Sex- and Gender-Based Analysis of Adolescent Health and Nutrition Programs in Indonesia

A POLICY BRIEF

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

NUTRITION INTERNATIONAL
Nourish Life

In partnership with Canada

The Habibie Center

CONTEXT

There are over 46 million adolescents living in Indonesia making up 17.3 percent of the country's population.[1] Among them, adolescent girls face the bigger burden of malnutrition with 18.5 percent of adolescent girls being stunted, 26.8 percent of girls aged 5 to 14 years, and 32 percent of those aged 15 to 26 years being anaemic.[2] Menstruation and consequent blood loss further raise the risk of anaemia for adolescent girls and women aged 15 to 49 years when the increased iron needs are not met by the diet. Food insecurity and social norms often mean that girls and women do not have optimal access to iron-rich foods.

The Government of Indonesia, with support from civil society organizations, has implemented various programs and policies to address the issue of adolescent health and nutrition. The National Action Plan on Food and Nutrition aims to improve nutrition, increase food availability and accessibility, and strengthen food and nutrition governance. The government also implements the mandatory weekly iron and folic acid supplementation (WIFAS) program for school-going adolescent girls as a strategy to prevent anaemia.

However, discriminatory social and religious norms such as food taboos, early marriage, early pregnancy, limited decision-making opportunities afforded to women, and limited access to education for girls (in certain districts) affect the health and nutrition of girls and women. Since they bear a disproportionately higher burden of malnutrition, it is important for interveners and policymakers to understand the nature of gender norms, attitudes, practices and gender power structure at family and community levels, and their correlation to other social, community and religious norms that impact the health and nutrition of women and girls. For example, girls are more likely than boys to drop out of school. According to UNICEF, for every 10 children that drop out of school at the secondary level, seven are girls. One of the primary reasons for this is early marriage and the traditional gender roles of society that limit their future productive potential, which can furthermore lead to negative nutritional consequences in the short and long term. An intersectional approach that considers various socioeconomic and demographic factors is therefore needed to deal with this issue and make policies and programs that prioritize gender equality as central to their interventions.

Since 2015, Nutrition International has been working with the Government of Indonesia to improve adolescent health and nutrition in the country. It is within this context that we conducted an in-depth study to assess and analyze gender issues relevant to Indonesia's adolescent health and nutrition (AHN) program.

1 National Census, 2020
2 RISKEDAS, 2018

THE STUDY

Nutrition International's Sex- and Gender-Based Analysis (SGBA) of the AHN program in Indonesia was conducted in two cities (Cilegon and Bogor) and two districts (West Bandung and Kupang) within Banten, West Java and East Nusa Tenggara provinces. The qualitative study included desk reviews, document reviews, key informant interviews and focus group discussions aimed at achieving the following objectives:

- **Assess the gender equality issues relevant to AHN in the three provinces to learn about contextual factors that have differentiated impacts on boys' and girls' nutrition, health, wellbeing, as well as their current and future socio-economic condition.**
- **Assess Nutrition International's current AHN program in Indonesia to identify opportunities to promote gender equality, identify inequities and vulnerable groups, and suggest interventions to make it more gender-responsive and increase equity in access.**
- **Identify and explain gender barriers, lessons learned and key entry points that worked well in previous AHN programs.**
- **Identify potential opportunities, risks and enablers, and provide recommendations to promote gender equality and girls' and women's empowerment, as well as highlight opportunities to work with youth on gender equality issues directly relevant to the project.**

A total of 166 people[3] participated in the study, including school-going adolescent girls and boys, parents, teachers, community leaders and representatives from various government ministries ranging from national to sub-district levels. Discussions with out-of-school girls were not included and were beyond the scope of this study, which is noted as a limitation.

3 110 females, 56 males

KEY FINDINGS

Prevailing gender norms and practices affecting adolescent nutrition and health

Perceptions and understanding of gender equality: Participants from urban areas are more familiar with gender terminology compared to those from district and rural areas. Many study participants stated that boys and girls have an equal right to higher education. However, there is a different perspective on reproductive issues between girls and boys. It is easier to talk about puberty as it relates to girls because menstruation is considered a health matter. It is harder to talk about how boys experience puberty. For example, nocturnal emission is viewed as a sexual matter that is considered taboo in the Indonesian context. When it comes to teaching and learning processes, gender norms and concepts influence access to education and play a role in creating gender-based barriers in the school environment.

Unintended pregnancy and early marriage: Early marriage is highly prevalent in many parts of Indonesia, with 13 percent of girls under the age of 18 being married in the country.[4] The study found that unintended pregnancy, which is one of the primary reasons for early marriage, is a critical issue among adolescent girls in Kupang district, where some instances of unwed pregnancy were the consequence of rape. The stigma and shame associated with pregnancy among unmarried adolescent girls can lead to their early marriage. Furthermore, since abortion is strictly prohibited by law,[5] individuals consider early marriage as the only alternative. Some girls even get married while still in elementary school, and girls are more likely to drop out of school when early and unintended pregnancy happens.

Access to information: Adolescents access health information through various sources including the internet, parents, teachers and community health workers. However, the type and extent of health information sought may be influenced by gender norms and communication patterns within families. While boys and girls have distinct preferences for their source of information, there are also differences observed in their understanding of health and nutrition. Parental influence plays a significant role in providing health information to both boys and girls.

Intersectional considerations: Adolescents — especially boys — who were raised by their grandparents due to their parents' divorce or their migrant occupation, often get involved in delinquent activities that might come with health risks. As a result, they struggle to meet their nutritional needs which significantly impacts their health and well-being.

Access to and control over resources, and division of labour: In some households, mothers manage the finances and make major spending decisions, even though fathers may be the primary earning member. In some households, management of the family's finances is a shared responsibility between the mother and father. Household chores are still seen as the primary responsibility of women. In women-headed households, where mothers earn and fully manage household finances, adolescents, regardless of gender, are involved in managing domestic tasks.

Food consumption patterns and gender: Adolescent girls reported consuming unhealthy snacks often and excluding vegetables from their diet. A different dietary pattern was observed among adolescent boys, with some boys in Banten paying more attention to their diet, especially their protein intake which is needed for building muscles.

4 RISKESDAS 2018
5 Health Law No. 36/2009, Article 75(1)

Potential opportunities and enablers for promoting gender-responsive adolescent nutrition and health

Government Policies and Programs

The current National Action Plan on Food and Nutrition (2020–2024) places gender equality as an important approach in designing and implementing food and nutrition actions. The plan also considers the potential influence of gender roles and responsibilities on nutritional requirements. The action plan recognizes that gender equality is important for empowering women to claim their rights to obtain adequate nutrition and food intake, to have a better quality of life and to attain better job opportunities to support the country's development. It also acknowledges that gender inequality can serve as a determinant of malnutrition. The National Development Policy states that gender mainstreaming must not only produce gender-responsive policies but also ensure that women are treated equally across development sectors. At the community level, there are examples of innovative programs such as Dad's Breastfeeding Support[6] and Youth Family Coaching[7] to facilitate understanding of gender equality concepts.

Since one agency oversees child protection, family planning and women's empowerment programs, programs may share similar themes around gender equality. However, coordination and collaboration between various departments and agencies — combined with diverse gender concepts and cultural and religious norms — can pose challenges to the smooth implementation of programs.

Education Sector

All of the schools that participated in the study implemented varying degrees of health-related activities including WIFAS, school lunch program, *Aksi Bergizi*,[8] nutrition and health education, adolescent counselling, immunization and health screening. During the COVID-19 pandemic, program delivery temporarily shifted from schools to various platforms and girls consumed supplements at home. Prior to the pandemic and when schools re-opened, it was beneficial to involve female students as peer educators for WIFAS. Not only did this approach help adolescent girls overcome confusion and hesitation regarding health and nutrition, but it also holds the potential to increase the agency and leadership skills of peer educators. Out-of-school girls are supplied WIFAS through Youth Posyandu, however greater support is needed to measure adherence to the weekly consumption of iron and folic acid supplements as well as continued and regular access to WIFAS.

The *Aksi Bergizi* program has not been implemented uniformly across the schools in the four regions. Several schools have established healthy canteens where nutritious foods and snacks are supplied. Compared to boys, girls are seen to participate more actively in the nutrition-related activities of the program.

6 A program to encourage men to support their wives during pregnancy and throughout breastfeeding.
7 A program to provide information on sexual and reproductive health, prevention of early marriage to parents of adolescents.
8 *Aksi Bergizi* (Action on Nutrition program) is an adolescent nutrition program to address the triple burden of malnutrition in Indonesia, which includes WIFAS and nutrition education sessions promoting healthy eating and physical activity.

Health Sector

The adolescent health cadres or *Duta Sehat* (Health Ambassadors) have helped spread the message of health and nutrition to adolescents. Their support is extended to schools where most of the adolescent health programs are implemented, and they have also been introduced as peer counsellors. One key challenge is that youth cadres at schools are predominantly female, and boys prefer to speak to other boys about health-related information. Girls were found to be engaging openly regardless of the gender of the person from whom they sought health-related information.

The lack of gender-disaggregated data in health services is an issue while designing gender-responsive programs.

Barriers, challenges, and risks

- Limited budgets are the main challenge to gender-responsive programs, resulting in program implementation in only some of the priority areas.
- Many nutrition and health programs are under different ministries, agencies and local government institutions, which means the budget for nutrition and health programs is not centrally managed and coordinated by a particular agency.
- Government policies and regulations such as *dispensasi nikah*[9] or marriage dispensation contribute to the prevalence of child marriage as the marital age exemption under this policy makes it easier for parents to marry off their children and adolescents.
- There is a lack of community awareness about gender equality concepts, especially among those with lower education levels. Gender differences in nutritional risks and needs are not well understood, and thus adolescent nutrition — especially for girls — is not prioritized.
- Higher women's participation in gender-related programs has led to the misconception of gender issues being viewed as "women's issues." As a result, more female government representatives are being delegated to gender related capacity-building programs.
- Due to the lack of women's and feminist organizations in most rural areas, schools assume the primary responsibility of providing gender education. However, they often face gaps in getting technical support for the programs.

9 Granting of marriage permission by the government through the court to prospective husbands or wives who are not yet 19 years old.

RECOMMENDATIONS

Central and local government

- Beyond the national level, the gender mainstreaming concept needs to be introduced at the grassroots level too, including at schools, Puskesmas, and communities.
- Multisectoral gender mainstreaming efforts (gender responsive planning and budgeting) need to be planned, coordinated and monitored through an action plan. This requires various government ministries and departments to collaborate to ensure that their respective health and nutrition interventions have the maximum impact.
- Coordination and communication need to take place at the district and community levels between and across departments such as health, education, Puskesmas, and local communities. This will ensure timely and adequate supply of WIFAS supplements for adolescent girls, and effective delivery of health modules of *Aksi Bergizi* and other services.
- Different kinds of schools may adapt the delivery of sexual and reproductive health (SRH) modules to suit their needs using the approved curriculum to respond to age-stage and unique needs. For instance, in special-needs schools parents and caregivers can be included in the education sessions; in co-education schools the modules can be delivered separately to boys and girls.
- Consider and re-evaluate the current policies on child marriage (for example, reconsider the effectiveness of and impact of granting *dispensasi nikah*) and build greater awareness among communities to prevent child marriage and early pregnancy, and to remove the stigma around pregnancy among unwed girls/women.

Community

- It is important to ensure adequate availability of youth-responsive health services at all Puskesmas and schools. More adolescent cadres need to be put in place for both adolescent girls and boys, including out-of-school adolescents.
- There is a need to invest in and introduce more health and nutrition programs, motivate adolescents to access these programs by making them appealing to adolescents, and build capacities of the adolescent health cadres by involving community leaders and the Family Welfare Movement (PKK). While designing such AHN programs, it is important to keep in mind the specific needs and preferences of girls and boys as well as their sex-specific nutritional needs.
- It is crucial to involve adolescents while designing and assessing programs to ensure their preferences are incorporated. Additionally, parents and community leaders can be engaged through regular communication.

Parents/caregivers

- Ensure adequate supervision (for instance, in the use of social media) and involvement in issues related to SRH and mental health.
- Adopt gender equality concepts in daily life — distributing domestic chores equally between boys and girls, providing adequate nutritious food to both boys and girls, and taking equal responsibility for caregiving roles at home.
- Collaborate with adolescents in the family to maintain a healthy lifestyle and balanced diets among family members.
- Learn about the unmet nutritional needs of adolescent girls, encourage full use of WIFAS to prevent anaemia and provide access to iron-rich foods and balanced diet.
- Encourage adolescent participation in health programs.

Development partners

- Initiate and advocate for gender-responsive AHN programs. They can provide technical guidance and capacity building for gender mainstreaming in health and nutrition programs.
- Evaluate current government-run programs to identify areas for improvement and suggest solutions to make them more gender- and youth-responsive.
- Engage extensively with youth to understand their needs and motivate them to act as champions of their rights and health.

ABOUT NUTRITION INTERNATIONAL

Nutrition International is a global nutrition organization headquartered in Ottawa, Canada. For more than 30 years, we have focused on delivering low-cost, high-impact, nutrition interventions to people in need. Working alongside governments as an expert ally, we combine deep technical expertise with a flexible approach, increasing impact without increasing complexity or cost. In more than 60 countries, primarily in Asia and Africa, Nutrition International nourishes people to nourish life.

For more information, contact:

Herrio Hattu
Country Director – Indonesia,
Nutrition International
hhattu@nutritionintl.org

NUTRITION INTERNATIONAL
Nourish Life

NutritionIntl.org