentuh sesuatu, saya tidak langsung mengatakan “jangan” atau “tidak”</p> <p>2. Sometimes true Kadang – kadang</p>

		<p>3. Mostly true, when my child looks or touches something, I always say don't or no</p> <p>Hampir selalu, ketika anak ini melihat atau menyentuh sesuatu, saya selalu mengatakan "jangan" atau "tidak"</p>
42.	<p>Do you like your child most of the time? Apakah Anda menyukai anak termuda ini hampir setiap saat?</p>	<p>1. Not very true. I usually do not like my child Tidak benar. Saya biasanya tidak menyukai anak ini</p> <p>2. Sometimes true Kadang – kadang</p> <p>2. Mostly true. I always like my child Hampir selalu. Saya selalu menyukai anak ini</p>
43.	<p>Does your child not need your help learning new things? Apakah anak termuda ini tidak membutuhkan bantuan Anda untuk belajar hal – hal baru?</p>	<p>1. Not very true. My child needs my help to learn new things Tidak benar. Anak ini membutuhkan bantuan saya untuk belajar hal – hal baru</p> <p>2. Sometimes true Kadang – kadang</p> <p>3. Mostly true, my child does not need my help to learn new things Hampir selalu, anak ini tidak membutuhkan bantuan saya untuk belajar hal – hal baru</p>
44.	<p>Do you talk to your child when feeding or eating with him or her? Apakah anda berbicara dengan anak termuda ini sewaktu anda memberinya makan atau makan bersamanya? 2.</p>	<p>1. Not very often I talk to my child when feeding him/her Saya jarang berbicara dengan anak ini ketika memberinya makan</p> <p>2. Sometimes Kadang – kadang</p> <p>3. Often, I talk to my child when feeding him/her Sering, saya berbicara dengan dengan anak ini ketika memberinya makan</p>
45.	<p><i>Do you give any toys or play materials for your youngest child?</i> <i>Apakah Anda memberikan mainan atau alat bermain untuk anak termuda ini?</i></p>	<p>1. Yes Ya</p> <p>2. No Tidak</p>

		3. <i>Dont know</i> <i>Tidak tahu</i>
46.	Do you think the youngest child have a safe and clean place to play? Apakah menurut anda anak termuda ini punya tempat bermain yang aman dan bersih?	1. Yes, really safe and clean Ya, sangat aman dan bersih 2. Yes, safe and clean enough Ya, cukup aman dan bersih 3. Not safe and clean Tidak aman dan tidak bersih 4. Don't know Tidak tahu 5. Etc... Lainnya...

F. NUTRITION PRACTICES PRAKTEK GIZI Pilih salah satu opsi dari jawaban responden berdasarkan pertanyaan yang ada, dan atau ikuti panduan pertanyaan dari masing-masing soal!		
47.	Has this youngest child ever been breastfed? Apakah anak termuda ini pernah disusui atau diberi ASI?	1. Yes Ya 2. No Tidak 3. Don't know Tidak tahu
48.	In the first 3 days after birth, what was given to the youngest child? (RESPONDENT CAN GIVE MORE THAN ONE ANSWER. DO NOT READ OUT THE OPTIONS) Dalam waktu 3 hari setelah lahir, makanan atau minuman apa yang diberikan kepada si anak termuda ini? (JAWABAN BOLEH LEBIH DARI SATU. PILIHAN JAWABAN JANGAN DIBACAKAN)	a. Breastmilk ASI b. Infant Formula Susu Formula c. Animal milk Susu segar misalnya susu sapi, susu kambing d. Plain water Airputih e. Tea Teh f. Juice Jus buah g. Honey Madu h. Other, specify... Lainnya, sebutkan... i. Don't know or Forget Tidak tahu atau Lupa
49.	Have you started giving semi-solid or solid food to the youngest child? Apakah Anda sudah mulai memberikan makanan padat atau	1. Yes Ya 2. No → skip to 52 Tidak

	lunak pada anak termuda ini?	3. Don't know → skip to 52 Tidak tahu
50.	At what age was the youngest child first given liquids or foods other than breast milk? Pada umur berapa anak termuda ini pertama kali diberi makan atau minum selain ASI?	[...in months] <i>If don't know, write 999</i> <i>Kalau tidak tahu tulis 999</i>
51.	In the past 24 hours, from yesterday morning until night, did this youngest child consume foods from the following food groups? READ ALL THE FOOD IN EACH FOOD GROUP BELOW Dalam 24 jam terakhir, dari kemarin pagi hingga malam, apakah anak termuda ini makan makanan berikut? BACAKAN SEMUA JENIS MAKANAN DI TIAP KELOMPOK MAKANAN DI BAWAH INI	
	1. Breastmilk Air Susu Ibu (ASI)	1. Yes Ya 2. No Tidak
	2. Grains, roots, and tubers Nasi, bubur, kentang, ubi putih, talas, roti, jagung, singkong atau biji – bijian, akar rimpang dan umbi – umbian lainnya.	1. Yes Ya 2. No Tidak
	3. Legumes and nuts Tempe, tahu, oncom, kacang kedelai, kacang tanah, kacang merah, kacang mete, kacang kenari, kuaci, kelapa, susu kedelai, edamame, kacang komak/biji kacang koro, kacang tunggak atau jenis kacang – kacang dan polong-polongan lainnya.	1. Yes Ya 2. No Tidak
	4. Dairy products (milk, yoghurt, cheese) Produk susu misalnya susu sapi, susu kambing, yogurt, keju	1. Yes Ya 2. No Tidak
	5. Flesh foods (meat, fish, poultry, liver/organ meats, insects, reptiles) Daging misalnya daging yang berasal dari sapi, kambing, kerbau, kuda, rusa Daging ayam, burung puyuh, bebek, burung merpati, kelinci, musang... Jeroan misalnya hati ayam atau jeroan ayam lainnya, hati sapi atau jeroan sapi lainnya... Jenis ikan misalnya ikan laut, ikan air tawar, ikan asin... Ular, kodok, serangga (belalang), Nyale (cacing laut),	1. Yes Ya 2. No Tidak

	<p>6. Eggs Telur unggas (telur ayam, telur bebek, telur puyuh)</p>	<p>1. Yes Ya 2. No Tidak</p>
	<p>7. Vitamin A-rich fruits and vegetables Buah atau sayuran kaya Vitamin A misalnya ubi kuning, wortel, papaya, mangga matang, paprika, labu parang, kangkung, daun bayam, daun kelor, daun sawi, pokchoy, daun selada, daun singkong, daun ubi jalar, daun papaya, daun labu, daun talas, dan sayuran berdaun hijau lainnya</p>	<p>1. Yes Ya 2. No Tidak</p>
	<p>8. Other fruits and vegetables Sayur dan buah lain misalnya apel, alpukat, kubis, pisang, mentimun, labu siam, kembang kol, terong, pare, jahe, sereh, jeruk, jambu biji, anggur, nanas, melon hijau, apel, strawberi, kiwi, manggis, rambutan, semangka, durian, buah naga, pear, mangga mentah, markisa, jeruk bali, tomat hijau, tomat matang, buncis, lobak.</p>	<p>1. Yes, Ya 2. No Tidak</p>
52.	<p>Saya akan menyebutkan beberapa pernyataan, mohon Ibu/Bapak dapat menanggapi dengan setuju, biasa saja, atau tidak setuju.</p> <p>My child does not like to try new vegetables Anak saya tidak suka mencoba sayuran jenis baru</p>	<p>1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat</p>
53.	<p>Getting my child to eat vegetables at meals is difficult Susah mengajak anak saya makan sayuran</p>	<p>1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat</p>
54.	<p>My child doesn't like the taste of vegetables Anak saya tidak suka rasa sayuran</p>	<p>1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food</p>

		Belum menerima makanan lunak/padat
55.	My child is a picky eater Anak saya pilih-pilih soal makanan	1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat
56.	The child does not like to try new fruits. Anak saya tidak suka mencoba jenis buah yang baru	1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat
57.	I don't like fruits myself Saya sendiri tidak suka buah-buahan	1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju
58.	I don't know how to cook vegetables. Saya tidak tahu cara memasak sayur-sayuran	1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju
59.	I don't like vegetables myself Saya sendiri tidak suka sayur-sayuran	1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju
60.	It is difficult to find recipes for vegetables Menurut saya, sulit untuk dapat resep-resep sayuran	1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju

61.	<p>Preparing the fruit to eat (peeling, cutting) is much work.</p> <p>Menyiapkan buah untuk dimakan (misalnya mengupas, memotong-motong buah) cukup merepotkan.</p>	<ol style="list-style-type: none"> 1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat
62.	<p>Preparing vegetables the child likes takes much time.</p> <p>Menyiapkan sayuran seperti yang anak saya suka perlu waktu lama.</p>	<ol style="list-style-type: none"> 1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat
63.	<p>I like to make the child happy by buying him a cake, candy, or a treat when we go out</p> <p>Saya suka membuat anak saya senang dengan membelikan dia kue, permen, atau jajanan saat saya pergi bersama anak.</p>	<ol style="list-style-type: none"> 1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju 4. Haven't received semi solid/solid food Belum menerima makanan lunak/padat
64.	<p>Grandparents, other family members, or friends often offer you cakes, sweets, or treats.</p> <p>Kakek nenek, atau anggota keluarga lain, sering menawarkan saya kue, permen, atau jajanan.</p>	<ol style="list-style-type: none"> 1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju
65.	<p>Fruit is expensive</p> <p>Harga buah-buahan itu mahal</p>	<ol style="list-style-type: none"> 1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju

66.	<p>Vegetables are expensive</p> <p>Harga sayur-sayuran itu mahal</p>	<ol style="list-style-type: none"> 1. Agree Setuju 2. Neutral Biasa saja 3. Disagree Tidak setuju
67.	<p>In the past 24 hours, from yesterday morning until night, did this youngest child consume these foods?</p> <p>Dalam 24 jam terakhir, dari kemarin pagi hingga malam, apakah anak termuda ini makan <u>makanan buatan pabrikan</u> sebagai berikut?</p>	<ol style="list-style-type: none"> a. Breakfast cereals, cake mixes, 'energy' bars; wafer, biscuit Sereal untuk sarapan misalnya Energen atau coco crunch, wafer, biskuit b. 'instant' packaged soups and noodles; Mie instant seperti Indomie atau Mie Sedap c. many types of sweetened breads and buns, cakes, pastries and desserts; Roti manis, kue-kue dan kudapan manis d. chips (crisps), many other types of sweet, fatty or salty snack products; permen, keripik atau snack pabrikan sejenis, coklat instan dalam kemasan bubuk misalnya Milo e. sugared milk and fruit drinks, soft cola and 'energy' drinks. minuman jus dalam kotak, minuman teh dalam kotak atau botol, minuman bersoda dalam botol, f. Pre-prepared meat, fish, vegetable or cheese dishes, pizza and pasta dishes, burgers and hot dogs, French fries (chips), poultry and fish 'nuggets' or 'sticks' ('fingers'); Daging olahan beku

		<p>misalnya sosis, nugget, burger; Kentang goreng</p> <p>g. Bread and other cereal products, animal products made from flour and salt with scraps or remnants of meat; Roti dan daging olahan yang dicampur tepung roti misalnya bakso, martabak telur, pangsit,</p> <p>h. cookies (biscuits), preserves (jams); Biskuit, selai</p> <p>i. sauces, meat, yeast, other extracts; saus (misalnya kecap, saus tomat, saus sambal, saus tiram), kaldu ayam bubuk seperti royco</p> <p>j. ice - cream, chocolates, candies (confectionery); Es krim, coklat, permen es krim, coklat batangan atau permen coklat,</p> <p>k. margarines; Margarin seperti Blue Band</p> <p>l. canned or dehydrated soups; sup dalam kemasan,</p> <p>m. infant formula, follow on milks, baby products. susu formula, susu bubuk untuk anak usia balita, biscuit bayi,</p> <p>n. Did not consume any of these foods Tidak makan satupun makanan di atas</p>
68.	Measure the youngest child's MUAC and record in centimetre:	[...in cm]

Ukur LILA anak termuda dan catat dalam satuan sentimeter:

G. LEARNING ABOUT CHILD CARING AND FEEDING PRACTICES		
Pilih salah satu opsi dari jawaban responden berdasarkan pertanyaan yang ada, dan atau ikuti panduan pertanyaan dari masing-masing soal!		
69.	<p>Where do you learn about child feeding practices? Di mana Anda belajar tentang praktik pemberian makan anak?</p> <p>RESPONDENT CAN HAVE MORE THAN ONE OPTION RESPONDEN BOLEH MEMILIH LEBIH DARI 1 JAWABAN</p>	<ul style="list-style-type: none"> a. Family members Anggota keluarga b. Health workers Tenaga kesehatan c. Community Health Worker Kader Posyandu d. Media and socialmedia such as newspaper, TV, radio, youtube, Instagram, etc. Media dan media social misalnya surat kabar, TV, radio, youtube, Instagram, dll. e. Community events Kegiatan masyarakat f. From elders Dari orang yang lebih tua g. From neighbours Dari tetangga h. Etc. Lainnya... i. Don't know Tidak tahu
70.	<p>Have health workers provided you with information on child feeding and care practices? Pernahkah Tenaga kesehatan memberikan informasi tentang praktik pemberian makan dan perawatan/pengasuhan anak?</p>	<ul style="list-style-type: none"> 1. Yes, often Ya, sering 2. Yes, sometimes Ya, kadang-kadang 3. Yes, once Ya, satu kali 4. No Tidak 5. Dont know Tidak tahu 6. Other, explain..... Lainnya, jelaskan.....
71.	<p>Have Community Health Workers provided you with information on child feeding and care practices? Pernahkah Kader Posyandu memberikan informasi tentang praktik pemberian makan dan perawatan/pengasuhan anak?</p>	<ul style="list-style-type: none"> 1. Yes, often Ya, sering 2. Yes, sometimes Ya, kadang-kadang 3. Yes, once Ya, satu kali

		<p>4. No Tidak</p> <p>5. Dont know Tidak tahu</p> <p>6. Other, explain..... Lainnya, jelaskan.....</p>
72.	<p>In your community, who do you typically ask for advice on child feeding and caring? Kepada siapa Anda biasanya bertanya tentang cara mengasuh dan memberi makan anak?</p> <p>RESPONDENT CAN HAVE MORE THAN ONE OPTION RESPONDEN BOLEH MEMILIH LEBIH DARI 1 JAWABAN</p>	<p>a. Family members, parents or family elders Keluarga atau orang tua/anggota keluarga yang lebih tua</p> <p>b. Neighbours Tetangga</p> <p>c. Friends Teman</p> <p>d. Community Health Workers Kader posyandu</p> <p>e. Health workers Tenaga kesehatan</p> <p>f. No one Tidak ada</p> <p>g. Others, explain..... Lainnya, jelaskan.....</p>
73.	<p>Do you use any media (radio, TV, internet (Instagram, Facebook, Youtube, etc)) to learn about child feeding practices? Apakah Anda menggunakan media misalnya radio, TV, atau internet (instagram, facebook, youtube, dll) untuk belajar tentang cara memberi makan anak?</p>	<p>1. Yes Ya</p> <p>2. No Tidak</p> <p>3. Don't know Tidak tahu</p>
74.	<p>Did you ever watch a health video developed by local people? Apakah anda pernah menonton video tentang kesehatan yang dibuat oleh orang lokal?</p>	<p>1. Yes / Ya → Specify...</p> <p>2. No / Tidak → Skip to 76</p> <p>3. Dont know / Tidak tahu → Skip to 76</p>
75.	<p>Do you think the video helps you for caring the child? Apakah video tersebut membantu anda dalam merawat anak?</p>	<p>1. Yes / Ya</p> <p>2. No / Tidak</p> <p>3. Dont know / Tidak tahu</p>
76.	<p>Have you participated in any training or educational programs on child feeding and caring practices? Apakah Anda pernah ikut dalam pelatihan atau program pendidikan mengenai praktik pemberian makan dan pengasuhan anak?</p>	<p>1. Yes, in Posyandu → Skip to 79 Ya, di Posyandu → Lewati ke no.79</p> <p>2. Yes, joining kelas kilat pengasuhan WVI Ya, ikut kelas kilat pengasuhan WVI</p> <p>3. Yes, other program, → Skip to 79 Ya, program lainnya,</p>

		<p>→ Lewati ke no.79</p> <p>4. Never → Skip to 80 Tidak pernah → Lewati ke no.79</p> <p>5. Don't know → Skip to 79 Tidak tahu → Lewati ke 79</p>
77.	How many times did you join the kelas kilat pengasuhan WVI? Berapa kali anda mengikuti kelas kilat pengasuhan WVI? kali
78.	Do you think kelas kilat pengasuhan WVI helps you for caring your child? Apakah kelas kilat pengasuhan WVI membantu anda untuk mengurus anak anda?	<p>1. Yes Ya</p> <p>2. No Tidak</p> <p>3. Don't know Tidak tahu</p>
79.	May I see your family card? Bolehkah saya melihat Kartu keluarga anda?	<p>1. Yes Ya</p> <p>2. No, I have one but I won't show it to you → Finish Tidak. Saya memiliki tapi tidak ingin menunjukkannya → Selesai</p> <p>3. No, I don't have it → Finish Tidak, saya tidak memilikinya → Selesai</p> <p>4. Don't know → Finish Tidak tahu → Selesai</p>
80.	Record the primary care giver name and date of birth Catat Nama pengasuh utama dan tanggal lahirnya	[Text] [DD/MM/YYYY] (Tanggal/Bulan/Tahun)
	Record the youngest child name and date of birth Catat nama dan tanggal lahir si anak	[Text] [DD/MM/YYYY] (Tanggal/Bulan/Tahun)
	If primary care giver is not the chil's mother, record Mother's name and date of birth Bila pengasuh bukan ibu kandung si anak, catat nama ibu dan tanggal lahirnya	[Text] [DD/MM/YYYY] (Tanggal/Bulan/Tahun)

THANK YOU

3. Random sample location based on population of sub-village

Sub-district	Village	Sub-village	Lokasi sample utk < 24 yo	Lokasi sample utk \geq 28 yo
Sembalun	Sembalun Lawang	Lebak Daya	3	3
		Lebak Lauk	3	4
		Dasan Kodrat	3	2
		Baret Desa	4	4
		Mapakin	2	2
		Dasan Telaga	2	2
		Lebak Benjor	2	2

Sembalun	Sembalun Timba Gading	Dasan Tengah Timuk	5	5
		Dasan Bantek I	3	4
		Dasan Bantek II	5	4
		Berugak Mujur	6	6

Sembalun	Sembalun Bumbung	Jorong	1	1
		Jorong Utara	1	1
		Jorong Tengah	1	1
		Jorong Timuk	1	1
		Bebante	1	1
		Bebante Daya	2	2
		Bebante Timuk	1	0
		Daya Rurung Barat	1	2
		Benyer	2	2
		Batu Jalik	1	1
		Daya Rurung Timuk	1	1
		Otak Desa	1	1
		Lauk Rurung Barat	2	2
		Bedurik	1	1
		Lauk Rurung Timuk	2	2

Pringgabaya	Labuhan Lombok	Saleh Sungkar	3	2
		Sandubaya Timur	2	3
		Sandubaya Barat	3	3
		Kampung Banjar	2	2

Sub-district	Village	Sub-village	Lokasi sample utk < 24 yo	Lokasi sample utk \geq 28 yo
		Kampung Baru	1	1
		Kampung Turingan	2	2
		Jati Makmur	2	1
		Pererenan	1	2
		Kayangan	1	1
		Jati Luhur	2	1
		Batean	0	1

Pringgabaya	Pohgading Timur	Bagek Gaet	2	2
		Bagek Lawang	2	2
		Gegurun	2	2
		Sukamulia	2	2
		Bagek Gaet Selatan	3	3
		Aik Sepolong	1	1
		Bagek Kembang	2	1
		Gegurun Lauk	2	2
		Gegurun Timuk	2	3
		Dasan Tengah	1	1

Pringgabaya	Tanak Gadang	Temanjor	7	7
		Temanjor Timur	6	7
		Tegaron	6	5

4. Summary of Indicators

Specific objectives	Indicators	Baseline Results		Endline Results		
		≤ 24	≥ 28	≤ 24	≥ 28	
To describe the social, economy, demography, assets and living condition of the households with children under-five years old including age, gender, education level, occupation, numbers of household member, electricity ownership, toilet facility type, source of drinking water, and regular income.	% of Households based on gender of Primary caregiver					
	Female	99.6%		100%		
	Male	0.4%		0%		
	· Primary caregiver age distribution					
	≤ 18 years old	2.2%		4.0%	44.7%	
	19 – 24 years old	46.9%		12.7%		
	25 – 30 years old	14.9%		21.9%		
	31 – 36 years old	20.2%		12.7%		
	37 – 42 years old	13.2%		1.8%		
	43 – 48 years old	1.8%		0.9%		
	49 – 54 years old	0.4%		0.9%		
	55 – 60 years old	0.4%				
	Age of biological mother	16 - 45 years old			15 – 50 years old	
	Age of biological mother in her first marriage, based on her report					
	≤ 18 years old	35.5%		39.9%		
	> 18 years old	64.1%		57.0%		
	· Youngest child age distribution					
	0 - 5 months old	11.4%		14.5%		
	6 - 11 months old	16.2%		14.9%		
	12 - 23 months old	31.6%		29.8%		
	24 - 35 months old	23.7%		20.2%		
	36 - 47 months old	12.7%		14.0%		
	48 - 59 months old	4.4%		6.6%		
	Gender of U5C					
	Girl	48.2%		54.4%		
	Boy	51.8%		45.6%		
	· Distribution of Primary caregiver status to youngest child					
Biological mother	98.7%		96.9%			
Father	0.4%		0%			
Grandmother	0.9%		2.2%			
Aunt			0.9%			
· Distribution of time since primary caregiver took care the Youngest child						

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
	0-5 months	12.3%	11.4%		
	6 - 11 months	19.3%	14.0%		
	12 - 23 months	31.6%	31.6%		
	24 - 35 months	25.4%	21.1%		
	36 - 47 months	8.8%	15.8%		
	48 - 59 months	2.6%	6.1%		
	· Distribution of youngest child's mother current location				
	Working abroad (different country)	0.9%			
	Working daily from 08.00 – 21.00 at a local pharmacy	0.4%			
	· Distribution of youngest child's biological mother's education				
	Did not go to school	0.9%		0.4%	
	Elementary school but not finished	4.8%		6.6%	
	Graduated from elementary school	10.1%		13.2%	
	Graduated from junior high school	27.6%		35.0%	
	Graduated from senior high school	44.7%		39.5%	
	Graduated from university	11.9%		5.3%	
	· Distribution of primary caregiver education				
	Did not attend school	0.9%		1.8%	
	Elementary School, not completed	4.8%		6.6%	
	Graduated from elementary school	10.1%		12.6%	
	Graduated from junior high school	28.1%		35.0%	
	Graduated from senior high school	44.7%		27.2%	
	Graduated from university	11.4%		5.3%	
	· Age distribution of youngest child's father				
	≤ 18 years old			1.3%	
	19 – 24 years old	16.2%		18.0%	
	25 - 30 years old	31.1%		24.6%	
	31 - 36 years old	25.0%		26.8%	

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
	37 - 42 years old	17.1%		14.9%	
	43 - 48 years old	8.0%		8.3%	
	49 - 54 years old	2.2%		4.4%	
	61 - 66 years old	0.4%		0.4%	
	· Distribution of youngest child's father education				
	Did not attend school	0.4%		0.4%	
	Elementary school, not completed	6.7%		9.2%	
	Graduated from elementary school	19.3%		16.2%	
	Graduated from junior high school	22.8%		31.6%	
	Graduated from senior high school	37.7%		32.9%	
	Graduated from university	11.8%		9.2%	
	Others, Graduated from Paket C & Diploma	0.9%			
	Do not know	0.4%		0.4%	
	· Distribution of primary caregiver occupation				
	Housewife	92.1%		98.7%	
	Farmer	17.5%		19.3%	
	Small business owner	7.9%		6.6%	
	Farming labourer	5.7%		11.0%	
	Food vendor	4.8%		3.9%	
	Teacher	4.4%		1.3%	
	Construction labourer	0.9%			
	Civil servant			0.4%	
	Others	4.8%		3.9%	
	· Distribution of total number of people living in household				
	2	4.4%	0.9%		
	3	57.9%	9.6%		
	4	18.4%	38.6%		
	5	8.8%	34.2%		
	6	6.1%	11.4%		
	7	2.6%	5.3%		
	8	0.9%	0.0%		
	9	0.9%	0.0%		

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
	Distribution of number of children under five years old living in household				
	1	90.3%	91.2%		
	2	8.8%	8.8%		
	3	0.9%	0.0%		
	· % of household with electricity	100.0%	98.3%		
	% of HHs with access to toilet				
	· Distribution of toilet types in household				
	Toilet with septic tank	95.6%	95.6%		
	Toilet without septic tank	2.6%	3.5%		
	other	0.9%	0.9%		
	No toilet	0.9%	0.0%		
	% of HHs with access to drinking water				
	· Distribution of drinking water sources				
	Covered well	58.8%	55.3%		
	Surface water	25.4%	28.0%		
	Piped water	7.0%	9.7%		
	Open well	4.4%	6.1%		
	Buy	4.4%	0.9%		
· % of households with regular income	51.80%	46.50%			
To describe food security status of the respondent.	· % of households with Food security status				
	· % of households that are food secured	28.1%	28.9%		
	· % of households with Mild food insecurity	46.5%	42.1%		
	· % of households with Moderate Food Insecurity status	22.8%	22.8%		
	· % of households with Severe Food Insecurity status	2.6%	6.1%		
To describe the child caregiving practices of the respondent.	· % of primary caregiver who received help taking care youngest child	79.8%	62.3%	88.6%	66.7%
	· Distribution of people who helped primary caregiver taking care youngest child				
	Grandmother	76.9%	53.5%	69.3%	48.7%

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
	Respondent's spouse	44.0%	62.0%	60.4%	67.1%
	Other relatives	25.3%	36.6%	16.8%	19.7%
	Grandfather	17.6%	14.1%	14.8%	15.8%
	Etc (Biological Mother, In-laws, Neighbour)	5.5%	8.5%	2.0%	5.3%
	Older sibling	2.2%	12.7%	4.0%	6.6%
	· % of primary caregiver who always wash hands with soap before feeding youngest child	57.0%	62.3%		
	· % of primary caregiver who always wash hands after going to toilet	83.3%	88.6%		
	· % of primary caregiver who can show youngest child's growth chart	84.2%	83.3%	80.7%	83.3%
	% of children < 59 months old who were taken to Posyandu in the last 3 months, based on card	96.3%		98.9%	
	· % of primary caregiver who knows at least 2 danger signs	41.2%	37.7%		
	· % of youngest child who ever received vaccination	97.4%	98.2%	93.0%	98.2%
	· % of youngest child who received deworming medication in the last 6 months (children ≥ 12 months old)	83.0%		88.2%	
	Practices to prevent childhood illness (distribution)				
	Vaccination	7.0%	3.5%		
	Hygiene practice	60.5%	78.9%		
	Food (food pattern, healthy food)	57.9%	59.6%		
	Others	11.4%	12.3%		
	Nothing	2.6%	2.6%		
	Don't know	0.9%	1.8%		
	· % of primary caregiver who gives ORS when the youngest child had diarrhea	13.2%	16.7%		
To describe parent-child interaction of the respondent.	· of primary caregiver responding correctly to all 18 brigançe questions	1.7%	1.7%	0.9%	5.3%
	· % of primary caregiver who gave toys to youngest child	89.5%	90.3%	89.5%	90.4%
	· % of caregiver who think				

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
	youngest child have safe and clean place to play				
	Really safe and clean place	18.4%	29.0%	17.5%	18.4%
	Enough safe and clean place	71.9%	64.0%	78.9%	81.6%
	Combination of safe but not clean and vice versa	8.8%	6.1%		
To describe Infant and Young Child Feeding practices by respondent	· % of youngest child ever been breastfed	97.4%	95.6%	99.1%	94.7%
	· % of youngest child who only receive breast milk during the first 3 days	60.5%	72.8%	74.6%	83.3%
	% U5C who received pre-lacteal feeds in the first 3 days after birth	39.5%	27.2%		
	· % of youngest child received solid/semi solid food ≥ 6 months old	59.0%	72.1%	62.7%	87.6%
	· % of youngest child age ≥ 6 months old who received at least 5 food groups in the last 24 hours	72.6%		84.1%	
	· % of youngest child age ≥ 6 months old who did not eat junk food in the last 24 hours	20.2%	19.3%	18.4%	19.3%
	% U5C who consumed Ultra-Processed Food in the last 24 hours	79.8%	80.7%		
	· % of youngest child age ≥ 6 months old whose muac is between ≥ 125mm	97.5%		96.9%	
	% U5C access GMP (Posyandu or Integrated Service Post) regularly	94.7%	97.3%	92.1%	95.6%
	% U5C with Growth Card (KMS)				
	Yes, shown to enumerator	84.2%	83.3%	80.7%	83.3%
	Yes, not shown	9.7%	12.3%	17.5%	16.7%
	Don't have	6.1%	4.4%	1.8%	0%
	% U5C who visited Posyandu in the last 3 months	96.3%		98.9%	
	· % of households who use iodized salt	19.3%	22.8%		
To describe the social behaviour change communication channel, information and	· Distribution of primary caregiver' current learning sources				
	Family	52.6%	36.0%	63.2%	43.9%
	Social media	47.4%	32.5%	58.8%	44.7%
	Community Health Workers	36.8%	45.6%	39.5%	61.4%

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
preferred method to learn about child caring and feeding practices.	Health workers	30.7%	44.7%	35.1%	52.6%
	Elders	8.8%	8.8%	22.8%	22.8%
	Neighbours	7.0%	11.4%	12.3%	8.8%
	Community events	0.0%	3.5%	2.6%	9.6%
	Others	20.2%	21.9%	4.4%	12.3%
	· % primary caregiver who received health education from health workers				
	Often	21.9%	29.0%		
	Sometimes	38.6%	51.8%		
	Once	15.8%	9.6%		
	· % primary caregiver who received health education from Community Health Workers				
	Often	27.2%	28.9%		
	Sometimes	33.3%	43.0%		
	Once	9.7%	8.8%		
	· Distribution of people whom primary caregiver trust and use as information sources for child caring and feeding				
	Family	71.9%	53.5%	92.1%	71.9%
	Neighbours	31.6%	32.5%	36.8%	36.0%
	Friends	9.6%	12.3%	14.9%	18.4%
	Community Health Workers	21.9%	29.8%	30.7%	49.1%
	Health workers	23.7%	30.7%	27.2%	38.6%
	· % of primary caregiver who use media (TV, internet, radio) as information source for child feeding knowledge	71.9%	51.7%	79.8%	71.1%
	% of primary caregivers who attended crash course on parenting			51.8%	70.2%
	· % of primary caregiver who attended training or other educational program for child feeding and caring practices.	33.3%	44.7%		
	· % of primary caregiver who wants to learn more on child caring and feeding practices	88.6%	88.6%		
	· Distribution of preferred ways for primary caregiver to receive information on child caring and				

Specific objectives	Indicators	Baseline Results		Endline Results	
		≤ 24	≥ 28	≤ 24	≥ 28
	feeding practices				
	Written materials	12.9%	14.8%		
	Direct education	78.2%	86.1%		
	Movies	6.9%	6.9%		
	Songs	0.0%	1.0%		
	Games	5.9%	4.0%		

XI. References

1. Joseph J. Valadez, PhD, MPH, ScD, William Weiss, MA, Corey Leburg, MHS. Using LQAS for Assessing Field Programs in Community Health in Developing Countries. 2001.
2. Bennett LR. Early marriage, adolescent motherhood, and reproductive rights for young Sasak mothers in Lombok. *Wacana* Vol 15 No 1 2014. 2014;
3. Herliana BR, Utami NWA, Kurniati DPY. Early marriage practices and the health impacts on female adolescent health in Central Lombok: a qualitative study. *Public Health Prev Med Arch*. 2018 Jul 1;6(1):61–7.
4. Rahiem MDH. COVID-19 and the surge of child marriages: A phenomenon in Nusa Tenggara Barat, Indonesia. 2021;
5. Rahmawati SM, Madanijah S, Anwar F, Kolopaking R. The effectiveness education of counseling of infant and young child feeding as intensive to improve counseling performance of Posyandu cadres in Bogor, Indonesia. *Int J Community Med Public Health*. 2019 May 27;6(6):2280.
6. UNICEF. UNICEF Conceptual Framework for Maternal and Child Nutrition. 2021.
7. Davis R, Luna J, Rodriguez-Lainz, Sarriot E. Davis, R., Luna, J2., Rodriguez-Lainz3, A., Sarriot, E2. The Rapid Household Surrvey: How to Obtain Reliable Data on Health at the Local Level. Public Health Institute and ICF Macro, an ICF International company; 2009.
8. CORE Group. Protocol for Parallel Sampling: Using Lot Quality Assurance Sampling to Collect Rapid CATCH Information [Internet]. 2008. Available from: <https://coregroup.org/resource-library/lot-quality-assurance-sampling-lqas-protocol-for-parallel-sampling-guidance-faqs/>
9. World Health Organization, UNICEF. Indicators for Assessing Infant and Young Child Feeding Practices: Definitions and Measurement Methods. 1st ed. Geneva: World Health Organization; 2021. 1 p.
10. Brigance AH, French BF. Brigance inventory of early development III / 0-35 months: early childhood edition. Standardized. North Billerica, MA: Curriculum Associates; 2013.
11. Food and Agriculture Organization (FAO). Food Insecurity Experience Scale (FIES) [Internet]. 2024. Available from: <https://www.fao.org/policy-support/tools-and-publications/resources-details/en/c/1236494/>
12. Monteiro CA, Geoffrey Cannon, Mark Lawrence, Maria Laura da Costa Louzada, Priscila Pereira Machado. Ultra-processed foods, diet quality, and health using the NOVA classification system. FAO; 2019.

13. Carlos A. Monteiro, Geoffrey Cannon, Renata Levy, Jean-Claude Moubarac, Patricia Jaime, Ana Paula Martins, et al. Food classification. Public health. NOVA. The star shines bright. World Nutr [Internet]. 2016 Mar;Volume 7(Number 1-3). Available from: <https://worldnutritionjournal.org/index.php/wn/article/view/5/4>
14. William Vargas, Caroline Jeffery, Joseph J. Valadez, PhD, MPH, ScD. LQAS Planning and Implementation Guide. World Vision and Liverpool School of Tropical Medicine; 2018.
15. USAID. Module 4B: Sick Child. 2006.
16. Kemenkes. Buku Kesehatan Ibu dan Anak [Internet]. 2023. Available from: <https://ayosehat.kemkes.go.id/buku-kia-kesehatan-ibu-dan-anak>
17. UNICEF Indonesia, Kemenkes. Mid-Upper Arm Circumference (MUAC) Tapes: A Simple Tool to Detect Child Wasting and Save Lives [Internet]. 2023. Available from: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.unicef.org/indonesia/media/19771/file/MUAC%20guidelines.pdf>
18. Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan RI. Riset Kesehatan Dasar Indonesia 2013 [Internet]. 2013. Available from: https://repository.badankebijakan.kemkes.go.id/id/eprint/4467/1/Laporan_riskesdas_2013_final.pdf
19. Gomes, A.I.; Pereira, A.I.; Nogueira, P.C.; Barros, L. Development of a New Questionnaire to Assess Parental Perceived Barriers When Promoting Healthy Eating Habits in Young Children: First Findings. *Nutrients* 2023, 15, 4672. <https://doi.org/10.3390/nu15214672>