Assessment of the Scale-up of Emotional Demonstrations in East Java Districts and Sigi District, **Central Sulawesi**

Introduction

Background information

In 2014, the national Ministry of Health of Indonesia requested the Global Alliance for Improved Nutrition (GAIN) to support the district governments of Malang and Sidoarjo in East Java Province to reduce stunting through improvement of maternal and infant nutrition. Subsequently, GAIN with funding from the Ministry of Foreign Affairs of the Netherlands and in collaboration with Save the Children, Paramitra Foundation, and PT. Holland for Water (Nazava) initiated the first phase of the "Baduta" programme[1]. Experiences and recommendations were used to inform efforts to scale-up those interventions shown to be effective[2] in Indonesia.

The first phase of the Baduta programme (Baduta 1) ran from 2015 to 2017. The Baduta 1 behaviour change communication strategy was developed based on the principles of "Behaviour Centered Design" (BCD), an approach to designing behaviour change interventions developed by the London School of Hygiene and Tropical Medicine (LSHTM) (1). Rooted in evolutionary theory, psychology, and commercial marketing, BCD aims to create innovative, imaginative, and provocative communication messages and activities that tap into people's emotional and psychosocial responses, over and above educational messages focused on health-related triggers. The approach attempts to use human drivers of behaviour such as fear, hunger, disgust, comfort, habit, and lust; emotional responses including hoarding, creating, nurture, and love; and the brain-centered interests of curiosity and play to stimulate behavioural change. In developing world settings, research has demonstrated that socially- and emotionally driven factors, such as nurture, disgust, cleanliness, and affiliation, are motivators to individual handwashing behaviour (2,3). Promotion of these psychological drivers has been successfully applied to improve handwashing practices (4,5). However, there is scarce evidence regarding how the use of social and emotional drivers influences adoption of improved nutritional practices.

Using the BCD theoretical framework, a behavioural change campaign was implemented focusing on four key behaviours including: 1. Exclusive breastfeeding among infants less than 6 months of age; 2. Complementary feeding: 3. Healthy snacks; 4. Nutrient-rich diets for expectant mothers to target during a communication campaign. The behaviour change campaign was channeled through social media, counseling, and national television spots. Participatory group activities in the form of 'emotional demonstrations' or emo demos were also created. The approach uses drivers in the form of emotions or social interests to generate emotional responses and trigger recall to form habits aimed to adopt desirable behaviours or discourage undesirable behaviours. To our knowledge, emo demos have not previously been applied to nutrition messaging.

Based on the results of Baduta 1, GAIN and five district governments in East Java scaled up selected components of the original package of Baduta interventions. Selection of the districts was based on the District Health Office (DHO) level of interest and health and nutritional problems affecting women of reproductive age and young children. GAIN worked with the MOH to select components of the

[1] "Baduta" means infant or young child in Bahasa Indonesia.

[2] Examples include community activations or emotional demonstration sessions promoting improved infant and child feeding practices and handwashing with soap.

original package of Baduta 1 interventions, including the 10 steps to successful breastfeeding, the MSC approach, and emo demo sessions, and to implement an intensive intervention, referred to as Baduta 2, in 50% of the areas in these districts. In addition, the government scaled up the interventions in the other areas of these districts and in other districts around the country.

Given their promising results, the interest they have generated, and the resources being invested in the emo demo approach in Indonesia, it is imperative to review and understand the strengths and limitations of the different strategies previously and presently employed to implement emo demos. In addition, emo demo modules developed in Indonesia are generating interest in other countries in Asia and Africa, with implementation ongoing in Mozambique. Before further roll outs and scaling up occur in other contexts, it is critical to examine the implementation processes utilized through the various phases of implementation during Baduta 1, Baduta 2 and the areas where Baduta 2 interventions were scaled up, and other districts in Indonesia, and consolidate evidence regarding factors enhancing or limiting implementation and their effect on the quality of emo demo sessions. Specifically, it will be important to explore key components of each strategy such as the technical assistance provided, the quality of training received, the technical capacity of people involved at different levels of implementation, and the way in which the different approaches have affected the quality of emo demo sessions. Study results can be used to identify aspects of the emo demo approach and sessions that function well and need strengthening. These can be shared with the Indonesian government and other health and nutrition stakeholders and may be used to plan future emo demo implementation and programming. In addition, findings will be relevant for other settings where emo demos are getting underway or being considered for implementation.

We conducted a qualitative assessment in Indonesia examining lessons learned from the implementation of Baduta 1 and the three ongoing interventions (intensive intervention, scale up in intensive intervention districts, and government districts implementing emo demos) and the quality of emo demo sessions conducted through each approach. Our aim is for the results to shed light on the strengths and weaknesses of each intervention and their potential for utilization as part of behaviour change strategies to improve child feeding in Indonesia and other areas of the developing world where undernutrition is prevalent.

Research Methods

A literature review examining theories related to motivators to behavioural change, including the BCD theory, and evidence-based results using BCD to stimulate adoption of improved health behaviours was first conducted, as well as a desk review of reports and publications on Baduta 1 and Baduta 2 . We employed a mix of qualitative methods to examine factors affecting execution of emo demos during Baduta 1, Baduta 2 (intensive intervention and scaling up in five districts in East Java province), and in government districts. Methods included key informant interviews with experts and stakeholders located in and outside of Indonesia involved in the past and current development and implementation of Baduta 1 and 2. To assess the execution of Baduta 2 and emo demos in government districts, we conducted in-depth interviews with key personnel working at different levels (national, provincial, district, and Posyandu) of implementation and mothers of children under two years of age who recently participated in emo demo sessions.

We carried out key informant interviews by teleconference. In-depth interviews were conducted in one lower performing (Jember) and one higher performing (Bondowoso) district where the Baduta 2 interventions were taking place. Identification of higher and lower performing was based on monitoring data related to the numbers of intervention implementers trained, mothers participating in the emo demo sessions, and information collected from key informants regarding the quality of

implementation in the intervention districts. To assess implementation of emo demos in government led districts, we conducted interviews in the districts of Sigi and Malang City. Table 1 provides an overview of the study design. A more detailed description of the qualitative methods and data collection is presented below.

Qualitative data collection

Key informant interviews

We conducted key informant interviews with a range of experts previously and currently working on developing, implementing, and evaluating emo demos to improve maternal and child nutrition and handwashing in Indonesia. The aim of these interviews was to examine the rationale for using the BCD approach and how it compares to other behavioural change interventions; the various steps in development and implementation of the different interventions; key players involved at different administrative levels of each approach, their roles, and training received; descriptions of the training approach and perceptions of the quality of the training received; monitoring, evaluation and reporting conducted; and programme based evidence gathered through monitoring and evaluation systems. We sought to identify data-based evidence and perceptions of the acceptability of emo demo sessions from the perspectives of implementors and child caregivers, as well as views on how specific aspects of the strategies affected the quality of emo demo sessions. We questioned key informants about the strengths and weaknesses associated with each phase (e.g. Baduta 1, Baduta 2, government interventions) of the approach.

We selected key informants purposively based on their expertise and prior involvement in emo demo execution in Indonesia. Key informants included GAIN staff, Ministry of Health (MOH) officials, LSTMH staff who guided and evaluated the initial design of emo demos, and NGO representatives involved in the implementation of Baduta 1.

In-depth interviews

In-depth interviews were administered with key personnel working at different administrative levels (e.g. provincial, district, and Posyandu) of emo demo implementation through the Baduta 2 intensive and scaled up interventions and in districts where the government led interventions. Information collected focused on training approaches and schedules, perceptions of the quality of trainings, roles and time devoted to interventions, and collaboration with partners. Information was also collected on supervision and mentoring, information sharing and learning, and monitoring and evaluation. We explored understandings of the emo demo approach related to the underlying theory, goals, session contents, and target audiences. Informants were asked to share facilitators and challenges in implementation and perceived strengths and weaknesses of the emo demo approach. We solicited recommendations regarding ways to address barriers and improve interventions. In the government led intervention areas, we also administered interviews with caregivers who had recently attended emo demo sessions. We selected informants purposively based on their involvement and participation in the interventions.

Table 1. Study design of the Baduta 2 qualitative evaluation according to the level of implementation, research method and type of intervention

Level of Implementation	Research Method	Type of Intervention			Informants
		Intensive Intervention and Scale Up East Java Province: Jember District	Intensive Intervention and Scale Up East Java Province: Bondowoso District	Government Led: Sigi (Central Sulawesi Province) and Malang City (East Java Province) Districts	
National	Key informant interviews	GAIN Indonesia personnel (4) GAIN headquarter staff and consultants (3) MOH officials (2) LSTMH faculty (1) Partners involved in implementation of Baduta 1 (2)			12
Provincial	In-Depth Interviews (IDIs)	PHO East Java office (1)	Same informant as approach A	PHO Central Sulawesi (2) PHO East Java (2)	5
District	IDIs	GAIN District Coordinator (1) GAIN Training Coordinator (1) DHO (1) Master Trainer (1)	GAIN District Coordinator (1) GAIN Training Coordinator (1) DHO (1) Master Trainer (1)	DHO Sigi (1) DHO Malang City (2)	11
Posyandu	IDIs	N/A[3]	N/A	Sigi Cadres (4) Malang City Cadres (4)	8
Village (mothers attending emo demos)	IDIs	N/A	N/A	Sigi Mothers (4) Malang City Mothers (4)	8

[3] Due to the COVID-19 pandemic, interviews with cadres and mothers attending emo demo sessions were not possible in Jember and Bondowoso Districts.

Data Collection Procedures

A 5-day training workshop was carried out prior to the study. We trained three research assistants with prior experience using qualitative methods. Training also included theoretical and practical sessions related to research ethics and obtaining informed consent. Training was led by an international medical anthropologist and a senior Indonesian qualitative researcher.

Initial data collection involved key informant interviews which were open-ended and lasted approximately 1 – 1.5 hours. The team leads carried out the key informant interviews through teleconference using an interview guide with questioning adjusted according to informants' backgrounds and expertise. Data collection was an iterative process, with the information gathered serving to inform subsequent key informant interviewing. Information collected from key informants was also used to inform the content of in-depth interviews. We interviewed some key informants on multiple occasions, with the goal to establish a relationship of trust and to reach data saturation.

In-depth interviews with key implementers and mother caregivers were carried out by teleconference or by phone. In all cases, we allowed informants to choose an interview setting of their preference; efforts were made to ensure that privacy could be maintained during the interviews. Data collectors followed a semi-structured guide, with each interview lasting no longer than 1h 15 minutes. If the research assistant was unable to address all of the questions in the guide, the assistant scheduled a follow up session to complete the interview at a later time.

Key informant interviews were administered in English or Bahasa Indonesia, the official language of Indonesia, while all in-depth interviews were carried out in Bahasa Indonesia. We audio recorded key informant and in-depth interviews; interviewers also took handwritten notes of information that would give additional insights into the data. Interviews conducted in Bahasa Indonesia were first transcribed verbatim and subsequently translated into English, while interviews conducted in English were transcribed directly. Research assistants reviewed the transcripts before sending them to the lead researcher.

Data Analysis

Based on reviews of data transcripts, research assistants and the two lead researchers worked together to develop a coding system. Coding categories were derived from the initial research themes and questions, as well as from key concepts that emerged during data collection. Coding of the interview transcripts was done on ATLAS.ti and NVivo, text-organizing softwares. Content analysis was used to identify trends of concepts in and across individual codes. The combination of data, environmental and methodological triangulation allowed us to analyze data across different research methods (e.g. key informant and in-depth interviews) and sites and across and between study participants.

Research ethics

The study protocol was reviewed, and ethical approval granted by the institutional review board at the Atmajaya University, Jakarta, Indonesia. We obtained signed informed consent from all the key informant and in-depth interview informants prior to data collection.

Results

Key Informants

Background of informants

We interviewed GAIN headquarters personnel and consultants (3), GAIN Indonesian staff (4), Ministry of Health (MOH) officials (2), LSTMH (1) staff who guided and evaluated the initial design of emo demos, and NGO representatives involved in the implementation of Baduta 1 (2).

Informants involved in Baduta 1 reported making regular planned visits to observe emo demo sessions. One informant who often accompanied donors and government officials to observe sessions mentioned that there was always a big ceremony and efforts to display the best sessions. Observations of emo demo sessions implemented during Baduta 2 were limited and only done by staff based in the field.

Theoretical approach

Key informants underlined the value of following the BCD theory to guide the development of the Baduta campaign strategy and the emo demos, mentioning that BCD principles were used to identify motives and address determinants of the four main eating behaviours targeted during the campaign. Key informants reported that the campaign focused on emotions such as disgust, love, nurture, affiliation, and social pressure to motivate behavioural change. Most key informants praised the theoretical approach, stating that a psychological based strategy designed to appeal to the senses, trigger emotions, and create surprise to engage the audience is new and more effective than the traditional knowledge based, educational approaches, which only affect a section of the brain. However, one key informant asserted that the model is complex and therefore needs to be simplified to make it more understandable. This informant also felt that GAIN should be less rigid in following the model, claiming it needs to be adjusted according to local contexts. The key informant underlined that the field of behavioural change is constantly changing and that guiding models must be altered to take into account improvements.

Description of Emo Demos

Participatory group activities referred to as emo demos became the center piece of the Baduta campaigns. Originally developed by LSHTM to promote handwashing with soap, emo demos are interactive sessions focused on the four main target behaviours identified during the research phase of Baduta 1 that aim to associate feelings with habits. Meant to be relatively short, emo demos are designed to capture women's attention and evoke emotions. Moving away from knowledge-based approaches, which our informants reported can be technical and boring and overload mothers, the approach uses drivers in the form of emotions or social interests to generate emotional responses and trigger recall to form habits aimed to adopt desirable behaviours (exclusive breastfeeding infants under 6 months on demand, feeding young children fruits and vegetables during mealtimes and as snacks, etc.) or discourage undesirable behaviours (introducing water, formula or semi-solids in the diets of infants under 6 months, giving young children processed, packaged foods, etc.). In addition to evoking emotions such as love, disgust, nurture, and social pressure, the aim is to stimulate an "aha" or moment of surprise about a barrier to improved behaviours. Key informants mentioned that sessions are meant to be easily understood and relatable.

Led by a facilitator, the approach is based on active participation and involves the use of props (e.g. handouts, balls, cups, etc) to allow for touch and visualization as part of the learning process and to enhance retention. One key informant stated:

In relation to the theoretical way that emo demos are designed, there's supposed to be this short activity that is not just about teaching but is about visualizing and demonstrating something in such a way that it creates kind of an 'Aha' moment, or a light bulb moment to make people think about a particular topic or behaviour in a way that they haven't thought about it before. And by creating that visual experience, and the 'Aha' moment of being slightly surprised, and by doing it in a group setting with other mothers, the idea is that it creates a salient moment that can be easily recalled when people go to practice the behaviour. Then there is some sort of social influence from a normative aspect, particularly if the same cohort of mothers is going to go back the next week and continue to discuss these behaviours. So that's the theoretical aspects of emo demos; how much that carries through in practice, I'm not sure.

Key informants generally expressed enthusiasm about the innovation of the emo demo approach and the focus on interacting with mothers, stimulating the senses, and triggering emotions, rather than the direct transfer of knowledge. They reported wide variations in the modules, with some very emotional and others strictly entertaining, and the emo demo sessions' capacity to evoke a moment of surprise and elicit a visceral response. Sessions such as the snacking module (mixing colourful snacks in water) designed to trigger disgust and the importance of exclusive breastfeeding (demonstrating the small size of the baby's tummy, visually showing the difference between the oil content of breastmilk and formula, holding a carton of formula while talking about the most important aspects of mothers' lives) focused on love and nurture were mentioned as particularly powerful due to the visual effects and surprise, with some suggesting that these modules are more memorable. More informational sessions such as the timeline of complementary feeding was considered less effective.

Key informants emphasized that facilitators are critical to the success of the approach, underlining that facilitators need to be entertaining, make the session lively and joke, and improvise in order to engage participants and stimulate their emotions and feelings. As reported later in this report under the sections describing Baduta 1 and 2, the cadres proved to be a major weakness. Other mentioned weaknesses included the repetition of the same emo demo sessions, particularly since the approach is based on stimulating emotions and surprise, although GAIN has tried to address this through the development of 12 new modules. Another limitation mentioned by key informants is that sessions are often held in locations that lack adequate space to accommodate mother participants and their accompanying children. Key informants reported that sessions can become very chaotic when space is inadequate, losing the attention of the mothers and diluting the effect of the sessions, with some informants noting that when this occurs mothers frequently leave the session for home.

When asked about introducing emo demos in different contexts, one informant warned that the modules should not be directly replicated, in part because the key behaviours and their barriers vary from one context to another. Key informants noted that scale up of emo demos may be better suited for contexts where health systems are strong and health workers have good capacity. It was also mentioned that the approach requires an extensive network of committed community health workers.

Description of Baduta 1

Baduta 1 started in 2013 with preparatory work including an initial assessment, formative research, intervention development, and testing and ongoing revisions of the interventions. The programme was comprised of a package of diverse interventions that ran for 24 months from 2015-2017 in two districts (three sub-districts in each district) in the province of East Java, including Sidoarjo, a peri-urban district, and Malang, a rural district. Key informants reported that the government selected these districts based on the reputation of the local governments and populations of being welcoming

and eager to try innovative approaches. The project targeted 113 villages, reaching about 660,000 people including 46,000 children under-five, (of which 18,500 were under-two) and 11,600 pregnant women.

Key informants described Baduta 1 as the gold standard in programme development and implementation due to the highly unusual large budget (about 10 million USD for implementation, 2 million USD for the baseline-endline evaluation) and long timeframe which allowed the innovative team to spend quality time on campaign development, including initial formative research that guided the design of interventions and an iteration of modifications informed by formative research and monitoring and evaluation. While the initial goal was to reduce the prevalence of child stunting by 5% and anemia, the elimination of a food component involving distribution of micronutrient fortified flour made that untenable. Rather, the programme focused on behavioural change related to key behaviours impacting maternal and child nutrition. The goal was to develop an approach that was easy to roll out, would attract buy in by the Indonesian government to scale up, and could be sustainable.

An initial assessment identified four key behaviours influencing child and maternal nutrition which were explored in more detail during formative research. The key behaviours included: 1. Exclusive breastfeeding among infants less than 6 months of age; 2. Complementary feeding: 3. Healthy snacks; and 4. Nutrient-rich diets for expectant mothers. During the formative research, barriers to and key determinants of the four behaviours were assessed. Subsequently, a creative workshop comprised of diverse partners was held to identify behavioural tasks to motivate behavioural change related to the four key behaviours. Specifically, a team at GAIN worked with a creative agency to develop the Baduta interventions and messaging. Key informants praised the creative input and two-way learning during the design workshop. Based on the formative research, a brand identity, called Rumpi Sehat – Healthy Gossip – was developed as the Baduta 1 uniting theme, which recognized that social status and reputation are strong drivers of parenting behaviour among caregivers of young children (6). Multiple interventions were developed and proposed for implementation including TV commercial spots, street visits, messaging during Quran recital meetings, and the distribution of posters and the erection of notice boards sharing information about the programme. Determinants of each key behaviour were used to develop sixteen to eighteen storylines aimed to address barriers identified during the formative research as critical to the adaptation of the behaviours. Storylines evolved into emo demo sessions accompanied by guidelines and props. Primary messages accompanying each behaviour were developed and included: 1. Don't give formula – breastfeeding alone is sufficient; 2. Feed your child a more diverse (colourful) plate and less (white) rice; 3. Give your child only healthy snacks and not close to mealtime; 4. Eat one portion of "strengthening foods", or liver (ati) eggs (telur) and fish (ikan) – ATIKA every day.

Subsequently, the package of interventions including emo demos was piloted over a three-month period in 20 villages to assess participation and acceptability of the activities and behaviour change messages. Results of the pilot test, which are available in several documents (e.g. 6,7), identified which components were feasible and acceptable and guided many important modifications in the campaign approach. Some critical decisions included the removal of the Quran meetings and changes in the emo demo venue from female credit programmes called arisan groups to Posyandu[4], village

[4] In Indonesia, District and municipal governments are responsible for the administration of district/municipal hospitals and organize health services through district/municipality health offices (DHO). DHO operate health services through primary health centres (Puskesmas). Civil society also actively participates in the health sector through a community initiative called the Posyandu. The Posyandu consists of health cadres, community

health posts where well-baby visits are held monthly throughout the country. Our key informants added that the Posyandus are a platform with extensive outreach and held in a location where women naturally convene, which the programme organizers believed would facilitate high coverage of message sharing related to improving child nutrition during emo demo sessions.

The pilot test found that mothers enjoyed the emo demo sessions, which key informants reported were highly participatory and showed promise for being "catchy" and captivating. In addition, partners at the field level found emo demos to be simple enough for caregivers to understand and to implement in the field. The findings highlighted components of the emo demo modules which were more acceptable to mothers, easier for facilitators to deliver, and feasible for scale up, allowing the team to narrow down the modules and refine the content and language. The pilot test also informed the decision to have emo demos the cornerstone of the campaign.

Based on the pilot results, a team of GAIN staff and the creative agency selected and revised eleven emo demos for implementation of Baduta 1 on the following topics: nutrition during pregnancy (three activities), breastfeeding (three activities), care during pregnancy (one activity), and complementary feeding (four activities). One handwashing activity was also developed based on previous work done by the LSTMH. Based on changes in the modules, the team revised the guides designed to accompany each activity module and established sets of materials or props for each session. Other campaign interventions included TV commercials which were aired 6-8 months and featured Ibu Rumpi and covered the four main behaviours; street visits whereby facilitators visited households and key meeting points where they shared Baduta messaging on a tablet; most significant change (MSC) stories collected from village beneficiaries (e.g. mothers, village leaders, cadres, fathers) and used as an advocacy tool to highlight success stories related to Baduta; a clean water and handwashing intervention; the baby friendly initiative involving hospital-based interpersonal counseling carried out by midwives on breastfeeding and complementary feeding practices; and branding to decorate and make the emo demo sessions festive, which involved giving uniforms to the facilitators sharing messages and hanging danglers and banners featuring Ibu Rumpi.

During Baduta 1, a local NGO called Paramitra Foundation was contracted to oversee programme implementation including training related to the execution of the emo demo sessions during monthly pregnant women classes and growth monitoring and promotion meetings. Paramitra employed district coordinators and village facilitators to oversee implementation of the interventions. Key informants described the facilitators as young, university educated men and women with media savvy, strong communication skills, and fun loving who lived in the village and were responsible for planning and overseeing activities. Each facilitator was expected to engage with government leaders in 6-10 Posyandu located in several villages. One key informant reported that the facilitators' dynamic, animated nature was inherently important to the emo demo methodology. A primary role of the facilitators was to train the cadres, the local community volunteers posted in Poysandu nationwide, on how to lead the emo demo sessions.

Key informants mentioned that government officials at the sub-district, district, and provincial level played key roles in introducing Paramitra staff to communities, coordinating activities, and addressing local challenges, and that government officials participated in regular coordination meetings. While government officials were not involved in programme development, they were involved in training. One informant reported that the level of government participation varied

volunteers who are trained by village midwives or other Puskesmas staff to provide assistance in preventive health services, including nutrition education to pregnant women and caregivers of children 0-59 months of age.

according to the individuals in charge, with one district leader playing a very active, supportive role key to implementation of activities.

The GAIN team invested extensive time to develop a training of trainer's (TOT) curriculum and toolkit for the Paramitra facilitators to train the cadres. Key informants described the curriculum as fun and interactive, with a focus on team building, practice, and feedback. Facilitators received a 5-day intensive training to introduce key concepts related to communication, the emo demo approach, and the TOT curriculum. Due to the number of and complexity of the emo demo modules, it was decided that cadres would first participate in a half day training during which communication skills and the emo demo approach would be introduced. Key informants stressed that to ensure high quality, trainings involved small groups of cadres who met in a central location. Subsequently, training was conducted monthly on each emo demo module the day before the emo demo session was held in the Posyandu.

Our informants indicated that the facilitators formed strong bonds with their working groups of cadres; the programme team felt that a good relationship between the facilitators and cadres based on trust would better ensure that the cadres responded well to mentoring and capacity building approaches designed to enhance skills needed to effectively lead the emo demo sessions and engage women. One key informant said:

> *The idea was that we needed an NGO to do this well, for us to learn how to implement the emo demos and for us to teach the government how to do this, to teach the cadres. We couldn't just hand this over to the cadres, because it is a different approach, and they weren't going to get it… We knew that we couldn't just do this in a 5-day training, like the old system. We needed a system where we mentored them, where we held their hand, where they practiced, practiced, practiced. And so it's a gradual process of building capacity. I think it's a great asset to this project, the recognition that they needed time to learn. Training isn't a one-week thing, training is actually a process.*

Key informants reported that the BCD theoretical approach was not taught at all levels, indicating that the concept and approach of emo demos automatically allows the BCD change principles to be replicated at a larger scale.

Scheduling of the emo demos involved one session per month, with all 12 modules supposed to be carried out over a year's period. Particularly during the initial phases, key informants stressed the importance of maintaining a set schedule until the cadres were conversant with each module. Key informants contended that monthly emo demos sessions ensured adequate practice, allowing the facilitators to retain the information presented in the guidelines and general approach.

The programme developed promotional materials such as danglers, banners, and posters to make the Posyandu location more attractive and brand activities, and stickers to motivate mothers to attend sessions. Lots of materials were developed to guide emo demo sessions, such as instruction cards outlining the aim and key steps when guiding sessions and videos of the sessions. There were also props, such as cups, balls, toys, etc., used for the delivery of each module. Key informants considered the props critical to the successful delivery of the sessions, noting that including objects that women can see, feel, and touch makes the message easier to grasp and more memorable. The programme attempted to select props that could be sourced locally, although some materials such as sparkles used for the handwashing module were not readily available. Key informants described the acquisition and transport of the props to be both time consuming and challenging. The six district coordinators oversaw organizing the props in packets and ensured packets were delivered before sessions. District coordinators also supervised programme implementation and facilitator activities.

However, key informants reported that supervision was not very effective, explaining that coordinators were older and often failed to understand the communication methodology employed by the facilitators.

During the first six months of implementation of emo demos, facilitators led the emo demo activations during monthly pregnant women classes and growth monitoring sessions and promotion meetings. They were assisted by cadres who observed the facilitators deliver the sessions, with the goal to train up the cadres so that they could guide the emo demo sessions independently during the subsequent six months. In addition to observing the emo demo sessions, during this period the cadres informed local stakeholders and mothers about the scheduling of emo demos, organized logistics, and carried out street visits.

Prior to each activation session, an icebreaker called *yell-yell*, which involved singing, dancing, and cheering, was held to reduce awkwardness and encourage participation of child caregivers. Key informants highlighted that delivery of the emo demos is central to participation and message retention. They stressed that the delivery requires good communication skills to evoke emotions and enhance participation, enjoyment, and retention of mothers. They observed that the best facilitators are more spontaneous and do not need to follow the module guides.

Following six months of having the facilitators lead the emo demo sessions, the cadres guided the emo demo sessions. The day prior to each session, facilitators led cadre training which focused on practice, feedback, and mentoring, with the overall goal to ensure that the cadres could attain the necessary skill level to lead each session. Key informants emphasized the importance of practice, which they claimed built self-confidence and capacity to lead activations, with one informant mentioning that cadres needed a lot of coaching and handholding.

While the facilitators were described as having an intuitive sense of entertainment and infectious spirit, key informants reported that many cadres were unable to lead the sessions as planned, explaining that cadres were frequently older and lacked good communication skills. Some mentioned that cadres failed to be playful and fun during the sessions and did not have the confidence needed to engage participants and trigger their emotions. Key informants added that cadres were accustomed to an approach that involved lecturing rather than interacting with mothers. Certain aspects of emo demos presented difficulties, such as understanding the flow of the storyline and remembering and conveying all of the triggering questions designed to evoke emotions; informants reported that some cadres read the session guides, causing the session to become a game rather than a learning activity, or only delivered sessions easier to lead. In response, programme organizers established a more regimented monthly schedule of emo demo sessions.

Key informants noted that programme organizers had little control over the cadre because they are volunteers, have a social incentive to keep their positions, and cannot be replaced. One key informant noted that the government no longer provides formal cadre training, contending that lack of training contributed to their low capacity. This key informant said:

> *The cadres were the main problem, because in some areas the cadres are very senior and the emo demo sessions really need a facilitator with good skills. Cadres usually are only involved in the drug and monitoring activities. For public speaking, most of them are not really good at it and usually carry out health promotion using leaflets and things like that, so they just read the information. But the emo demo sessions need more advanced skills in facilitating and triggering emotions. So that's what we identified, that's the risk of delivering the emo demo using cadres. The cadres really need to have good facilitating skills to*

successfully deliver the modules because, otherwise, if the modules are not delivered well, it ends up being like a demonstration without really triggering the emotions of the mothers.

Some informants underlined that Baduta 1 aimed to answer whether the modules change behaviour but did not aim to improve cadre capacity. Due to the challenges faced using the cadre, Paramita facilitators replaced those cadres considered incapable of guiding emo demos effectively with the hired facilitators. During the six-month implementation period prior to the impact evaluation, most emo demo sessions were led by the Paramitra facilitators, with key informants noting that the capacity of the facilitator to lead emo demos had a tremendous influence on whether women adopted behaviours. This key informant stated:

We changed the strategy because initially we trained the cadre, all the cadres in the Posyandu to conduct the emo demos sessions. After that we realized that there was a big struggle in the field because not all the cadres could deliver the emo demo sessions effectively because they are old. We found that there is a range of capacity of the cadres, and in the second phase, we changed the strategy by only selecting the productive, communicative cadres. At the later stage, there was also a change so that all the emo demo sessions were conducted by the field facilitators of Paramitra, so the strategy evolved along the way. Emo demos use a 2-way approach, so it is quite different from the usual education sessions delivered by the cadres, because the majority give one-way sessions, like lectures. So, the question was how to build communicative skills, communication with the mothers during the emo demo sessions is very important so that the mother enjoy the game, participate in the session. By participating they're involved, and the key message is remembered.

Some key informants considered the failure to build capacity among cadres to lead the emo demos as a major limitation to the success and sustainability of the approach. At the same time, the systematic implementation of monthly emo demos in Poysandus was considered a tremendous success.

When asked to assess the campaign package of interventions, key informants described the mass media approach, MSC stories, street visits, and emo demo activations led by the facilitators as complementary and highly successful in increasing demand for healthy eating behaviours, while the water sanitation approach failed to attain high quality and coverage. They described the TV ads as visually pleasing and essential to reaching a broad audience, raising awareness, and branding the interventions, but expensive to sustain, with 300 30 second TV spots costing about one million USD. The informants considered the MSC approach, which generated 100s of stories and 24 videos, which were shown on local television talk shows monthly, as a powerful advocacy tool to raise awareness about behavioural change inspired through Baduta and to foster competition to generate success stories at the village level. Key informants praised the participatory nature of the MSC approach, which involved local officials at different administrative levels who served on selection panels to judge MCS stories, and the fact that the approach is affordable. Through street visits, key informants claimed that key messages were disseminated to family members involved in decision making regarding child feeding. However, one key informant expressed concern about the sustainability of street visits, questioning whether volunteer cadres would be willing to carry out the work regularly. Key informants reported that the emo demos served to captivate women's attention by providing surprise, evoking emotions, and sharing detailed messaging related to childcare and feeding, with some mentioning that Posyandu attendance improved with the introduction of emo demos.

When describing the package of interventions, one key informant explained that Baduta 1 followed concepts related to AIDA communication funnels by initially using mass media and street visits to draw the attention of a large audience and subsequently funneling the audience to the emo demos where detailed messaging on key behaviours was provided or to the baby friendly initiative where breastfeeding counseling was given. The Rumpi Sehat and MOH logos were used to link the local

activities to the mass media commercials, with one key informant indicating that TV commercials are viewed as more sophisticated, thus providing credibility to the campaign. Key informants considered the feature TV character, Rumpi Sehat, as highly persuasive in conveying messages; they described the TV commercials as clever, visually strong, and memorable, with some adding that the TV commercials generated a lot of attention. One key informant said:

> *There are these marketing funnels that the private sector talks about where you try to reach all target women very broadly at the top and then funnel them down, and as you funnel them down, you're using different communication strategies to add a level of complexity and messaging. The approach captures people at a very high level and then uses branding to support the lower-level interventions. So, the fact that people could identify the Rumpi Sehat logo from the TV, and then they could see the same logo in their communities, at the clinic with the flags, and during the emo demo sessions, and understand that that they came together, it added credibility for the work involving direct communication. Because TV is fancy and has very high production value. And so, the way that these things fit together, was really great, was brilliant.*

Informants reported that while social pressure was not emphasized during the emo demo sessions, the Rumpi Sehat campaign moto, 'If it's wrong, make it right', combined social pressure with other emotional triggers. They reported that the campaign focused on the mother, acknowledging that the project did not strive to carry out interpersonal messaging to other family members influencing child feeding. One informant added that the modules concentrated on child feeding barriers that mothers can easily change, intentionally avoiding messages requiring changes in socioeconomic or structural factors affecting child feeding.

Baduta 1 had monitoring systems designed to assess ongoing activities, which key informants described as first class, robust and systematic. Monthly quantitative data was collected on process indicators such as training, activity implementation, and mother's participation in emo demos, with one key informant mentioning that increased participation in emo demos demonstrated that sessions were generating interest. The programme also carried out periodic qualitative assessments (approximately every six months) involving focus groups and in-depth interviews to test acceptability of the modules and implementation. These assessments guided revisions on the module content and language, as well as other aspects of the overall approach. In addition, programme staff held monthly meetings with facilitators to assess execution of the emo demos and other field activities. Key informants lauded the approach, which involved iterations of research and evidence-based programme revisions, as highly unusual and a strength of Baduta 1. They described a strong level of cooperation between partners and focus on problem solving and improving interventions. One key informant said:

> *I really love this project for so many reasons. I thought that the level of cooperation between the different partners was extraordinary, this involved the government, Paramitra, and the creative agency. It's always hard to get people to come together--everyone in this project worked so hard. The level of problem solving, there was just great communication, great… I felt that it was a gold standard because it was operationally, very well planned, we would identify problems, we would fix those problems, we would talk about those problems, we would fix them. It was just a process, a constant process of improvement, and the fact that the government has adopted this. For me, this is a real paradigm shift, I don't think that's too strong of a word, like people use that phrase sometimes in a hyperbolic way. But I would say, this is a real paradigm shift from a flip chart education system, where we are talking at people to a system where we are getting a group of women to voluntarily join, pay attention, learn, have an 'aha' moment, have a sense of a social, cohesive moment, coming back, not*

just going once, but actually returning and everyone was like, 'Ahh, I get it, ok, yea, this is good', and then, how can we improve it? How can we improve that? How can we make it more efficient? How can we tweak the guides, the sessions, the monitoring? It is the way projects are supposed to go and very rarely do, the people got it and they joined the movement.

Project staff presented monitoring findings during government meetings at the national and district level, with project staff reporting receiving government praise regarding the quality of reporting. In addition, university students carried out monthly observations of 100 emo demo sessions and provided systematic feedback. The number and quality of the MSC stories submitted for review was also considered a monitoring tool and sign that the activities were gaining attention. In addition, a process evaluation carried out around the time of the pilot provided valuable feedback on programme activities, with one key informant mentioning that the findings pointed to weaknesses in the cadres and the need to decrease the number of modules. Key informants underlined that a strength of the project was to collect real time feedback from a variety of sources, analyze the data in a timely fashion, and use the data to make ongoing course corrections.

Two formal evaluations were also conducted. Results from a study evaluating the pilot suggested that emotional motivators worked towards improving dietary diversity and regularity of vegetable and fruit intake among children aged 6–24 months (6). Findings suggesting that emo demos can enhance the measurable effect on nutrition-related behaviour change attributed to mass media messages. However, results highlighted that changing several behaviours at once is challenging.

A quasi-experimental impact evaluation measuring impact of the package of interventions (i.e. emo demos plus commercial advertisements on television) after 18 months of implementation showed no measurable differences between the intervention and control areas in relation to primary outcomes (stunting and anaemia) (8). However, several secondary and tertiary outcomes were significantly and positively impacted including indicators of infant and young child feeding, as well as in mothers' knowledge. Specifically, Baduta 1 contributed to a significant increase in the rate of exclusive breastfeeding among infants less than six months of age, which was 14 percentage points higher in the intervention group. Other indicators involving children 6 to 23 months in the intervention group improved, including: the proportion consuming iron-rich foods (12 percentage points higher) and the proportion consuming a minimum number of food groups (13 percentage points higher).

Key informants noted that the impact evaluation was not set up to assess the effect of individual interventions, including emo demos, but rather assessed the campaign package. Some informants considered it important to evaluate whether the BDC theory worked to evoke emotional response through the emo demo modules. They noted that there is no empirical evidence demonstrating that the modules triggered emotions and impacted on behavioural change or that the theory worked. Some key informants emphasized the need to understand the mechanism by which exposure to the modules may lead to behavioural change. One informant said:

I think it's reasonable to say we don't know anywhere near enough on all aspects of behaviour change… The kind of trials that were implemented during the pilot or during the larger impact evaluation, neither of those are designed to understand the impact of individual emo demos on behaviours. So, I think, unfortunately, we do not know about the direct impact of any one emo demo on how that's influenced behaviour. GAIN has quite a lot of anecdotal evidence of women being interviewed, describing how their behaviour has changed. That's got all the normal problems of social disability bias and things like that.

GAIN has anecdotal evidence gathered through the MSC approach, which emphasizes the success of the emo demos through individual stories.

Description of Baduta 2

Based on the results of Baduta 1, GAIN and the district governments of Bondowoso, Jember, Probolinggo, Trenggalek, and Surabaya scaled up selected components of the original package of Baduta interventions including emo demo sessions. Funding for Baduta 2 involved about 2.5 million USD with the goal to integrate emo demos in approximately 4,494 Posyandus across 521 villages and to reach close to five million pregnant women and children aged 6-23 months.

Selection of the five districts was based on the District Health Office (DHO) level of interest in the interventions and the health and nutritional problems affecting women of reproductive age and young children in the districts. GAIN worked with the MOH to select components of the original package of Baduta 1 interventions to implement a more intensive intervention referred to as Baduta 2. Health teams in the five districts identified 50% of areas in the sub-districts where the intensive intervention would be implemented with GAIN support, and the government implemented activities in the other areas of the sub-districts. Key informants considered government buy-in and interest in scaling up the approach as a tremendous achievement based on years of collaboration and good relations with the MOH in Indonesia.

Baduta 2 was launched from April 2018 to November 2020. Co-funded by the Dutch and Indonesian governments, the programme focused on government adoption of interventions for improving IYCF practices, with an overall objective to scale up interventions and establish sustainability. Due to budgetary constraints, programme components were extensively scaled back, with main activities including the baby friendly hospital initiative, MSC approach, and emo demos, which were once again at the center of the Baduta 2 programme. While the content of the emo demo modules was unchanged, other aspects of the approach such as training, supervision, and monitoring were modified, mainly to reduce costs. Although national media was no longer used to raise awareness, the programme distributed USBs with recordings of the Sehat Rumpi campaign and MSC videos, which were shown on televisions located in public spaces such as Puskesmas (government medical centers) and village offices and on local TV stations in three intervention districts. Tablets were distributed to some midwives in Jember District, but generally street visits were discontinued.

As part of the Baduta 2 strategy, scaling up in the remaining 50% Posyandus operating in each of the five intensive intervention districts was rolled out in April 2018. The approach for scale-up was meant to involve: a) building commitment and capacity of the local government; b) cascade training on emo demos; c) providing support to Posyandus to procure emo demo tools; d) establishing mentoring mechanisms for Posyandu cadres; e) setting up reporting systems; and e) conducting baseline-endline surveys and participatory evaluations. Intensive work towards scaling up started in early 2020, with specific activities including: (i) establishing a district level trainer; (ii) developing a joint annual plan of key activities; (iii) implementing participatory evaluations through most significant change stories; (iv) budget advocacy and identification of local budget sources; (v) development of DHO and village level budgets; (vi) technical support in the scaling up processes; and (vii) media coverage. No significant programmatic differences existed between the intensive and scaled-up interventions implemented in the five districts, with emo demo sessions designed to be aligned.

Sources of funding differed, with finances for scaling up including cascade training, mentoring, and monitoring emo-demo sessions in Posyandus, and procuring and distributing emo demo tools to Posyandus provided by the DHO or village development budgets. Activities administered in the intensive intervention area (quarterly cascade training, distribution of emo demo tools, technical assistance to sub-district team and participatory monitoring) were completed in December 2019.

Limited funding forced major changes in implementation and shifted the focus on building local capacity (district and village level trainer teams) and ensuring that the local government and communities could conduct activities independently.

In each of the district intervention areas, GAIN hired a district and training coordinator, many of whom had participated in Baduta 1, to oversee training and coordination with government personnel. In the intensive intervention areas, GAIN provided funding and technical assistance for implementation; coordinators worked with local governments to establish a team to lead the cascade training. In the scaling up districts, GAIN only provided support for master trainers to lead training sessions.

The programme recruited master trainers to follow a cascade model of training, which was deemed most feasible given the extensive scale up and funding constraints. Master trainers, who were trained by GAIN trainers, were responsible for training district level staff, including primary health center staff and village midwives on the emo demo modules, with village midwives subsequently charged with training two cadres working in each Poysandu. Key informants reported that training in intervention areas was introduced gradually, with sessions held every 2-3 months, while in the scale up areas training was held during one four-day session, with three modules introduced daily. Video tutorials of each emo demo sessions were distributed and used so that cadres could have refresher training, with informants mentioning the videos mitigated the risk of poor training quality. Informants reported that about 11,000 people were trained every two months. The baby friendly hospital-based training for breastfeeding counsellors, which originally entailed 40 hours, was also simplified to rely more on online training.

Key informants acknowledged that modifications in the training approach from the Baduta 1 model, which involved sequenced and refresher training directly before the emo demo session, affected the quality of the training in scale up areas and likely impacted the ability of the cadres to comprehend the approach and conduct the emo demos as planned. Our informants perceived this as an essential sacrifice, arguing that the focus of Baduta 2 was on adoption of the initiative rather than capacity building of cadres. While the midwives were instructed to select and train two of the five cadres best qualified to lead emo demos, our informants once again highlighted insurmountable limitations of many cadres. When talking about problems faced during Baduta 2, one key informant said:

> *The Posyandu cadres are mostly old people – old… and they're not accustomed to talk in front of an audience… Some of them also have difficulty understanding Bahasa Indonesian language because they don't speak Bahasa properly, so they modified the emo-demo sessions using their own language, like Maduranese language. That's what's happening in the field. We don't have a specific strategy to address the reality of the capacity of the cadres.*

Materials distributed for Baduta 2 only involved the emo demo props, with branding materials discontinued. In intensive areas, the programme was responsible for ensuring that props are purchased and distributed before the training, with purchasing done in bulk for all five districts to reduce costs. In scale up areas, the district government purchased props and bags to store the props with their own budgets. Key informant affirmed that most props could be obtained in local markets.

Key informants indicated that supervision schedules depended on district level approaches, but generally involved master trainers who monitored activities and provided feedback to the primary health care center workers, including midwives. In the intensive areas, a small amount of funding was given to the district coordinators to visit Posyandus, but time and the number of Posyandus in each district (1,600 in Jember) limited the number of sites they could visit. Midwives were responsible for supervising cadres carrying out emo demos and providing feedback related to problems observed.

In response to concerns district governments raised regarding cadres' capacity to lead sessions and the need for mentoring, midwives in the intensive areas were given a small incentive for monthly transport to observe and mentor cadres more regularly. However, key informants acknowledged that there was limited focus on cadre supervision and mentoring, with no mechanisms in place to assess mentoring. Cadres were instructed to review emo demo tutorial videos when in need of refresher training.

One key informant admitted widespread skepticism regarding scale up due to the weakness of the cadres. However, this informant argued that, even if the cadres did not fully grasp the gist of the approach, and the emo demos were not implemented exactly as planned, scale up provided the cadres with a new set of skills to engage women while at the same time increasing Posyandu attendance. Another key informant questioned whether cadres could engage women in the way needed to generate emotions and feelings, stating:

> *Participant acceptability is high, but engagement is low. The engagement is the entry point for successfully triggering feelings targeted through the modules. Because it should be active engagement. It really depends on the cadre capacity to engage, and that's the weakest point of the cadre… But in several Posyandu, the engagement was good, and then the participation was also very high. That's my experience observing emo-demo sessions.*

Monitoring in the intensive intervention areas was done on WhatsApp, with midwives submitting a photo and short summary of emo demo sessions to the district and training coordinators every two weeks. The information submitted included a description of the modules presented, where the session occurred, the number of mother participants, challenges faced, and solutions proposed. Budgetary and time constraints prevented carrying out regular observations to assess the quality of the sessions. An evaluation of the Baduta 2 intensive intervention areas has been conducted and was being analyzed at the time that this reported was being completed.

Key informants reported that the Baduta 2 had many accomplishments, particularly related to government adaptation and sustainability. An app including emo demo materials and training was developed to limit the need for face-to-face interactions, particularly during COVID-19. Baduta 2 was given widespread publicity through activity progress reports featured in district newspapers, as well as a Facebook page with updates on coverage. Other achievements included the adoption of the emo demo modules in 15 university nutrition curricula around the country. To address possible fatigue, twelve new emo demos were developed by nutrition students in universities. The programme team also worked with universities to develop contextually appropriate food recommendations for children under 2 in 17 districts. A major achievement cited by key informants was the buy-in by the government to scale up the emo demo approach using a platform that facilitated widespread coverage and could lead to improved Posyandu attendance.

Differences between Baduta 1 and 2

Baduta 1 focused on developing and improving a package of interventions designed to change IYCF behaviours and testing the BCD theoretical approach to see whether it was effective in changing behaviour in a relatively small geographical area comprised of 113 villages. The Baduta 2 strategy involved scaling up of the emo demo activations and baby friendly approach and working to ensure that tools and approaches could be implemented by the government in a vast area comprised of 546 villages and 5,000 Posyandus. Because scale up involved major reductions in funding and resources, Baduta 2 had to cut back on many components of the original Baduta package. For instance, the original package of interventions reached different people potentially influencing child feeding behaviours, while the main focus of Baduta 2 was on mothers. While Baduta 1 was controlled

and focused on strengthening interventions and capacity of service providers through oversight and mentoring, Baduta 2 was primarily concerned with ensuring the government could adopt the strategy and maintain good coverage. Key informants recognized that the focus on coverage would impact the quality and effectiveness of the emo demos and baby friendly hospital interventions, with one key informant mentioning that they could not expect widespread behavioural change, stating:

> *Since the beginning we knew this is the adoption, we realized from the beginning that we will sacrifice some of the quality of the intervention, and we are not expecting the behavioural change effectiveness to be similar with Baduta 1. We haven't measured it yet, but in my estimate, the effectiveness will be lower, but the coverage will be much higher. With Baduta 1, with a 10 million USD budget for implementation, we only covered 113 villages. Compared to now, our implementation budget is only around 2.5 million, but we reached about 546 villages. The number of Posyandu is also… is increased significantly – now we cover almost 5,000 Posyandus in five districts.*

Government district intervention areas

The attention that emo demo sessions have drawn has generated government interest to introduce emo demos in other districts in East Java and beyond. In this regard, the government started implementing emo demos in September 2018. GAIN's involvement has concentrated on providing training assistance. In East Java Province, requests to initiate emo demo activities are submitted to and approved by the PHO, while districts located beyond the East Java Province require approval by the Community Nutrition Directorate within the MOH.

During Baduta 2 implementation, GAIN received at least 53 requests from other districts to establish local training teams for scale up. Beyond the initial start-up training, little was known about the status of implementation and the processes involved, such as the extent to which key intervention activities are followed, the numbers of Posyandu reached, which emo demo sessions are being implemented, and the effect of mass scale-up on the quality of emo demos. While GAIN has pushed the government to include an indicator of emo demo sessions in the regular monthly monitoring system followed by primary health centers, no formal monitoring mechanism has been established.

Key informants reported that GAIN has developed strong collaboration with both national and provincial government officials, which helped build support and likely catalyzed government buy in to scale up in districts. In addition, emo demo sessions were showcased at different high-profile events including provincial seminars attended by heads of districts and regency offices and a national coordination meeting of the stunting programme attended by 100 priority districts. An emo demo session was featured during an ASEAN Summit international scientific conference and during the National Nutrition Days celebration.

Baduta 2 Intervention Areas

District and Training Coordinator Jember

Background information

The information presented in this section is mainly derived from interviews with the GAIN district coordinator (DC) and training coordinator (TC). However, we also included some information collected from a master trainer and the head of the DHO; it is important to note that more detailed information collected from the DHO is presented in a separate section starting on page 43.

The Jember DC had 14 years previous experience working with NGOs but had no prior knowledge of emo demos before taking the position. Her primary role as DC involved management and organization of activities and advocacy with government officials and regional apparatus organizations (OPDs), the administrative level under the DHO, with the aim to encourage government institutions to provide funds to support the programme in scale up areas. Specifically, the DC mapped OPD funding sources and budgets and promoted emo demos to OPDs with potential to fund the programme. Other mentioned tasks involved coordinating Baduta activities, designing training approaches, assisting the TC with training preparation and evaluation and supervision of MOTs, particularly those deemed weaker, and participating in monthly monitoring meetings with MOTs. She also supervised emo demo sessions, adding that Jember district was too big for the TC to oversee all training and emo demo sessions. The DC reported visiting 25-30 emo demo sessions during her tenure with GAIN. Her work in the scale up areas mostly focused on advocacy.

The TC had a background in nutrition and had worked as a facilitator in Baduta 1, noting that all the GAIN training coordinators had been involved in Baduta 2. Her main roles involved drafting training modules, developing training schedules, organizing and leading trainings, monitoring MOT activities, supervising emo demo sessions, and assisting the DC with advocacy work. Her role required that she be in close contact with communities, which involved visiting Posyandus and observing emo demo sessions. However, since the intervention area included 131 villages and 1406 posyandus, it was impossible for the TC to visit all Posyandus. The TC also worked with MOTs disseminating information about emo demos on a talk radio programme. The TC had limited responsibilities in the scale up areas, although she occasionally helped government officials connect with vendors to procure props and provided training assistance. The TC was sent to government led districts outside of Baduta to lead trainings.

The DC and TC started work on Baduta 2 between April and June 2018, with the DC beginning earlier. The DC emphasized that they worked as a team, helping each other fulfill responsibilities and maintaining a united face. We were told that GAIN provided key equipment to facilitate their work, such as laptops, a printer, and a camera. There was no office space available for them to work in the DHO. As such, the DC primarily worked from home, while the TC shared an office with other workers in the DHO office or worked in the home of the DC, particularly when meetings were convened.

MOT roles involved leading training of trainer (TOT) sessions, supervising TOTs, and monitoring emo demo activities in a specified target area, with our MOT informant mentioning that she spends 10-15 days monthly supervising emo demo sessions in the six villages in her area.

BCD theory

GAIN informants had different levels of understanding of the BCD theory. The DC indicated that the theory concentrated on appealing to the senses, touching emotions, and stimulating behavioural change. The TC, who had been involved in Baduta 1, had a deeper understanding, stating that the theory focused on appealing to the senses in a way that touches feelings and emotions and alters mindsets so that message recipients have a desire to change behaviours. She indicated that the process encourages participants to evaluate their personal childcare practices and through self-assessment realize that a different behaviour would improve the health of their child, and in some instances, be more practical for the mother. She emphasized that evoking surprise and emotions are critical to the approach, and that learning through the senses makes it easier to understand and retain messages. She also reported that conventional approaches involving one-way counseling and

visual aids, only reach a portion of the brain and are often complicated and boring, causing messages to be quickly forgotten.

Description of Baduta 2 and emo demos

Informants reported that Baduta 2 aims to change behaviours related to breastfeeding and complementary feeding and improve child nutrition in communities, with one informant mentioning that mothers and children under five years are the main targets. They added that Baduta 2 covers five districts in which 50% of the district area implements activities funded by GAIN, while in the other 50% of district areas, Baduta activities are funded by the government, OPDs, and community and village empowerment funds (DPMD), although training is provided by GAIN.

Informants highlighted the innovation of emo demo sessions, which they reported deviate from traditional approaches by engaging participants in games and focusing on a small number of central messages during each session. They claimed that the play-like sessions and supporting tools make it easier for facilitators to engage participants and share information and for mothers to understand messages. We were told that participation is designed to trigger emotions critical to motivate behavioural change and to allow mothers to process the messages and understand the significance of the modified behaviour. Another advantage mentioned by the DC was that sessions are included in existing Posyandu activities and that leading emo demos empower cadres.

Informants reported that the MSC approach, which was described as a qualitative monitoring and evaluation tool that is also used to publicize and promote Baduta 2, constitutes another component, as does LMKM—the 10 Steps to Successful Breastfeeding. Informants mentioned that LMKM started implementation in September 2020 in 23 facilities, 4 hospitals, and 19 Puskesmas, and that three emo demos related to breastfeeding were conducted during pregnancy classes.

Emo demo sessions involved the original 12 modules developed during Baduta 1 with slight modifications. Informants mentioned that initially it was difficult for health staff to understand the methodology, which contrasted from conventional approaches. To avoid repetition, a competition was held in conjunction with a university to encourage development of a second set of 12 modules. At the time of our interviews, the new modules had been tested and finalized and a tutorial video had been developed introducing the new modules; the video was included in a package of materials delivered to the government at the closing of Baduta 2.

In Jember, the intervention area included 16 sub-districts which were divided into 7 clusters each comprised of 2-3 sub-districts. The programme began with outreach events from March through June of 2018 in the district capital and in intervention sub-districts. Interventions were implemented in 25 Puskesmas and 1406 Posyandus spanning Jember. There were 15 sub-districts in the scale up areas where the government was in charge of implementing activities with training assistance from GAIN.

The first emo demo sessions began in October 2018; subsequently, modules were introduced monthly in intensive intervention areas. MSC selection began in January 2019. Informants reported that other activities, such as the establishment of a group of women producing healthy snack foods, an elementary school breakfast programme, and the introduction of the reckless snacking module in preschools, occurred organically. Stakeholders such as village heads also got involved by providing material support and encouraging local innovations, such as giving gifts to mothers actively engaged.

Informants reported that in Jember emo demos were primarily conducted during Posyandu sessions held in health posts or cadre homes, which target mothers and other primary childcare providers

such as grandmothers and, less often, fathers. Informants reported that modules focused on four themes related to exclusive breastfeeding; child feeding and snacking; nutritional intake during pregnancy; and a mix of other subjects including handwashing, and that one module was presented during each session. Some Posyandu held sessions before well baby visits, while others led sessions after other Posyandu activities were completed. Midwives were responsible for supervising sessions and responding to questions that the cadre or supervising MOTs were not qualified to answer.

Informants reported that emo demo sessions targeting pregnant women were conducted during pregnant women classes. In addition, emo demos were introduced during preschool or kindergarten classes where children, caregivers and teachers were targeted, and in Taman Posyandu (under five children family development sessions) or PKK meetings which are also attended by caregivers of children under five. We were told that in cities PKK meetings are a good way to target working mothers who often have nannies accompany their children to well-baby visits.

Sessions were led in Bahasa Indonesia, Javanese or Madurese depending on the prevailing language in the area. Informants stressed that GAIN encouraged adaptation and innovation, as long as target outputs were achieved and messages understood.

Implementation of emo demos in intervention areas

Training

Due to the large size of the district, two TCs were involved at the height of training activities in Jember. We were told that 24 MOTs with a range of backgrounds, including retirees, housewives, and university students, participated in a three-day training.

A cascade training approach was used involving training of MOTs, TOTs, and cadres at the district, sub-district, Puskesmas, and village level. MOT training was led by the DC and TC and covered all four themes and 12 modules. TOT training was progressive and held four times, every two months, starting in September 2018; each session focused on one theme and the corresponding three modules. TOT sessions lasted 4-5 days and involved 5-7 classes which ran simultaneously, with each class consisting of 16-18 people. The TC and MOTs administered the TOT training which included representatives from the district and sub-district health offices and Puskesmas staff involving Puskesmas heads, nutrition officers, midwife coordinators, and health promotion workers and PKK representatives; informants reported that TOTs were mostly Puskesmas and FWD workers. Subsequently, two TOTs from the Puskesmas, generally the village midwife and head of the FWD, trained cadres in the village setting on the same theme and corresponding modules; during the cadre training, a MOT or the DC or TC was always present. As was the case with the TOT, classes were held simultaneously, with cadres training lasting 2-3 days. Cadre training included a minimum of six and maximum of 24 cadres, depending on the need in the area.

Training of MOTs and TOTs was the same, while the cadre training skipped the theorical basis for the approach and focused on the content and delivery of the modules. We were told that training of the cadres was often challenging due to their lower educational background. Another challenge occurred when some invited trainees could not attend, forcing organizers to change the schedule. An evaluation took place post training to assess the skillset of those who were trained.

Informants reported that 24 MOTs, 330 TOTs, and 2812 cadres were trained in the intervention area. MOT and TOT sessions were held in hotels--TOTs were given 150,000 rupiah for travel and honorarium to participate in the training. Cadre trainings were held in villages, and cadres were given 50,000 rupiah for travel and food expenses. We were told that not all districts provided a training

allowance to the cadres; in Jember, the allowance was provided by the district's regent and village funds. Village level training allowed village heads, who were given transport money, to attend and for villagers to be exposed to the new methodology. GAIN provided refreshments during the cadre training, which informants reported drew positive attention from villagers.

Regarding training of GAIN staff, the DC participated in a 2-day induction training; because the TC started after the initial launch, she received private briefing sessions and supplementary training provided by other TCs and GAIN staff. Due to her involvement in Baduta 1, the TC was already familiar with the main concepts and emo demo modules. The TC also participated in a meeting focused on drafting new emo demo modules and other capacity building activities including a session on the MSC approach. In addition, she attended special events, such as the ASEAN conference during which GAIN gave a presentation on emo demos, which the TC claimed served as additional training.

Props

Informants considered props essential to the conduct of the activations. The DC said:

> *Props are very important for the games. The foundational theory of BCD is based on listening, seeing, touching, and doing, all those things to encourage memorisation. So, the props had to be there to leave an impression, to use during the games so that participants did not forget easily. They were compulsory.*

GAIN divided props into printed and non-printed materials. In the intervention area, GAIN provided the printed props (manual, module guidelines, etc.) at the start of the programme, while other props, such as balls, marbles, plates, measuring cups, etc, were provided in advance of trainings. In the scale up areas, GAIN provided digital files of the printed materials and names of vendors where props could be obtained; GAIN staff also assisted with procurement of the props as needed. When budgets in the scale up areas were insufficient, props were made or other improvisions was used to reduce costs, such as substituting a baby bottle with a pen or telephone. Informants indicated that most props were easy to obtain, with the exception of the UV lamp and lotion used for the handwashing module.

Supervision

Supervision was carried out primarily by the TC and MOTs, with the DC and a GAIN programme staff from Surabaya also providing assistance as needed. The DC mostly assisted when a specific problem needed to be addressed; for instance, when cadres refused to partake in emo demos in one Posyandu. The goal was to supervise emo demo sessions in all 1406 posyandus over a 12-month period. Supervisory visits were tracked on an application called Map Maker.

The TC reported supervising emo demo sessions in the second and third week of the month and selecting Posyandu that had not been previously supervised and where cadres had a lower capacity. The TC mentioned that during visits she learned about special challenges; for instance, while visiting one Posyandu she found that villagers were trying to convince women to arrive to the Posyandu late to avoid emo demo sessions.

MOTs took on the brunt of supervision, supervising emo demo sessions in 2-3 villages each month. During supervisions, MOTs assessed the number of participants, delivery of the emo demos by the cadre, whether props were prepared before the session, challenges faced during the session, and proposed solutions; they also took photos of sessions. If MOTs were unable to reach a Posyandu

scheduled for supervision, they requested that the midwife send a report of the activities. When Posyandus failed to reach at least 80% of GAIN's targeted participants, MOTs recommended adjustments to increase participation, such as that the Posyandu hold an additional session in the afternoon. MOTs received monthly payments based on the number of supervisions they conducted.

The TC and MOT informed the village midwife the day before the supervision. Cadres were not informed in advance of the visit, with the TC stating that this would make the cadres nervous. Supervisors provided feedback to the midwife and cadres after the session.

There was no set supervision of the DC and TC, although they occasionally received visitors from the GAIN provincial or central level offices. The DC and TC stated that their work was monitored through regular reporting; they also participated in quarterly meetings with their supervisors in Surabaya when achievements, upcoming work plans, challenges, and solutions to problems were reviewed. The work of the MOTs was monitored by the DC and TC through monthly reports and meetings when they discussed ongoing activities and challenges. Sometimes the TC or DC would accompany MOTs during supervisory visits to assess how the MOT was performing.

Emo demo supervision by the DHO occurred during regular supervisory visits to Posyandus, although there was no set supervisory schedule of emo demos. When DHO workers attended emo demos, they followed a checklist to assess the number of participants and the quality of the sessions; DHO supervisors tried to address any problems identified.

Monitoring

Monitoring data was collected by the midwife overseeing emo demo sessions or the MOT supervisor and entered in a template on WhatsApp along with photos. Monitoring data included where the session was held, the target number of under-five children, the target number of under-five mothers and pregnant women, the number of mothers and pregnant women who participated in the session, the cadre leading the session, the module presented, as well as challenges and proposed solutions. Reports were sent to a MOT WhatsApp group, which was forwarded to a central level Baduta WhatsApp group. The DC stated that hundreds of thousands of reports were submitted.

The MOT reported that participation was good in both the intervention and scale up areas, stating that people were curious due to the singing and newness of the approach. She also mentioned that the involvement of heads of villages and Puskesmas staff motivated mothers to attend, noting that in the scale up areas heads of villages sometimes participated in sessions.

Initially, the DHO had routine meetings with GAIN staff to assess progress, but with the pandemic these meetings became less regular. Before the pandemic, DHO also held meetings on WhatsApp with health workers at the Puskesmas level to motivate them to engage in the emo demo sessions.

Reporting

Informants described parallel reporting systems. GAIN developed a template which allowed MOT supervisors or midwives to enter data collected on emo demo sessions directly in a WhatsApp group. Since MOTs covered more than 30 Posyandus, MOTs typically generated emo demo session reports daily. MOTs were responsible for compiling monthly data of Posyandu sessions held in their target areas; reports were submitted to the DC and TC. MOTs were also responsible for submitting reports to GAIN synthesizing training sessions.

The DHO also collected data, which was entered on an Excel template by the midwives and sent to TOTs; subsequently, TOTs sent the report to the MOTs who submitted the report to a DHO WhatsApp

group. At the end of each month, the TC would crosscheck both reporting systems to assess whether the data coincided. Once the data was cleaned, she would submit a monthly report to GAIN. GAIN developed monitoring and evaluation reports that included all the district data. We were told that while the DHO initially generated monthly reports, the frequency of reporting decreased after the start of the pandemic.

Collaborators

The main GAIN collaborators included MOH staff at the central level and health personnel at the district and sub-district levels; GAIN activities were positioned in the public health division in the DHO. In addition to providing technical, training, and financial support to the government to implement Baduta activities, GAIN staff developed district implementation strategies, which included outreach and was tailored according to the district needs and budget. District strategies were reviewed by GAIN programme staff in Surabaya and national level personnel. GAIN staff also assisted the DHO in the development of the implementation TOR which included targets for activities, work and implementation plans, timelines, and monitoring of implementation. Government collaborators led correspondence about the programme such as invitation letters to events and launching of special proceedings. The DHO leadership worked closely with the DC to encourage health staff to implement activities according to the implementation strategy and workplans.

Cadres

Informants reported that the midwife, along with the head of Family Welfare Development and the nutrition officer in Puskesmas, selected two of the five Posyandu cadres for training in the intensive intervention areas. Selection was based on assessments of cadres' abilities to speak publicly and lead sessions. During monthly meetings, midwives would often give a refresher training of the upcoming emo demo session which involved having cadres lead the module; the goal was to try to ensure that cadres were adept and relaxed at leading sessions and able to engage participants. The DC said:

> *Usually, the midwives would hold a refresher for the cadres. So, for example, suppose they were doing the emo demo session on the bond between the mother and baby this month, then they would have a [refresher training] during the cadre meeting at the end of the month. In the meeting, the midwife would ask the cadre to perform the emo demo module in the forum, so that during the session in the Posyandu, the cadres were not nervous, and not only end up going through the motions of the game, because if they don't really know the steps to the game, if it's incorrect, it will turn out boring. That is to say, the mothers will not listen, will not be engaged.*

Refresher training was held at the end of the month, while emo demo sessions were led anywhere from the beginning to the middle of the subsequent month. The TC reported that some villages held formal refresher trainings funded by the village government.

Cadres would decide among themselves who would facilitate and co-facilitate each session; co-facilitators oversaw preparation and distribution of session tools or forms to participants. We were told that the first module was presented in October 2018 and over the subsequent 11 months modules were followed sequentially. After the full set of 12 modules was presented, the order by which modules were administered was up to the Puskesmas staff and frequently based on situational needs.

Informants stressed that village midwives played a pivotal role in the success of emo demo sessions. Midwives with authority and respect, and who were engaged, took charge by opening sessions. Engaged midwives also provided critical mentoring to cadres and tried to involve the other three cadres so that they felt to be part of the approach.

We were told that problems were faced when the two trained cadres were absent or the cadres not chosen for emo demo training expressed jealousy for not having been selected to lead sessions. In these instances, the jealous cadres would continue their work or intentionally cause distractions during the emo demo sessions or refuse to attend cadre meetings. GAIN staff recognized that disgruntled cadres could harm the approach; in response, efforts were made to train the other three cadres in the Posyandus, although this did not occur systematically across villages. When training did occur, the two trained cadres, along with the midwife, led abbreviated trainings for the three remaining cadres who became specialists in certain (often 2-3) modules.

Informants reported that midwives, PKK representatives, and MOTs provided mentoring to the cadres; the MOT informant mentioned that MOTs made lists of cadres who required additional supervision and provided tips and "cheat sheets" to help less skilled cadres deliver sessions. There was no set schedule for mentoring, which was at the discretion of the midwives, head of the FWD, and MOTs. Our MOT informant also mentioned that cadres required ongoing prompts, such as reminding the cadres about essential preparation before sessions.

We were told that the cadres had a wide range of capabilities delivering the sessions, noting that this is not surprising given that there are no specific criteria to become a cadre and that some cadre only had an elementary school education. Informants mentioned that cadres from lower SES, with less education, and who were older faced more challenges presenting, while cadres with speaking experience such as teachers were more effective. The key was that the cadre systematically followed the main steps of the module, which were designed to create a "wow" effect and convey a clear message; it was also important to be causal, interject jokes, and continually engage participants. We were told that many failed to follow the steps, provided extraneous information, or turned activations into a counseling session, talking longer than needed and causing participants to become bored. Those who were shy lost the respect and attention of the audience.

Cadres in Jember received 100,000 rupiah monthly for their regular work but were not incentivized for leading emo demos. Informants indicated that the cadres were motivated by the opportunity to speak publicly, the special recognition they received leading sessions, the opportunity to acquire additional knowledge and skills, and the contribution that they made to the community.

Caregivers

Perceptions

Informants reported that some mothers were extremely enthusiastic, particularly at the outset, about the novelty of the approach and the fact that they were gaining new knowledge; the TC mentioned that some mothers shared session contents with family members. We were told that during sessions mothers recounted stories describing behavioural change inspired by the emo demo sessions, with some successes featured as MSC stories.

However, the DC reported that interest often waned over time, particularly if the cadres performed poorly, which impacted on the ability to evoke emotions or generate surprise and decreased participant curiosity. The DC said:

At first, they were happy, because this was something new. They attended and enjoyed the sessions. They wanted the knowledge, often asking, 'What else is there? Are there any new emo demos tomorrow?' like that. They were happy and enthusiastic. But they were happy up to a certain point, and then the happiness would wane… Particularly, when the cadre was not very good in delivering the session. Because based on their first impression… they wanted emo demos to be like, 'wow', right?... But afterwards, there were mothers who felt like, 'This emo demo is taking a long time.' Like, the delivery was too long. Afterwards, I was trying to observe why there were mothers that said these things. Well, this happened in places where the cadres were, uhh… maybe they were not very prepared, or not very fun, something like that.

We were told that some mothers felt that sessions only prolonged the Posyandu visit and were too long. Others were reluctant to participate in certain activities, such as dancing (the Salam Rumpi Sehat dance) due to shyness. There was also mention of participants who felt insulted because they did not apply promoted behaviours and thus refused to attend additional sessions. An example entailed mothers who fed their children formula felt offended after attending sessions promoting the benefits of exclusive breastfeeding. It was also mentioned that some messages contradicted engrained taboos (e.g. pregnant women should not eat fish) or traditional food beliefs. Informants also stated that children were often fussy and noisy, causing mothers to lose their concentration. When disinterested women attempted to skip the session, cadres would stop providing other services so that the mothers were forced to attend. Informants also stated that mothers attending repeated modules lost interest and were bored.

Challenges

Mentioned challenges included that parents, in-laws, and grandparent, who had decision making authority over breastfeeding and complementary feeding practices, particularly in the cases of young and new mothers, rejected the adoption of certain promoted behaviours. Informants also reported that husbands sometimes opposed new practices, which informants reported diminished confidence in mothers to adopt changes. We were also told that caregiver peers sometimes negatively influenced the acceptance of messages. Informants added that mothers themselves opposed some behaviours; for instance, prior to childbirth many women plan to give formula which is considered prestigious and "cool." Moreover, it is difficult for working mothers to exclusively breastfeed.

To overcome challenges, women were encouraged to share messages with their husbands; in addition, husbands were encouraged to attend maternity classes and some husbands attended emo demos.

Scale up areas

GAIN provided the initial trainers and assisted the government with activity planning; other training costs, props, and support activities had to be provided by the government and through village funds. GAIN informants reported that advocacy was critical to generate interest and secure funds. To generate interest in emo demos, scale up area health staff were invited to orientation sessions in East Java. In addition, GAIN staff met with the head of the district and DHO to describe the evolution of emo demos in intervention areas and promote implementation in the remaining 15 sub-districts in Jember. The DC reported that the district head was supportive of emo demo implementation in the scale up areas. In addition, during visits and phone calls the DC and TC advocated for emo demo implementation in all scale up areas; all sub-district heads were invited to special events promoting emo demos, as were village heads under DPMD.

Because the DHO did not have a specific budget for emo demos, other options had to be identified to fund emo demo implementation. The DC advocated for the DHO and Puskesmas to use BOK (Health Operational Assistance) funds allocated for stunting prevention, a topic of primary interest at the national level. GAIN informants contended that emo demos comprised behavioural change communication critical to stunting prevention and that sessions constituted essential complements to supplementary feeding programmes offered in Posyandus. Information on emo demos and their role in stunting prevention was also circulated in Jember newspapers.

GAIN leadership also considered the Community and Village Empowerment and Health Services (DPMD), which typically finance Posyandu and cadre activities, as a promising funding source; the DC advocated for use of DPMD funds to implement emo demos. During meetings with the DPMD, the DC promoted emo demos by emphasizing that the approach enhances community and cadre empowerment. Subsequently, the head of the Jember DPMD circulated a letter to all sub-districts stating that emo demos will be part of stunting activities. However, our informants noted that all villages are not under DPMD; furthermore, the DPMD has limited authority because village funds involve other ministries. It was essential to advocate for use of DPMD funds all the way to the village level and to inform villages about other funding sources such as OPD funds

As soon as activities got underway in intervention sub-districts, the DHO started preparing staff in scale up areas for emo demo implementation. In 2019, scale up areas were encouraged to adopt emo demo sessions. Key informants indicated that GAIN promoted flexibility and innovation in planning and implementation, as long as the main objectives were achieved. In coordination with sub-districts, Puskesmas developed their own annual workplans based on the numbers of Posyandu and availability of funds. At the village level, planning and scheduling of training and emo demo sessions activities involved the village head and secretary.

Rather than using the cascade approach involving different levels, trainers in scale up areas primarily included Puskesmas staff. The DHO coordinated with the DC and TC to invite MOTs to lead training in scale up areas. Specifically, 24 trained MOTs were deployed to 25 Puskesmas for TOT of two people, generally the nutrition and health promotion officers, in each Puskesmas. Subsequently, TOTs trained other Puskesmas staff, including the midwife coordinator and the head of the PKK, to train the cadres. Depending on the needs of the local area and the capabilities of the TOT staff, sometimes MOTs trained the cadres. Due to the high number of villages and cadres, the TC also occasionally led trainings.

In scale up areas, all five Posyandu cadres were trained, and training sessions were larger than in the intervention areas. While the training content was generally the same, all the modules were introduced during one training, with three modules introduced each day. One informant mentioned that trainees were unable to retain all the information due to the short training period. Informants mentioned other challenges. For instance, some Puskesmas TOTs were nervous to train their colleagues and friends. In addition, MOTs faced language barriers training the cadres; many MOTs had regular jobs and were not always available to train.

Because the DHO did not have a specific line item for emo demos, funding presented a major challenge. Funding for scale up areas primarily came from the BOK, which could only be allocated at the village level; each of the 24 Puskesmas submitted a BOK budget for emo demos. Training of cadres and purchase of props was mainly supported by DPMD funds, but funding depended on whether the village head was supportive of conducting emo demos. Generally, village budgets for emo demos were less than five million rupiah, which could only support some aspects of activities.

Informants reported that the example established in Jember to use village funds to buy props and finance training was subsequently followed in other districts.

While cadres were trained in all modules, emo demo schedules were adjusted according to local needs and preferences, with the TC indicating that Posyandu often chose to implement those modules that were easier to implement and with adequate tools. She reported that cadre were generally enthusiastic to have the opportunity to participate in emo demo training and to lead sessions. Mentoring and follow up was up to the village midwife, with informants mentioning sustainability of the programme in scale up areas was dependent on the involvement of the midwives. As was the case in the intervention areas, informants reported that many cadres lacked confidence and the capacity to understand and lead sessions proficiently and that props were often missing due to insufficient village funds. Puskesmas staff were frequently forced to make props out of paper or to improvise props. In addition to human resource and material limitations, it was often hard to identify a location with adequate space for emo demos, with informants stating that Posyandus were frequently too narrow. Mobility of government personnel was a major problem, with trained staff often relocated to other areas.

Emo demo reporting was done by the village midwives following a template and submitted to the DHO. Heads of the DHO and public health department participated in the emo demo WhatsApp chat by checking reporting and sending messages to encourage participants to implement and report emo demo activities. Interestingly, informants mentioned that reporting at the end of 2019-early and early 2020 was higher in the scale up areas compared to the intervention areas and that scale up areas were conducting a higher percentage of emo demos in Posyandus. Informants noted that started to decrease after full implementation of the 12 modules in the intervention areas. GAIN informants speculated that staff in scale up areas, where local funds were used for implementation, took greater ownership and were more enthusiastic about receiving training and implementing activities. In contrast, after a year the newness of the activities appeared to decline and workers in the intervention area became weary; the DC speculated that staff in the intervention areas may have felt that activities were imposed on them, which affected their sense of belonging and enthusiasm. In March 2020, emo demo sessions had to be halted due to the onset of the pandemic. At the time, all 24 Puskesmas in the scale up areas were implementing sessions.

We received mixed reports of implementation of the MSC approach in scale up areas. While MOTs were responsible for collecting stories in intervention areas, in scale up areas it was up to the cadres to identify success stories which were sent to the TC or to a MOT. We were told that 2-3 successful stories originated from the scale up areas.

Other non-intervention areas

Orientation events promoting emo demos in East Java served to raise awareness about emo demos among health professionals working in other districts in the province. During these events, participants were told that GAIN offers free training and were given the DC and TC contact information; those interested in implementing emo demos were asked to send a request letter to the Provincial Health Office copying GAIN.

GAIN received many requests to lead training in districts outside of Buduta 2--the Jember TC and MOTs were among those sent to government districts to lead training. The TC also responded to training requests from universities. While training in districts was supposed to be held for 3-4 days and to cover three or four modules daily, we learned that trainings were often shortened due to budgetary constraints. When this occurred, trainers focused on fewer and more difficult modules, and provided training tutorials for the remaining modules. Budgetary constraints also forced

government led districts to make their own props, reduce the number of props, or purchase props gradually. Informants indicated that MOTs with regular jobs faced challenges taking continuous leave and often had to decline requests to travel to other districts.

Successes and weaknesses

Reported strengths of the approach included that emo demo sessions focused on a few key and relatable messages, generated emotions and in some instances surprise, and were generally participatory. Other mentioned advantages included the game-like approach involving alluring competitions, songs and dances, as well as the newness of the methodology and messages, which generated interest and engagement. It was also noted that emo demos were presented in other venues and to various audiences such as during pregnant women and parenting classes, sessions for mothers of malnourished children, and in preschool, elementary and junior high schools where adolescent girls were targeted to increase intake of iron rich foods. Another mentioned strength was that emo demos could potentially impact multiple indicators, including Posyandu attendance, eating behaviours, and weight gain in children. Informants reported hearing many anecdotal stories of behavioural change.

The most frequently mentioned weakness related to the limited capacity of the cadres, who prior to emo demos had had a limited role in counselling and health education, to lead the modules and use the props effectively. Informants noted that caregivers attending sessions were often better educated and the cadres may have considered the mothers more knowledgeable. The combination of lack of experience and a feeling of inferiority in the face of mothers likely affected cadres' confidence leading sessions. Another reported obstacle was that cadres tended to follow instructions received during the training verbatim. The TC explained:

> *Cadres usually do exactly what we train them to do. If, for example, we deliver the training with theories, I am afraid that they will do the same (e.g. deliver the theory) in the Posyandu. One time, after we trained cadres on the module themes and had them read the emo demo module guidelines out loud, I observed the Posyandu cadre lead the session exactly as we had done during the training. I guess maybe the cadre paid too much attention during the training. While the focus should be on the emo demo activity, the cadre instead read the guidelines, 'Emo demo is…' as if she was starting a lecture. I was shocked. It got way too long; only 15-20 minutes is needed per module.*

Informants reported that cadres who lacked capacity often made the sessions long and boring. Certain sessions, such as Imagining Your Future, which requires that the presenter understand aspects of fetal development, were mentioned as particularly challenging for the cadres.

Limited capacity of the cadres increased the importance of midwives' roles to oversee emo demo sessions and ensure that the cadres do not deviate too far from the approach. Both the DC and TC emphasized that the support provided by the village midwives was critical to the performance of the cadres. Specifically, they insisted that if midwives were enthusiastic and treated sessions seriously, the cadres placed more importance on their performance. They also stated that good guidance and direction provided both by the midwives and MOTs increased the cadres' desire to execute sessions well and improved their confidence. Unfortunately, not all midwives had the same level of engagement and dedication to ensuring success. Informants reported that implementation and monitoring of emo demos created an added burden on Puskesmas and Posyandu staff and required a strong level of commitment among all staff involved, including the cadres.

Another mentioned weakness involved the Posyandu environment, which informants mentioned can be crowded and noisy due to crying babies and not always conducive to participation, particularly for activities which aim to evoke emotions (e.g. Imagining Your Future). One informant stated that the multiple layers of trainers involved in the cascade approach diffused the training quality, especially at the cadre level. The same informant mentioned that that the reporting system missed many emo demo participants. Another weakness related to the fact that women living in cities often preferred to go to other more trusted health workers, such as pediatricians, for well-baby visits or that working mothers frequently sent nannies to Posyandus.

The constant transfer of workers and vacancies in the government workforce created another challenge. GAIN informants reported that during preparations and implementation of Baduta 2, the Jember head of the public health division post was vacant, as were other positions in the public health division, forcing them to collaborate with the head of the DHO. High attrition of workers in leadership positions at the DHO and sub-district levels, and vacant posts, made it difficult for the DC and TC to coordinate activities. Many workers trained by the programme were transferred during the programme period, forcing GAIN to train their replacements; most notably, 330 trained midwives were relocated to other posts. The DC also reported that trained nutrition and health promotion officers were transferred to other Puskesmas, and the head of one sub-district, who had received extensive training and was engaged in the programme, left his post. While MOTs were responsible for informing the DC and TC when positions were vacated, sometimes there were long time gaps before GAIN personnel learned about staff changes, which impeded activities. Staff attrition forced the DC and TC to carry out advocacy and outreach sessions designed to orient workers about emo demos a second time in all collaborating sub-districts. In some cases, GAIN provided individual training—which they described as inefficient and time consuming—to new government recruits.

Informants suggested that the size of the programme, which involved 1400 Posyandu, affected the quality of activities. Because they were unable to conduct regular field visits to observe activities firsthand, monitoring relied heavily on information entered in the WhatsApp application. TC monitoring visits mainly concentrated on locations that reported low attendance and faced difficulties or areas where the training evaluation reported staff weaknesses. Informants expressed concern about lack of resources for continuation of the programme and the fact that GAIN would not be available to provide mentoring and technical assistance in the future.

The DC mentioned that communication between the DC and TC was not always adequate. While the DC was in charge of leading public presentations related to advocacy and outreach, she was not always familiar with the details of emo demo implementation and module content. When unable to respond to questions asked by authorities, she was placed in an awkward position which she felt undermined the programme and GAIN's reputation. She indicated that improved sharing of information regarding the TC role would have allowed her to better fill in when the TC was overburdened.

Recommendations for improvement

Recommendations from the DC and TC focused on the need to ensure that the midwives play an effective role in creating an environment conducive to conducting emo demo sessions, stating that the setting must be appropriate and the person delivering sessions competent. They added that the midwives need to manage the room so that it doesn't become chaotic and noisy. Informants insisted that cadres review module contents and guidelines a day prior to the sessions so that they are familiar with the key steps and adept at leading sessions; they also recommended advanced preparation of the tools and avoiding long wait time before sessions. The DC emphasized that

evoking emotions and leaving a memorable impression on caregivers can only be achieved if the cadres are well prepared and skilled at leading sessions; she also stressed that sessions should not last longer than 25 minutes. The TC recommended additional funding for capacity building of both the cadres and midwives.

The DHO emphasized the importance of sustained, high-quality monitoring and evaluation, preferably carried out by an objective third party. Our MOT informant mentioned that monitoring and evaluation should focus less on the number of participants but more on the quality of the sessions, including whether mothers understand the messages and adopt improved behaviours. The MOT also suggested improvements in the training quality, which she contended is negatively affected by the multiple layers in the cascade approach, recommending that higher level staff lead cadre training.

TC and DC Bondowoso

Background information

We interviewed the district coordinator, who had a Master's degree in Environmental Health and a Bachelor's degree in Public Health. Prior to joining Baduta 2 in 2018, the DC had been working in community empowerment. Her role in Baduta 2 included management of programme activities, advocacy of Baduta 2 and emo demos, and training preparation.

We also interviewed the training coordinator, who had worked as a village facilitator in Malang for six months and in Sidoarjo for one and a half years during Baduta 1. As a training coordinator for Baduta 2, her role included scheduling and overseeing training activities, ensuring the availability of props, and advocacy activities which she conducted with the DC.

At the time of the interviews, modules were still being introduced in the scale up areas, while in the intervention areas a full round of modules had been implemented.

BCD theory

The DC informant mentioned that the BCD, which was previously referred to as SCENTS (Simple, Story, Emotional, Real, Unexpected and Social), focused on changing behaviour by appealing to emotions designed to change people's understandings of a feeding practice and mindsets. The TC indicated that the theory stimulates change by encouraging mothers to reevaluate a current behaviour that is inappropriate and potentially harmful and introducing an improved behaviour beneficial to children. She stressed that the theory focuses on conveying messages that trigger specific sections of the brain and ensuring that messages are received in an appropriate social environment.

Description of Baduta 2 and emo demos

The DC stated that the goal of Baduta 2 is to improve community nutrition during the first 1000 days of life and that the approach focuses on decreasing child stunting. She added that Baduta 2 includes 10 LMKM (10 Steps to Successful Breastfeeding) and emo demos, which aim to change child feeding behaviours of caregivers by introducing interesting, participatory games designed to trigger emotions. She added that Baduta 2 is unique because of the introduction of emo demos but also due to mechanisms used to measure impact, stating that the programme monitors both the number of beneficiaries and changes occurring qualitatively through the MSC approach. The DC stated:

> *The innovation that I experienced from the programme was not just that the programme provides knowledge through games. In my opinion, the evaluation of the programme is*

something new, I have never in my previous experience seen an approach like the Most Significant Change, which is about picking a story of change with the most significant meaning. Usually, evaluation is measured in a quantitative or numerical way, such as looking at how many people have changed, how many children have increased nutritional status, and so on. However, Most Significant Change is about the most meaningful changes found in the community, they are created into stories and the stories are entered in a contest. So, it turns out that changes are not just a number, but there are qualitative changes that are recorded. The story of the most significant changes is visible, for example, the mother from a village who fed her newborn lotek or mashed banana changed her behaviour after participating in emo demos. Hence, these changes are visible.

The TC described differences between Baduta 1 and Baduta 2, stating:

I feel that because Baduta 2 touched more people, it was more suitable, maybe because Baduta 1 was a pilot project, so maybe it was treated differently. I was more comfortable with Baduta 2 because in Baduta 1 there was no empowerment. I mean, I was the one who led the emo demos, the village facilitator was the one who did the emo demos, so we were the ones who trained all the cadres, and since each cadre had a different capacity, so the facilitator needed to intervene and take over. Because of that some cadres and areas felt that it wasn't their programme, they didn't feel that they belonged to the programme. Since Baduta 2 was facilitated by the regional government and the health office, they participated in the entire process, we only guided them, they felt that they belonged. Starting from the top key figures down to the health workers in all Puskemas, the cadres, both the village and the district PKK staff, they all knew about the emo demos, because they were involved in every aspect. While in BADUTA 1, they were implemented in only some of the sub-districts. For me Baduta 2 is better, because it had more coverage. The differences are not only in the area coverage, but also in the design.

Informants reported that emo demos primarily targeted pregnant women and mothers of children under two and five years of age, but other caregivers such as fathers and grandmothers were also targeted. They mentioned that sessions lasted from 15 to 20 minutes. Informants indicated that each session involved participatory demonstrations using props, which encouraged mothers to think about and digest the messages. The TC described sessions as, "interactive, fun, emotionally touching, and engaging," highlighting that emo demos are unique. She stressed that during sessions participants evaluated their own behaviour and realized on their own that it was inappropriate. The DC reported:

So, participants are invited to have an interactive dialogue. So, for example, if an answer is wrong, so then the other mothers are asked, 'What about the other mothers?' right, 'Mrs A's answer is like this, is it true or false?' Then we have this phrase 'If it's wrong, correct it,' something like that, so that the mother doesn't feel, 'Oh, I gave the wrong answer,' so they do not feel bad or embarrassed, no, 'It's okay, Ma'am,' if it's wrong, then we will correct it together so then she remains enthusiastic to answer again, and continue to play.

The DC mentioned that at the end of the session a new, and often memorable, message is conveyed which aims to enhance retention of the information.

Informants reported that sessions are also conducted in Posyandu for the elderly and adolescents, during pregnancy, toddler, and early childhood education classes, during parenting classes (e.g. Bina Keluarga Balita = Guiding Families with Toddlers), and during ANC, thus broadening the target audience.

Implementation of emo demos

Training

Our informants reported that GAIN supported funding for training in the intervention areas, which involved a cascade approach and included the MOT, TOT, and cadre training, with two cadres trained in each Posyandu. Since there are generally five to seven cadres in each Posyandu, the local government was responsible for covering funding for the remaining cadres to be trained. The DC said:

> *For the intervention location, we provided a training of master trainers in the beginning, then training of trainers, Posyandu cadre training, and the provision of educational props for emo demos. Props were provided by GAIN. The money, monitoring, and evaluation activities that we followed up to the Posyandu level was also funded by GAIN. Moreover, GAIN provided financial support in the MSC competition and facilitated a meeting every three months at the district level.*

Props

GAIN provided all the props in the intervention sites, and the local government also gave funding to procure additional props for the same areas. One informant mentioned that there are two sets of props for each Posyandu, one from GAIN and another one from the local government, and that each session has a different set of props. Because props are considered critical, Posyandu operational funds were also used or sometimes cadres donated consumable props or lent items from their homes that served as props.

Supervision

The TC and DC led supervision of training activities, from the MOT down to the cadre training, as part of quality control. An evaluation of trainees was carried out at the end of each training, with TOTs only able to train cadres after having demonstrated adequate capacity to lead training. The DC said:

> *We have a form that must be filled in when assessing the training of MOTs which highlights their strengths and their weaknesses that must be addressed. We have a joint evaluation after the event and the MOTs are reminded not to repeat the mistakes identified. We also carried out the same assessment during the TOT. So, we first held a briefing with the MOTs who were positioned to teach at the level of TOT, to strengthen their performance before the TOT training activity. I was involved in the assessment process to ensure the quality of the training and make sure it did not differ from what we had planned. TOTs were only allowed to train cadres when they were ready, and their assessment results were good. We went to the field to supervise our trainers, to monitor and provide assessments when they were training cadres. We evaluated and presented the results of the evaluation at the end of the session. The DC duties included evaluating the TOTs on whether the teaching method was correct or if there was anything that needed to be improved and whether training outputs met expectations. We did not only supervise but we also provided coaching on what needs to be improved.*

Prior to the pandemic, DC and TC usually conducted ten supervisory visits to Posyandus monthly; because they had different responsibilities, they generally carried out these visits jointly and with DHO staff. Aside from supervisory visits, the sub-district or village midwives were responsible for direct supervision of emo demo sessions in all the Posyandu, and informants reported that heads of Puskesmas also supervised sessions. DHO and GAIN staff held quarterly meetings to discuss emo demo activities.

Monitoring

The DC stated that monitoring entailed submitting information on emo demo sessions to a WhatsApp group. Specifically, midwives or other Puskesmas staff entered session information in a template which was subsequently uploaded to the application. The DC considered the MSC approach as a monitoring tool to assess the way emo demos were changing behaviours and benefitting the community.

Monitoring of the cadres was carried out by Puskesmas staff, particularly the midwives, who provided additional training and mentoring to weaker cadres. The DC said:

> *The Puskesmas staff did mentoring of cadres with low capacity, the midwives tried to improve their capacity one or two days before the session. Or during cadre meetings, the midwives would have two or three cadres practice the modules while being observed by their colleagues. In Posyandus with good cadres, mentoring was rarely conducted because the cadres were already capable.*

Reporting

The midwife submitted emo demo reports to the Puskesmas nutrition section, as well as monthly Posyandu reports, which were forwarded to the DHO. Reports were also forwarded to GAIN staff, who were responsible for compiling and analyzing the data. MSC stories constituted a way of reporting success stories.

Collaborators

Collaborators included the local government, particularly the DHO, and the Regional Apparatus Organizations under the local government. We were told that offices at various levels of the health system supported and strengthened activities GAIN initiated in intervention areas. The DC said:

> *We are supported by stakeholders which involve the bureaucratic system led by the DHO. In the beginning, we coordinated with the DHO to deliver a letter of assignment, which conveyed our role in the programme and described activities to be carried out when we mobilized. Our cooperation and coordination was not only with the Dinkes (public health office), because the DHO is not the only district office we work with, but we also coordinate with stakeholders in the Bondowoso Regency Government and we cooperate with the Bappeda (Regional Development Planning Agency), DPMD (Community and Village Empowerment Service), Women Empowerment Institution, and Family Planning Agency, and other networks ... There are also networks under the DHO such as the Puskesmas and the sub-district offices. First, we carried out outreach and orientation sessions at the district level and got a joint commitment and then we followed up with outreach sessions at the sub-district level and carried out coordination.*

Implementation

Informants mentioned that the 12 initial modules were introduced by GAIN and executed in the district. The DC added that the emo demo modules have been included in the Tapos book (the official book for Posyandu Parks) for East Java Province. Moreover, modules have been officially incorporated into the Family Welfare Program of East Java and also made into a book for their use. The TCs, including the TC from Bondowoso, was involved in the development of 12 new emo demo modules.

Prior to the pandemic, emo demo sessions were running as planned, with one session held monthly during Posyandu sessions. After the pandemic, the government mandated that all Posyandus close,

thus curtailing implementation of emo demo sessions. Even when some Posyandus opened, they only provided basic services such as weighing and vaccinations. Our informants indicated that the government is committed to restart sessions once the situation permits.

Cadres

Usually, two out of the five or seven cadres from each Posyandu were selected by village midwives to participate in GAIN funded training. GAIN requested that selected cadres be able to speak in front of audiences, have a minimum of a junior high school degree, and be proficient at reading and writing, with midwives often choosing candidates based on their experiences with cadres. Selected cadres did not receive incentives for implementing emo demos, and according to the DC, some did not want to lead emo demos since there was no change in their monthly stipend, which was described as meager. Informants reported that some cadres who guided sessions were ridiculed by mothers. In general, informants reported that cadres faced a lot of challenges leading sessions, with the TC stating:

> *When I visited Posyandus, I could see that there were obstacles. Sometimes there were cadres who weren't confident, because they had never done counseling or explained things in front of the mothers, usually their job was only to take notes, weigh babies, and help the midwife. With the start of emo demos, they suddenly had to explain something, sometimes mothers of the toddlers, who felt they were better educated than the cadres, made remarks such as, 'You are just a cadre, how can you provide counseling and give health information.' There were people like that, or others said, 'This should be the job of the midwives.' Eventually the cadres ended up losing confidence and told us, 'I don't have the courage to lead sessions because I was being ridiculed.' There were all kinds of obstacles we encountered in the field.*

The main motivation for the cadres to conduct emo demos related to their interest in contributing to the community.

Caregivers

Perceptions

Both informants believed that mothers enjoyed the sessions, mentioning that mothers living in rural areas have few distractions and that sessions became a source of entertainment. Informants also emphasized they participants gained knowledge during the emo demos, which was far different from previous Posyandu activities. However, the TC mentioned that some mothers were shy to engage in sessions. The DC mentioned that the most interesting and enjoyable sessions were "Baby Tummy," "Reckless Snacking," and "Building Blocks," while the TC mentioned "Reckless Snacking" and "Getting Ready to Go Out." The session that seemed to be less effective was "Creating Bonds." They also mentioned that cadres had difficulties leading "Being Pulled in all Directions" and "Imagining your Future."

Informants provided several examples of successes featured as MSC stories, or which they learned about during field visits. One DC shared examples, stating:

> *The first story involves a mother who was unable to speak. Her child was given formula milk, he was not exclusively breastfed. After participating in the emo demo session and listening to the cadre describe the stomach size, the mother realized that she was wrong to give formula milk to her child. She changed her behaviour and was determined to breastfeed her child up to the age of two years. A second mother had fed her baby sogu—a complementary food made of bananas--before her child turned two months. Based on what she learned during emo demos, she stopped giving the young baby complementary foods. While the family of the mother argued against this change, stating, 'But, the child is hungry, it lacks this and that,' the*

mother replied, 'No that's not allowed. Ms. Cadre said the size of the baby's tummy is this big (very small).'

Key informants emphasized that the success of sessions reflected the innovation and simplicity of the approach, focus on appealing to emotions, and inclusiveness, suggesting that past approaches were top down and often patronizing.

Challenges

The DC contended that home environments could be either supportive or discourage changed feeding behaviours. She indicated that some mothers shared stories that their mothers-in-law interfered with the mothers' strong desire to exclusively breastfeed. The DC reported:

There is a story from a MSC about a young mother who broke the tradition of 'sobuk,' which is the custom in the village, right? Usually, babies a few days old are given small cut bananas or green coconut. After participating in emo demo session, the mother of the baby told her grandmother who she lived with not to give the baby semi-solid foods. The mother insisted, stating, 'No, don't give it to the baby, yesterday I was taught at the Posyandu that you can't feed it to the baby, it's not time yet.' This example shows the motivation of mothers who have participated in sessions, but that discouragement comes from the family, like unsupportive husbands or in-laws, which can be tough to combat. Of the few MSC stories that we received, the mothers who won were strong and unwavering in facing their struggles.

Informants also reported that social and economic factors influenced behavioural change. For example, they mentioned that giving formula milk involved pride and prestige.

Scale up areas

According to informants, the main difference between intervention and scale up areas was the funding source. The DC stated:

This programme was launched as part of a commitment conveyed to the respective district governments. GAIN only financed or provided a budget for the intervention locations and the rest of funding had to be generated by the district. However, the emo demo activities in the intervention and scale up areas were not much different. The only difference is the location of the intervention area, which was fully funded by GAIN, while the replication or scale-up area was funded by the district. Activities in the Bondowoso Regency were not much different, meaning that the adaptation of the programme in the scale up areas was almost the same as the way GAIN implemented in the intervention areas.

Informants mentioned that several meetings were held in the intervention areas to ensure full engagement from local authorities prior to training. The same meetings were not conducted in the scale up areas due to funding limitations. Rather, activities would usually start directly with the training phase. When advocacy meetings with local authorities were held in the scale up areas, they were informal, while in the intervention areas advocacy was carried out systematically using a cascade approach. The DC noted that the level of enthusiasm was similar in scale up and intervention areas.

Other non-intervention areas

Informants mentioned that in Bondowoso there are 21 master trainers; the DHO chose civil servants from different sectors and programmes, which they believed would improve sustainability. Informants also mentioned that there is an emo demo facilitator association (ASFED) consisting of trainers from across East Java available to travel to other cities and districts in East Java and all over Indonesia to conduct trainings. When called to lead training in non-intervention districts and cities, MOTs most

often trained village midwives, nutrition and health promotion officers, the midwife coordinator, and the head of the village TPPKK (Family Welfare Development Activator Team). We were told that the introduction of the programme usually started with outreach and advocacy with stakeholders. The TC mentioned that trainers follow monitoring of activities in non-intervention areas on WhatsApp.

Successes and weaknesses

Cited successes included the ability to engage with and transfer knowledge to mothers in a fun and participative way that touches emotions, with informants emphasizing that when emotions are evoked knowledge is more easily retained and caregivers are more likely to change behaviours. They stated that when the facilitator was adept at using the visual aids and able to draw firm conclusions at the end of the session, messages were well received by mothers. Another mentioned strength related to the cascade training, which informants indicated was systematic and provided clear technical guidelines for programme implementation. Informants also contended that engagement of different stakeholders enhanced the sense of ownership by local government. The TC stated:

> *The strength is that there is tiered training, which means that there are personnel who have been prepared to carry out activities in the field. When the programme is completed or has achieved scale up, there are personnel who are ready, ready to follow up, and sustainability can be maintained. Another strength is that there are experts at the central level who prepared the materials, so the plan is clear, it's not an open menu of activities, but (the activities) are predetermined. From planning to implementation to the result, the process is coherent and systematic. Everything is clear. A third strength is involving stakeholders from the central level, the Ministry of Health, the Provincial Health Office to the District Health Office, this is a plus. Why? Because they feel that the programme is also their programme, they have a sense of ownership. So, it's not like they are only assisting, or that GAIN has done everything, and that GAIN is also in charge of ending the programme. They are fully involved, starting from the initial planning and implementation to M&E activities. That's the strength.*

Informants mentioned that the primary challenge was the range of capabilities of cadres, with informants mentioning that many cadres had limited ability to lead sessions. As a result, delivery of the emo demos was not optimal, or the midwife had to lead sessions. The TC said:

> *The weakness is that the role in the Posyandu is mostly taken on by the midwife, there is no (other) capable human resource. It is unfortunate when the message is not delivered well. For example, they (the cadres) often forget the material, stand there frozen and cannot gain the attention of the audience to participate. In some instances, the cadres came across as monotone, for instance during Reckless Snacking, asking, 'What do you think about this, can you eat it?,' in a stiff manner, so that the audience only responds with, 'No, Oh no, Okay.' When the delivery was monotone, mothers became confused about the point of the demonstration, about the output. When that happened, the mothers became confused with the activity, the conclusion, and what they needed to do next. Usually, the midwives explained it again until the audience understood… The weakness is when the facilitator does not master the material, it's not just mastering the material but also mastering the situation. So, while we need to build an atmosphere that is more flexible, more enjoyable, not everyone is able to do that. Those who do not master the material and only deliver the message, are very stiff, very monotone. For them, it doesn't matter whether the audience understands it or not, as long as they conducted the emo demo.*

Other mentioned challenges included that some mothers do not participate up to the end, leaving the session midway through. They reported that particularly in urban centers mothers often don't

participate because they have household work or must return to a paying job or send other caregivers to the Posyandu.

Informants also mentioned that in government areas they are unable to follow implementation because here is no monitoring system set up. As a result, it depends on the district area to implement the approach rigorously or not.

Recommendations for improvement

A primary recommendation related to ongoing capacity building of the cadres. Informants insisted that cadres require refresher training, stating that many cadres forget the material over time. Another benefit to refresher training is that trainers can learn more about the capabilities of each cadre, which will allow them to understand where to direct their attention during supervision. Another recommendation related to ensuring ongoing availability of props. The DC said:

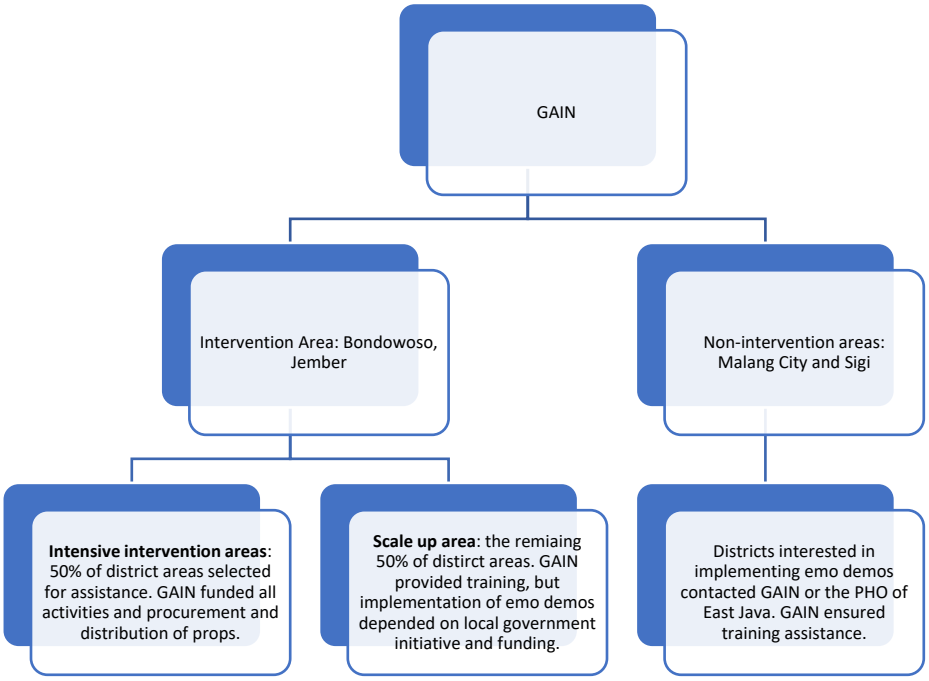
> *The props must be updated, meaning that some props disappeared or were used up, while others were still available. Sometimes props in the Posyandu got lost. When we talk about sustainability, it is indeed the responsibility of the district government, which means that the tools/props must be monitored, whether they are still in stock, still intact, damaged, or lost, there must be a replacement. Hence, the first recommendation relates to the props, that the props must be on standby and ready to use. The second recommendation relates to human resources, improving the quality of human resources. To increase the cadres' ability, their knowledge must regularly be reinforced, which will increase their confidence. The last recommendation is to increase cadres' incentives.*

In addition, informants underlined the importance of buy-in from the local government to enhance sustainability, which entails getting government workers involved in decision making and implementation from the outset. The DC recommended:

> *Ideally, each programme should position the people that we assist as subjects, not objects, right from the start. When they are given roles as part of the satgub [Governor Task Force] and we only facilitate, provide suggestions, and assist on the technical side of things, the results are better than when we give activities to implement, 'Here, please carry this out,' that's different. So, when they are involved directly, we already have determined the activities, but when we plan that activity, we involve the related OPD, that's a strength. They are asked, 'What's the best way to do this? Who are the participants?' and involved in accordance with circumstances in the district. In my opinion, when we involve the stakeholders from the beginning to end, the results are different. This is because they have a sense of ownership, and in the end, they are well prepared so that the programme succeeds, not only to achieve targets and aims, but to contribute to society.*

Figure 1. Difference between intervention and non-intervention areas

Baduta 2 Intervention and Scale Up Areas



Provincial Level (PHO): East Java

Background information

We interviewed a staff member who worked in the health promotion division. Our informant had a Master's degree in Management and over 15 years of experience working in maternal and child health and health promotion. His role in Baduta 2 involved ensuring that the five target districts received funding to implement emo demos, integrated emo demo activations into ongoing health services offered in Posyandus or integrated services posts, carried out requisite training of health workers on the emo demo approach, and supervised emo demo activities. He was also in charge of overseeing coordination of activities between the district health offices and GAIN staff.

Description of the emo demo approach

The informant suggested that the Baduta 2 programme complemented the First 1,000 Days programme by focusing on key issues and concepts designed to improve nutrition in pregnant women and young children, and to combat child malnutrition. The informant praised the novelty of the original Baduta package, noting that the MSC intervention, which uses real-life success stories, was innovative and inspired community members to change behaviours. He added that the emo demo approach involved tools and instruments that helped to guide the cadres, and that the emo demo approach is flexible and can be adjusted according to existing needs.

The informant thought that the main goal of the Baduta programme was to reduce stunting. He stated this can be achieved through capacity building of health officials at the district, sub-district, Puskesmas, and Posyandu levels on improved behaviour change communication related to infant-young child feeding and maternal health. According to the informant, an added benefit is that emo demo activations encourage mothers to attend Posyandu activities. The informant said:

> *Emo demos in the Posyandus encourage mothers to change their behaviours related to child feeding, and overcome problems linked to underweight or undernutrition in children. When participating in the emo demos, mothers are exposed to nutritional issues that play an important role in child feeding. Before emo demos, some mothers were lazy and chose not to go to the Posyandus.*

The informant noted that unlike other programmes promoting behavioural change, Baduta 2 assisted with training and provided props to help convey messages during emo demo activations. He praised the support offered by GAIN, calling it exceptional compared to other programmes and stated that it eased programme implementation, stating:

> *GAIN contributed a lot to carry out the emo demo programme. GAIN provided props as well as training. Other NGOs only work to improve the capacity of workers… The difference between Baduta and other programmes is the support GAIN provided; GAIN has a very clear objective.*

Our informant reported that emo demo activities were introduced in Posyandus in the five Baduta 2 target districts in 2018. He said that emo demo methods enhanced participants' understanding of key health messages compared to traditional didactive approaches involving lecturing. He added that the props serve as teaching aids and enable participants to see and experience activations first-hand, thus facilitating comprehension of the key messages conveyed. The informant said:

> *For example, participants can imagine the effects of snack foods in a baby's stomach if we show them what happens when three or four types of snacks are mixed with water in a glass. The audience can smell the unpleasant odour and visualize the mixture directly. However, this is hard to imagine through an explanation because they can't see the colours or smell the snacks. Mothers find messages easier to understand when they involve seeing and smelling real objects first-hand. Explanations and visual examples have very different outcomes.*

Processes involved in implementation

A standard set of props was distributed by the provincial health office to all the intervention districts. The informant reported that health office staff carried out supervisions of emo demo sessions and monitored activities. According to the informant, monitoring included tracking funding available for training and the number of Puskesmas personnel trained. In addition, monitoring data of emo demo activities was collected at the Posyandu level and transmitted to Puskesmas, which are responsible for reporting to the district health offices. Reporting data was also shared with and analysed by GAIN staff.

Training

The informant did not participate in MOT training, but two of his colleagues in the PHO became MOTs. He represented the PHO during the training launch ceremony and oversaw some emo demo training sessions.

Our informant described the organisation of the training sessions as a cascade approach. Initial training was led by GAIN and involved PHO and DHO staff who were trained as MOTs; the MOT training lasted a week. Trained MOTs subsequently trained TOTs.

According to the informant, GAIN covered all training expenses in the intervention areas. In the scale up areas, funding for DHO staff to attend MOT training and train TOTs came from the non-physical DAK (Dana Alokasi Khusus) special allocation fund. These funds are sourced from APBN revenues and allocated to certain regions with the aim to help fund special activities which fall under regional affairs and are in accordance with national priorities.

Trained MOTs led a three-day emo demo orientation with other DHO staff working in non-intervention areas. Once trained, non-intervention area districts interested in implementing emo demos were invited to send a letter of interest to the PHO, which in turn, notified GAIN. Subsequently, GAIN would send a MOT from the nearest intervention area to the non-intervention area to lead the training. The informant reported that training sessions entailed an introduction to concepts related to the emo demo approach, the content of the sessions, how to conduct the emo demo activations, as well as practice leading the different sessions.

Funding

GAIN funded all expenses in the intervention areas. For the scale up areas, GAIN only paid for the trainers, including their travel costs and allowance. GAIN also assisted with procuring props. According to the informant, funding for scale up areas was sourced from the BOK (health financial aid) and DAK from the APBD. The informant mentioned numerous parties involved in the Baduta programme, such as but not limited to, Family and Welfare Development (PKK); the National Population and Family Planning Board (BKKBN); the Office of Women's Empowerment for Child Protection and Family Planning (DP3AKP); the Community Empowerment Service; the Education Office; the Department of Agriculture and Food Development; the Regional Apparatus Organization (OPD); and the Regional Development Planning Agency (Bappeda); as well as religious organisations.

Emo demo sessions

Our informant reported that there are 12 emo demo modules and that the target audience is pregnant women and mothers of children aged under two. He mentioned that he often observed sessions, noting that women were engaged, enjoyed participating, and appeared to understand the messages conveyed. The informant added that emo demo sessions are strategically scheduled at the time when women arrive for Posyandu services, noting that if they were held after well-baby visits, women would opt to return home and skip the sessions. He explained that cadres, who are volunteers and do not have to meet any set requirements, lead the emo demo sessions at the Posyandus. Describing the cadres, he said:

> *Cadres assume their roles voluntarily, and it's a matter of pride, really. Because their roles are voluntary, we are not so picky. We don't say, 'Oh, cadres should at least hold a high school degree.' It's impossible to do so. Even people without formal education, if they're highly dedicated, if they have a strong will, their spirit is what we need to provide service. So, because there's no criteria, that cadres have at least an elementary school degree, their capabilities vary based on their educational background, but they support each other. So, they work according to their ability and adapt the skills needed at the Posyandu level.*

When asked about topics shared during sessions, the informant mentioned the session promoting exclusive breastfeeding up to six months (Baby Tummy), which demonstrates that a young baby's stomach is the size of a marble, and the session discouraging giving children low quality, processed snacks (Reckless Snacking).

The informant described several strengths of emo demo activations, the first being that sessions convey messages designed to address causes of malnutrition, particularly stunting, which he reported places a burden on both families and society at large. Another strength relates to the emo demo approach, which the informant claimed helped participants understand key messages through visualization and concrete, relatable examples. A third strength involved GAIN's role, which he described as both supportive and accommodating. The informant highlighted the capacity of GAIN staff to promote the Baduta programme to other stakeholders and provide support for training. He added:

> *Without a sponsor, district level facilitators would think twice about spending their own money to participate in a regency/city level outreach forum. But GAIN provides support, and when a regency/city hosts a forum, GAIN will come to give an orientation on emo demos. That is how a lot of people became interested, and that is why our colleagues at the regency/city level grew to appreciate GAIN.*

Weaknesses related to securing funding; the informant explained that the PHO cannot push districts to allocate a budget for emo demo implementation, and that it is up to the district or regency to determine whether they want to invest funds in the programme. He added that if sufficient funds are not made available, particularly for planning, training and procurement of props, the approach will not take hold.

> *Our colleagues at the regency/city level have their own priorities. We can't insist that they implement emo demos, we can't do that, because we have agreed upon regional autonomy, we can only suggest. Most health officials accepted because of the convenience that GAIN offered.*

Another limitation was that Posyandus often do not have the space needed to conduct the sessions. The informant explained that Posyandus are often narrow, while some of the activities require a wide, spacious area. Since the Posyandus are often located in a house, sessions must sometimes be led out of doors where there may be distractions, or if carried out during the day, it may get too hot.

COVID and other contextual factors

The government mandated that only Posyandus in areas with low COVID-19 cases could operate as usual. Since East Java had a high prevalence of COVID-19 cases throughout the province, most Posyandus had to close for service. This impacted the conduct of emo demo sessions in scale up areas where modules were being implemented at the start of the pandemic. Because of this, GAIN and the DHO shifted to online training in some areas of East Java where caseloads were high.

District Level (DHO): Jember

Background information

The informant has a master's degree in public policy and had been working for the DHO since 1992. In April 2019, she became the acting head of the DHO. Her role in Baduta 2 involved providing support to supervision and monitoring of the programme but did not involve direct involvement in programme activities. The informant had not received emo demo training; this is in part because she started her position as DHO acting head after the emo demo implementation was underway.

Description of the emo demo approach

The informant reported that Baduta 2 started around April 2019; she did not know why Jember was selected for the Baduta programme and emo demo implementation. A first step was to carry out a situational analysis, which focused on where nutritional problems, particularly stunting and anaemia, prevailed. The situation analysis guided selection of intervention target sites, which the informant reported to have higher prevalence of stunting and micronutrient deficiencies.

From her perspective, the primary goal of the Baduta programme was to improve child nutrition and growth in Jember. The informant reported that emo demos had several innovations, including active participation of a wide range of stakeholders, such as government officials and local organisations, community engagement, and capacity building of Puskesmas staff and programme officers stationed in both district and provincial health offices. She reported that the DHO encouraged staff in the scale-up areas to follow the Baduta activities and results in the intervention areas and to discuss how to secure funding from village fund allocations for programme implementation.

The informant was not familiar with the BCD behavioural change theory. From her perspective, emo demos aimed to motivate consumption of healthy local food products and empower community members to produce and sell healthy foods, such as vegetables, so that over time residents become more reliant on local food sources. She considered modules focused on complementary child feeding to be particularly important to improve child nutrition. However, she conveyed some doubts about the impact of emo demos, stating:

> *However, it cannot solve all the nutrition problems found in communities. We don't even know whether the complementary feeding messages hit the target or not, or whether it sufficiently fulfilled our target's needs; this is what needs to be evaluated. In Baduta 2, there are a lot of modules that we had to think about, how to deliver them to the targets, how to give them real-life examples.*

She suggested that two modules, ATIKA and Reckless Snacking, convey messages that can have a high impact on the community, also mentioning that Reckless Snacking is being introduced to kindergarten school children and is critical to changing behaviour related to child nutrition.

Processes involved in implementation

During supervision, which the informant explained is generally done by the nutrition staff in the DHO, the informant reported that a checklist is followed, and information is recorded for reporting purposes. Recorded information included the emo demo theme presented, the number and type of participants, and how many times emo demo sessions were held in the Posyandu. Our informant said:

> *First, there is the presentation of the emo demos and how many women were present. We hoped that emo demos didn't only provide examples, but also impacted participation in Posyandu — I evaluated this. It is useless if we deliver the emo demo session but participation decreases, which means that people hesitated to come. This was what was reported by staff; they stated that caregivers had to wait in line for a long time for the Posyandu to start (which made them hesitant to participate).*

The informant added that she receives monthly progress reports developed by the GAIN district coordinator, as well as monitoring reports prepared by the nutrition division in Puskesmas. When data discrepancies occur, the informant provides feedback to the nutrition division. A WhatsApp group chat, which involved Puskesmas and other field staff, also provided up-to-date information on the programme.

The informant asserted that supervision and monitoring carried out by a non-government group such as GAIN is helpful, claiming that the quality is generally better, and they are more transparent about programme weaknesses that need to be addressed. Interestingly, the informant suggested that monitoring data showed no major difference regarding participation in the intervention and scale-up areas; however, variation did occur at the outset, which she attributed to GAIN's involvement. She also mentioned that regular coordination meetings were conducted with GAIN prior to the pandemic, but that these meetings were not being held at the time of our interview.

The informant reported that several groups and institutions were involved in emo demo implementation in Jember, such as PKK (Family Welfare Development), DPMD (Community and Village Empowerment and Health Services), subdistrict-level government, village-level government, Bappeda, and the Diskominfo (Communication and Information Office). In addition, the informant recalled that Universitas Muhammadiyah and Universitas Airlangga were involved in the programme evaluation.

Training

The informant indicated that the cascade training process was led jointly by GAIN and the DHO. Training participants included people from the district, sub-district, Puskesmas, and village level (cadres). The informant failed to report on how many times training was held at each level and the training duration and content; she indicated that key information was conveyed so that training participants could subsequently carry out their respective roles. She stated that there were no major differences in the training approach in the intervention and scale-up areas, and that both established teams of trainers at the district and sub-district level. Selected trainers generally consisted of a midwife coordinator, a nutritionist, a health promotion counsellor, and a member of the PKK.

Funding

In the scale-up areas, the programme was funded by the Village Fund (Dana Desa), the Village Fund Allocation (ADD), and the DHO Health Operational Assistance (BOK), and GAIN provided support in the intervention areas. The informant reported that extensive collaborative work was required, which involved meeting with the different entities at the village level to introduce the emo demo approach, coordination with the various stakeholders, and securing funding. The informant did not disclose the amount of funds allocated for emo demos.

Emo demo sessions

While mainly conducted in the Posyandus, sessions were also carried out in playgroups (PAUD-Pendidikan Anak Usia Dini early childhood education) and kindergartens. According to the informant, the primary target audience was caregivers including both mothers and fathers of children under five years of age. In playgroups and kindergartens, the audience involved child caregivers and teachers, as well as young children. She considered the primary goal was to enlighten child caregivers to become more aware of, and work towards, improving the health status of their children. The informant admitted that she had not observed any emo demo sessions in Posyandus but suggested that she has followed the progress of the programme through reports and received details of implementation during meetings. ATIKA and Reckless Snacking are the only emo demo sessions she was able to name. The informant recommended adding another set of modules so that caregivers do not get bored participating in the same sessions multiple time. She said:

> *If mothers have the time to join emo demos— for those mothers I asked to make emo demos interesting and not monotone, and that the implementers develop an approach according to the context of each region. If one module is repeated with similar examples and material, the*

targets will get bored. That's why there must be innovation in each region. Even with the same module, they could use different examples or stories so that the target audience will not get bored.

Reported strengths included that message are designed to be memorable and provide caregivers with information to make practical and attainable changes in their behaviour, although she noted that some changes involve sacrifices. Regarding weaknesses, she mentioned that caregivers often arrive at the Posyandu at different times, forcing some caregivers to wait a long time before enough participants (about ten to 15) are present to start activities. She also noted that many women do not make time to participate, or when they participate, are in a rush to leave, failing to fully benefit from the messages. She reported that large groups of participants (more than 15) may not be conducive for learning. The informant added that the organisation of Posyandu sessions must be modified to suit the needs of participants.

A reported constraint lies in the ability of the cadres to lead sessions. The informant indicated that cadres become more confident after receiving additional emo demo training and mentoring by Puskesmas staff. She described 'successful' cadres as women who followed emo demo key messages while caring for their children, suggesting that this gives them credibility when leading sessions. She also mentioned that cadres from lower economic status and with less education may feel inadequate when sessions are dominated by better educated women from a higher economic status.

Another challenge relates to the commitment and effort given by the Puskesmas or health office staff to monitor emo demo implementation in Posyandus and mentor cadres, noting that some staff only go through the motions and are less interested in the quality and outcome of the activity, which she suggested relates to whether children's weight is increasing. She noted that some health staff consider emo demos to be time consuming and an additional burden, stating:

A challenge relates to the workload on the staff. Since the beginning, this activity really burdened the staff because it required more time to complete Posyandu activities. Usually, activities in the Posyandu finish quickly, so they could return to the Puskesmas and do other things, but since the start of emo demos, they had to put in extra time. There were more evaluations. I think doing this routinely is quite a challenge… Many staff at that level only do their work for the sake of doing it. For them, it's enough to show up; it doesn't matter whether the target audience understands the material or not. They only care whether the targets come to the Posyandu and are weighed. Whether the weight increases or not, that doesn't matter.

She felt that it is inappropriate to rely on routine participation reports as a mechanism to evaluate the programme, indicating that it is essential to examine key outcomes such as weight changes and whether there is an association with behavioural change. She reiterated the benefits of having monitoring and evaluation process done by a non-government health party, stating that routine government reports are insufficient to assess the quality and impact of the interventions.

COVID and other contextual factors

At the onset of the pandemic, Jember district curtailed all Posyandu services and activities. Posyandu services were gradually made available, but with restrictions on the number of participants. Furthermore, many parents were hesitant to go to the Posyandu due to concerns of exposure. She added that COVID-19 prevented the district from implementing emo demo activities as planned.

District Level (DHO): Bondowoso

Background information

The informant is a 42-year-old medical doctor who started work in the DHO in 2013, where she is currently the head of the Public Health Division. For Baduta 2, she was responsible for planning and budgeting – her role involved securing funding for training in both intensive and scale up areas. She was also involved in monitoring and evaluation of the Ten Steps to Successful Breastfeeding component at the Puskesmas level. She attended MOT training and supervised district level TOT trainings and Puskesmas level cadre training, but due to her busy schedule, was unable to lead trainings.

Description of the emo demo approach

The informant reported that Bondowoso was selected as one of the GAIN intervention areas due to the high prevalence of stunting in the district. In addition, the Bondowoso district government welcomed the introduction of Baduta interventions. Started in 2018, Baduta 2 interventions began in 15 sub-districts with GAIN support, and in 2019, interventions were scaled up in ten additional sub-districts.

The informant indicated that the overall goal of the Baduta programme was to decrease stunting in Bondowoso. She reported that the approach aims to convey messages in a fun and playful way that captures people's attention and is acceptable, changes the way people think about child feeding, and improves knowledge on children's dietary needs and nutrition. The informant mentioned that the emo demo approach is different because it relies on two-way communication, compared to traditional health counselling which involves sharing of theories and one-way instruction. She added that the emo demo modules actively engage participants and unconsciously direct them to change their attitude about child feeding. She said:

> *Counselling is about theories, it is boring. But in emo demo the audience is requested to get involved, it raises their curiosity, influences the way they think and directs them regarding the right thing to do. It is not one-way education, they are asked to play and unconsciously we get into their minds.*

The informant claimed that the key innovation of emo demos is that they do not instruct participants, but rather encourage people to think about their own behaviours and determine the best practices to follow based on messages conveyed, stating:

> *So, this programme doesn't go directly to the goals, we guide the participants gradually. The participants think about what they usually do, then [they think], 'What is the right thing to do based on what was explained?' We don't tell the participants what to do, but the participants decide themselves what they should do, and come to the realization that, 'Oh it means I've been wrong all this time.' The participants come to that realization on their own.*

Processes involved in implementation

The informant was involved in supervision of emo demo sessions held during PKK meetings, which are attended by mothers of children at all ages, at the district, sub-district, and village levels. During supervisions, she observed how the cadres led emo demo sessions and gave feedback to the village midwife regarding the cadres' level of confidence and capacity to guide the sessions and properly

use the props.[5] The village midwife would subsequently communicate the feedback to the cadres. The informant mentioned that the number and characteristics of participants was recorded during supervisory visits.

The informant indicated that cadres are responsible for recording key components and reporting emo demo activities. Reports are sent first to the Puskesmas and then to the DHO. Our informant reported that she entrusted heads of Puskesmas and programme officers in nutrition, health promotion, and adolescent health at the DHO level to monitor implementation. The informant mentioned that there were no regular monitoring meetings with the GAIN Bondowoso district and training coordinators. Instead, they had a WhatsApp group chat involving the DHO staff and GAIN Bondowoso. There was a regular meeting every six months with GAIN staff in East Java to discuss programme progress and funding, and to plan for the following six months.

Our informant mentioned that several institutions collaborated on the programme, including Bappeda, PKK – the Family Welfare Development, DPMD – the Department of Community and Village Empowerment, as well as the Education and Culture office, subdistrict-level government offices, village-level governments, and some schools.

Training

The informant received MOT training in August 2018, which lasted three days and was led by GAIN. She considered the trainers to be proficient at conveying the purpose of the approach and content of the emo demo sessions and stated that the training equipped her with the capacity to carry out her responsibilities as a MOT.

Our informant stated that training involved four levels: GAIN trained the MOTs, MOTs trained the TOTs (Puskesmas)[6], the TOTs trained the village midwifes and village-level PKK, and the village midwives trained the cadres (see Figure 1). She reported that both the MOT and TOT training covered all 12 modules in three days, while the cadres in the intervention areas received training gradually every three to four months by theme. The informant claimed that the training equipped MOTs with the confidence to lead TOT training in Bondowoso in both intervention and scale-up areas, and also in other provinces such as Papua, Kalimantan, and Jambi. She indicated that a MOT association has been established to manage requests for MOT training coming from other districts or provinces.

In both intervention and scale-up areas, two cadres in each Posyandu were trained by the end of 2019. The remaining three Posyandu cadres in the intervention area were trained at the end of 2019 and early 2020, while additional cadre training in the scale-up areas was postponed due to the pandemic.

[5] In Indonesia, it is inappropriate to critique somebody directly. Therefore, the supervisors would provide feedback on the cadres to the midwives, who were responsible for transmitting the information to the cadres.

[6] TOT participants included the midwife coordinator, Puskesmas nutrition staff, Puskesmas health promotion staff, and the village midwives.

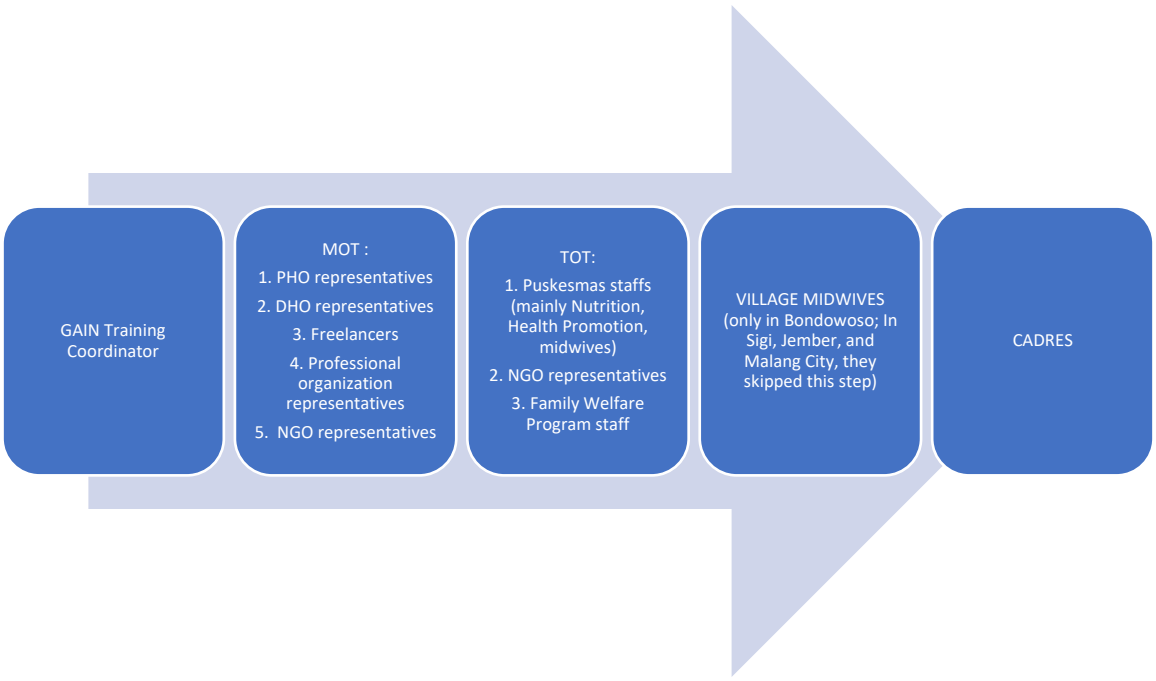


Figure 1. Training hierarchies

Funding

All funding for the intervention areas was provided by GAIN. For the scale up areas, financial support was made available through government funds, such as the BOK Sekunder (Secondary Health Operational Assistance), BOK Puskesmas (Puskesmas Health Operational Assistance), and PAK APBD (Health Budget - Local Government Budget). She added that the BOK Sekunder and BOK Puskesmas are funding schemes offered through the central government, while the PAK APBD is part of the annual local government budget plan.

The Baduta 2 programme in Bondowoso spent Rp 2,412,143,000 Indonesia Rupiah in total for orientation and training in both GAIN intervention and scale up areas. Funds were allocated for TOT orientation in 10 villages (7%) and Posyandu cadre orientation and training (93%). Overall, 3,912 Posyandu cadres located in 1,068 Posyandus received training.

Emo demo sessions

The informant reported that emo demos guide participants to make better decisions related to nutrition. She mentioned that the conveyance of messages in a fun, playful manner encouraged participants to engage in the sessions and subsequently adopt improved behaviours, adding:

> *The main purpose of emo demo was to change people's mindsets, especially about nutrition. That's the purpose of emo demo. And the other purpose is to explain the key messages in a relaxing environment and to ask people to actively participate … Following these principles, participants don't feel that the messages are being pushed on them.*

The informant stated that emo demo sessions were held monthly in Posyandus, in the hope that sessions would increase Posyandu attendance. Sessions were also held in kindergartens and elementary schools and during PKK meetings. The informant explained that the cadres facilitating

the emo demo sessions had varying degrees of confidence and that most were not fluent in Bahasa Indonesia, stating:

> *I told them at the beginning that they don't need to use Bahasa Indonesia; if they can't speak Bahasa Indonesia fluently, they can use Madurese. There was no problem in the MOT training or the TOT, because the TOT used Bahasa Indonesia, the hard part was when the village midwives trained the cadres. Some of the midwives can understand a little Madurese, some of them can speak it fluently, but the new ones usually don't understand Madurese. So, we had to consider their language ability. In addition, some of the cadres claimed, 'I don't think I'm capable, I'm shy.' I've told the village midwives to train several cadres, not just one cadre. They (cadres) should take turns, especially in the intervention areas where there are five cadres trained by GAIN. The others can help with preparation, assist with the demonstrations, or take notes on the participants. They must split the tasks.*

The informant mentioned that the target audience included pregnant mothers and caregivers of children aged under two or breastfeeding mothers. Kindergarten and elementary students were exposed to specific modules, such as the module on reckless snacking. Modules that the informant remembers most vividly remembered included: Baby Tummy, ATIKA, Child's Plate, and Reckless Snacking.

A strength that was mentioned was that the Bondowoso district government was very supportive and contributed to a smooth implementation of the programme. Widespread training of staff from the district to the village level constituted another strength. Initially the plan was to only hold emo demos in Posyandus, but the decision to offer sessions in other locations, such as schools and village-level forums, expanded the target audience to include students, teachers, all women of childbearing age, and men.
She informant highlighted the level of innovation of the emo demos and the engagement and excitement by participants, especially first-timers.

The informant cited several weaknesses associated with the training. First, the training approach was new, requiring that the trainer first demonstrate, and participants subsequently practice sessions, and involved long days. It took a long time for trainees – especially cadres – to comprehend the content and practice the sessions. She also mentioned that funding regulations complicated receipt of honorariums for trainers and Puskesmas health workers, which they eventually had to forgo.

She also reported that some caregivers arrived late to the Posyandu, making it impossible to hold emo demo sessions before well-baby services. The informant noted that attendance may be lower after Posyandu services are completed due to other commitments. For instance, some caregivers may need to go to work or cook lunch for family members and cannot stay long enough to participate in emo demo sessions held after Posyandu services. She added that some mothers, particularly wealthier women, are not necessarily the caregivers who attend Posyandu services and participate in emo demos. Therefore, the key messages might not reach intended targets. Our informant also noted that enthusiasm waned during the second year when mothers were exposed for a second time to the modules.

The informant mentioned that early marriage is common in Bondowoso and that young mothers, who live with their in-laws, have little decision-making authority related to child feeding. Moreover, some emo demo messages contradict deep rooted feeding traditions followed by older generations, although the informant claimed that when grandparents participate in the sessions their perspective may change.

COVID and other contextual factors

With the onset of COVID-19, all activities related to emo demos were stopped and DHOs and

Puskesmas were ordered to shift their focus to COVID-19. Funding for training for the three remaining Posyandu cadres in the scale-up areas was transferred to activities associated with the pandemic. At the time of the interview, the informant hoped that funds for training would be secured, and emo demo activities resumed.

Government Led Areas

Provincial Health Office: Central Sulawesi

Background information

We interviewed two informants working in the PHO, including a woman with a Bachelor's degree in public health who has been working in the Central Sulawesi health office, Family Health and Nutrition Unit, since 1999. Our second informant was a man with a Master's degree in environmental health who worked in the Environmental Health and Public Health divisions.

The male informant was first trained as a TOT, and both informants were trained as MOTs, which involved leading TOT training to health officials in DHOs and staff in the Family Welfare Development (PKK), and supervising TOTs who led training of cadres. Informants mentioned that they had to obtain permission from their supervisors to leave their post to conduct trainings. The male informant was actively exploring ways for emo demos to be adopted by other programmes, and he also mentioned that he was involved in introducing emo demo training to food handlers and in jails.

Description of the emo demo approach

Informants reported that emo demo activities were first conducted in October 2019 when MOT training was initiated. Before implementation, emo demos had to be approved by PHO and DHO health officials. An action plan for three target areas, including two districts and one city in the province, was developed. The three target areas had been severely affected by an earthquake that occurred in September 2018 and were receiving emergency support from Save the Children (STC), an organization that had been involved in emo demo implementation in Malang, to work to reduce the high rates of child malnutrition. GAIN suggested that the research team collect data in Sigi District, which had the highest rates of stunting of the areas affected by the earthquake.

Informants stated that emo demos are designed to change behaviour, especially among mothers, related to nutritional practices and personal hygiene, and to improve the nutritional intake of breastfeeding and young children. The male informant emphasized that the approach presents a feasible way to improve children's nutrition and address high rates of stunting in Central Sulawesi. Informants stated that the emo demo objectives are in accordance with the Health Promotion and Nutrition Division's goals.

The female informant described emo demos as a novel form of counselling, which combined information dissemination and simulation and relied heavily on good interactions between the facilitators and the participants. The second informant explained that emo demos are used as a method to change people's behaviour by invoking emotions and providing practical demonstrations. He reported that emo demos are comprised of 12 modules, with each module conveying different information. He stated that the approach is designed so that information is easily understood, and caregivers are inspired to explore and adopt improved behaviours. He also noted that evoking emotions through live demonstrations and active participation in game-like activities is much more effective than traditional counselling or lecturing. The male informant added that other approaches may be perceived as patronizing, while during emo demos, facilitators interact with participants, touch emotions, and encourage caregivers to enjoy the process. Both informants reported that emo

demos are the only component of the Baduta package introduced in Sigi District, which the female informant maintained complemented other interventions carried out during maternity classes or in Posyandus.

Differences cited with other programmes included that emo demos involve demonstrations of key childcare practices and participant involvement, while other programmes typically employ lecture-like methods followed by question-and-answer sessions, or laborious counselling and problem-solving approaches using checklists, which informants indicated do not efficiently induce change. The male informant considered the combination of sharing knowledge and demonstrations as innovative, although he mentioned that the STBM (Community-based Total Sanitation) programme and the First 1,000 Days of life use similar methods. He said:

> *The innovation of emo demos is that we educate plus demonstrate examples. Other programmes only educate without examples. So, emo demo's innovation is in the examples. We basically do action directly, we illustrate, and we demonstrate it directly. So, it's not simply a picture in a leaflet or a flipchart, but we show the object. That's the innovation.*

He felt that the modules promote practical solutions that can be easily incorporated into daily lifestyles.

The male informant claimed signs of behavioural change started shortly after emo demos were introduced in Posyandus. The female informant reported an increase in iron intake among mothers exposed to the ATIKA session, which in her view served as a confirmation that emo demos constitute an effective way to change behaviour. Neither informant provided empirical data to verify these claims.

Processes involved in implementation

Informants reported that no official supervision schedule had been established, but the female informant mentioned that MOTs and TOTs carry out visits to Puskesmas and Posyandus. The male informant reported that prior to the pandemic, he was notified when emo demo sessions would occur and travelled to Puskesmas to observe sessions. Since the onset of COVID-19, these visits stopped.

Informants reported that Sigi District did not have a formal monitoring and reporting system for emo demos. While an action plan had been developed, it had never been implemented due to the pandemic. At the time of the interviews, reporting involved informal coordination meetings with other emo demo implementers through a group chat platform via WhatsApp. The female informant stated that she had never attended a monitoring or coordination meeting at the provincial level, and since the start of implementation, she had never received or developed a report regarding emo demos. While there used to be a WhatsApp group involving cadres who submitted photos after an emo demo session was held, the group was no longer active.

We were told that STC provided props for the emo demos, which were given to MOTs and TOTs during training. Informants reported that the provincial office has two sets of props and props received by TOTs were kept in Puskesmas. Posyandus did not store props. Instead, facilitators from Puskesmas transported the props to Posyandus when demonstrations were held. While the original plan was to develop a budget for procurement of props for Posyandus, our informants reported that no specific MOH programme is attached to emo demos and therefore no budget line item can be used for emo demo expenses. Our informants indicated that GAIN had provided pricing information of props.

Training

Informants participated in the same MOT training – this was divided into two sessions, with training on the first six modules held in October 2019 and training for the remaining six modules conducted in January 2020. Informants reported that three GAIN staff from East Java led the training; participants were from the PHO, DHO, City Health Offices, the Family Welfare Development (PKK), and Puskesmas, as well as people from professional organisations, such as the Indonesian Midwifery Association and the Indonesian Nutritionist Association. One month after the first MOT training, newly-trained MOTs conducted the TOT training. TOT teams included DHO personnel, midwives, and PKK staff. TOTs trained cadres in February 2020, right before the start of the COVID-19 pandemic.

When describing the cascade training approach, informants reported that MOTs trained TOTs (Puskesmas staff located in districts and cities) and TOTs trained the cadres. STC requested that MOTs supervise TOT led training of the cadres and provide mentoring and feedback as needed. If TOTs were not available, they would request MOTs to perform the cadre training.

Informants reported that MOT training lasted six days in total and involved an introduction to each module, followed by practice sessions on how to communicate with mothers, explore caregiver attitudes and behaviours related to specific child feeding practices, and evoke emotions. The aim was to ensure that participants enjoy interacting with facilitators and participate in activities. Our informants indicated that training emphasizes using approaches that elicit information from, and engage, participants.

Funding

STC provided funding for the emo demo programme in Sigi from early 2019 to 2020. This included procurement of props, training costs, and technical assistance. In February 2020, Sigi also received assistance from Wahana Visi Indonesia (WVI) for training held in an urban setting.

During preparation for emo demo implementation, STC staff met with the DHO head of the public health unit to propose using the local government expenditure budget (APBD) to increase the number of facilitators. However, due to the limited funds available in the APBD budget, the proposal was not approved. STC also advocated to use APBD funds in the following fiscal year, but this proposal was also rejected. One informant suggested that because the approach is only being introduced in three districts, it is difficult for the provincial office to justify funding. The informant suggested that Involving programmes outside of the health sector is one way to raise funds.

Puskesmas faced barriers since the health office did not have funds for emo demos. Subsequently, the PHO suggested to use village funds at the Puskesmas or Posyandus level. Health officials advocated to village authorities for allocation of village funds; however, at the time of our interviews, village funding had not been secured. Informants explained that a major obstacle relates to the fact that emo demos are not considered part of a specific government programme with a budget line item and do not align under a specific funding source.

Emo demo sessions

Informants reported that sessions held in Posyandus targeted caregivers of young children attending Posyandu services, as well as pregnant women participating in maternity classes. As indicated, emo demo training was also introduced in a food handler training programme, and three jails.

Both informants had observed several emo demo sessions being conducted in Posyandus.

They reported that the cadres led the activity, and that one module was presented during each emo demo session. According to the male informant, caregivers actively participated and generally appeared to understand the information conveyed through the demonstrations. He added that traditional educational approaches have not generated significant change, while results from the emo demos have led to extraordinary behavioural change.

Informants mentioned that module sessions included Reckless Snacking, Wash Hands with Soap, Baby Tummy, Getting Ready to Go Out, and ATIKA. The male informant was able to give detailed examples of the way topics are presented and steps followed to explore what mothers do and think, evoke surprise, and highlight correct feeding approaches, while not blaming the mother. He reported that the cadres were taught to focus on sensory perceptions to invoke emotions such as disgust (Reckless Snacking module) when conveying the messages. When describing steps followed during the Baby Tummy module, he recounted the following:

> *During the demonstration, there must be good communication with the mothers, they must explore and evoke their emotions by asking them questions about their babies and how they are fed. First, it is important to explore what the mothers think: 'Ma'am, what about your baby, has he been given a banana?' 'Yes,' she proudly answers. 'How old is he, Ma'am?,' 'He's three months old.' Information about practices is gathered while at the same time facilitators avoid laying blame or ridiculing anyone. That's how we were taught, so that mothers in the community enjoy communicating. After gathering information, you move on to the demonstration, that illustrates that babies between zero to six months of age ideally should not be given complementary foods. We tell mothers that babies between zero to six months old should be exclusively breastfed, but we do not explain why. Caregivers just say 'yes' without knowing the answer. In emo demos, you give examples. For example, we show a peanut, a marble, a ping pong ball, then we ask, 'How large do you think the stomach of a one-month-old baby is?' Mothers will reply and then we will indicate which answer is correct. We right the wrongs. That's how it is in the emo demo system. We have those right the wrongs chants, so we do not blame the mothers. So, later mothers understand why a baby cannot be given complementary food, it turns out a baby's stomach can only contain something the size of a marble. Mothers understand and the message evokes feelings from within them, 'Oh, yes, I'm so sorry, I guess my baby is not yet ready to eat,' something like that.*

Reported strengths included the acceptability of the emo demo methods and the clarity and practicality of the messages. One informant mentioned that the use of games created an informal environment and made the session relaxed and enjoyable for both facilitators and participants, while at the same time, the messages stimulated participants' emotions and generated an interest to change behaviour. This informant also appreciated the interaction between the presenter and the participant, stating:

> *There were lots of games as we learn, so [the atmosphere] is not formal. It's different from normal counselling, where the presenter shares information and participants only listen. Here with [emo demos], participants also practice [the material] until they got the hang of it.*

Informants added that the accompanying tools effectively guide the facilitators. Another strength mentioned was that other stakeholder, including PKK women, successfully mobilized community members to attend sessions, claiming that PKK personnel play a crucial role in the continuity of the emo demo programme. The informant added that district trainers performed well and that STC funding enabled them to implement emo demos.

Informants agreed that the success of the emo demo sessions depends on the skill of the facilitator to convey messages correctly. They indicated that a lack of focus by either the facilitator or

participants can impede knowledge transfer and emotional stimulation. A challenge involved keeping the cadres engaged and enthusiastic; informants mentioned that cadres who received incentives from village funds were more active than those who did not get any motivation. To motivate the cadres, several Puskesmas provided free medical care.

Informants reported that the setting where sessions are held is critical, indicating that if the room is too small or crowded, demonstrations could not be delivered properly, causing mothers to lose focus and forcing cadres to rush or terminate sessions early. They also mentioned that special materials such as ultraviolent lights and glow in the dark lotion are difficult to obtain, and that the availability of a complete set of props is essential to the delivery of certain sessions. Another challenge was the lack of government policy to implement emo demos, with informants reporting that without a formal policy, Posyandu are not obligated to implement sessions. In addition, emo demos were not adopted under a particular government programme and plan, causing funding challenges which informants cited as a major problem. In Sigi, the local government and health offices had not provided funding support, although informants reported that they considered emo demos as an effective way to change behaviour.

COVID and other contextual factors

Since the start of the COVID-19 pandemic, most Posyandu activities stopped, including emo demo sessions and TOT training in most of the province. Sigi was the only district that still allowed to carry out some Posyandu activities--the district head created a limited time slot for mothers who wanted to visit the Posyandus. All Posyandu staff and mothers who visited Posyandus had to follow specific health protocols and practice social distancing. Informants also reported that most government and village funding was redirected to COVID-19, which made it harder to allocate funds for the emo demos.

District Health Office: Sigi

Background information

The informant has an educational background in public health and worked as the head of the Family Health Unit in the Sigi District Health Office for four years. She was one of three MOTs trained in Sigi. Her role as MOT was to lead TOTs and encourage improvements in emo demo implementation in Sigi. She also monitored emo demo sessions if they happened to occur during routine visits to Posyandus, although these visits were not formally scheduled and few Posyandus were implementing emo demos. She did not devote specific worktime to emo demos.

Description of the emo demo approach

She reported that the Sigi district-initiated training of MOTs in early 2020 and started conducting emo demo sessions just before the pandemic started. According to the informant, the goal of the emo demo programme is to change health behaviours of pregnant women and mothers of children aged under five, which in turn, will help to improve the nutritional status of their children.

The informant described emo demos as a new method that is easy to deliver involving demonstrations and games to convey health education messages rather than counselling. The informant argued that the approach is unique due to the direct involvement of mothers and the interaction between the facilitator and participants, which she considered effective. She believed that messages are easy to understand and more readily accepted compared to information conveyed through traditional counselling methods, which she added can be boring.

The informant mentioned that the innovation of the emo demo approach lies in the simplicity of the design and game-based approach, claiming that using games to transmit meaningful messages can affect mothers' child-feeding behaviours. She also mentioned that mothers in the district prefer the emo demo method to regular counselling due to the relaxing environment and enjoyment they experience participating in the games. She claimed that emo demos have been effective and regretted that only three of 19 Puskesmas in Sigi implement the sessions.

Processes involved in implementation

The informant mentioned that manuals and props provided by STC were given to each MOT during the training. While STC aimed to distribute props to all Puskesmas staff and cadres who had received training, not all Posyandus had received props. Due to the lack of budget from the health office and limited village funds, the informant reported difficulties procuring new props and manuals for Puskesmas and Posyandus that wanted to carry out additional training. She added that they did not know where to obtain some of the required materials.

According to the informant, no supervision systems were established for the emo demos. In her role as MOT, she had no specific duties regarding supervision or monitoring of emo demo sessions. No coordination meetings were held in Sigi.

Reporting systems also had not been set up. While cadres shared information on sessions to the facilitators at the Puskesmas level, Puskesmas staff were not required to report the information to the sub-district or district offices. However, the informant mentioned that informal reporting from facilitators in Puskesmas to the informant occurred via online chat platforms. GAIN trainers had contacted the informant several times to inquire about the implementation of emo demos.

Training

The informant reported that MOT training was conducted for three days in Palu City; the training was organised by STC and facilitated by the provincial health office. She recalled that there were 75 materials, including communication aides in the form of manuals and guides, which were given to participants. During the training, GAIN facilitators from East Java introduced seven themes or modules. The informant indicated that the training should have been longer to allow participants more time to practice leading activations. She also suggested that quality control is needed to ensure that the skillset of trainers is maintained.

The informant stated that MOTs trained TOTs selected from several Puskesmas in Sigi. TOTs subsequently trained the cadres to lead emo demo sessions carried out in their respective Posyandus.

Funding

STC provided initial funds for implementation of the emo demo programme in Sigi, which included facilitator training and procurement of the modules and props; funding ended in 2020. GAIN was only responsible for providing trainers to lead MOT training. The informant tried to include an emo demo budget in the health operational assistance plan, but this was not permitted because emo demos are not officially in the health office activity menu. Several villages utilized village funds to implement the emo demo programme. At the time of the interview, no organisations or groups outside the government funded the programme.

Emo demo sessions

The informant did not mention how many times she observed the emo demo sessions, stating that she has many responsibilities at the health office and entrusted emo demo implementation to Puskesmas staff, particularly the nutrition programme officers. She recounted an experience observing demonstrations conducted in a temporary shelter built after a recent earthquake. The informant mentioned that the village midwife was present to help the cadres lead the session and that between 20-30 mothers of children aged under five and pregnant mothers participated. She

described the atmosphere as relaxed and conducive to learning, reporting that participants appeared to enjoy the session.

The informant mentioned many weaknesses in the programme, which included the limited number of trained cadres, specifying that cadres in only eight of 356 Posyandu in Sigi have been trained. Furthermore, in the eight Posyandu, which are located in four Puskesmas, not all of the cadres have been trained. She linked the limited number of trained cadres to funding challenges, since the only possible funding source involves village funds.

The informant asserted that the cadres' ability to lead sessions needed improvement, claiming that their capacity was generally low, but that this varied according to their educational background. She recommended that refresher training be carried out frequently to ensure that the cadres retain content and lead sessions correctly. She also reported language barriers, noting that some mother-participants lack fluency in Bahasa Indonesia, while not all cadres leading sessions are proficient in local languages spoken in their work area. In the future, the informant recommended only training cadres who have a high school or bachelor's degree, which she believed would guarantee adequate capacity to lead sessions.

Another mentioned limitation related to the absence of formal monitoring and evaluation systems, as well as coordination between stakeholders at the different levels. She emphasized that good monitoring and evaluation and coordination would better ensure sustainability of the programme.

Perhaps the biggest challenge related to the lack of funding for continuity of the programme. The informant mentioned that several villages implementing emo demos are relying on village funds to sustain it. She indicated that the main difficulty is that emo demos are not included in the health office budget menu, emphasizing that district health offices must convey the benefits of emo demos to decision-makers with the authority to approve inclusion of emo demos in the PHO budget.

COVID and other contextual factors

The informant reported that the pandemic affected all aspects of health services. Posyandus located in red zones (areas with high caseloads) were closed at the beginning of the pandemic, and some remained closed up to the time of our evaluation. For Posyandus that continued operating, only a limited number of clients (she mentioned ten) were allowed to attend sessions at one time. Over time, Posyandus have continued to adjust their schedules and activities according to COVID-19 caseloads in their area.

Posyandu level: Cadres (Sigi)

Background information

We interviewed four cadres – three cadres had high school degrees and the final cadre had a Bachelor's degree in education. Their average age was 42 and they worked as a cadre for an average of nine years. All cadre were housewives and one engaged in trade. Cadres reported that the official length of service for cadres is five years, adding that they can resign at any time.

All cadres received emo demo training, but only three were selected to lead activities, two in the Posyandu and one during maternity classes for pregnant women and mothers participating in Dasawisma, a programme to encourage PKK mothers to cultivate crops, raise livestock, and make handicrafts. When holding sessions with women participating in Dasawisma, cadres explained the content of the modules using visual aids but did not invite women to participate in activations. One cadre mentioned that in her area they sometimes lead emo demos for participants in the pregnancy class, pregnant women attending Posyandu, and mothers attending sessions for children under five at the same time.

Among those leading sessions, two cadres reported that they had been involved in emo demos since 2019 after the earthquake and before the COVID-19 pandemic, while another cadre suggested that she started to implement emo demos in February 2020. Informants leading emo demos in Posyandus mentioned that they usually spend about 15-20 minutes a month on sessions, while the informant who directed sessions outside the Posyandus stated that she led emo demos four times monthly.

Description of the emo demo approach

Cadres stated that the goal of the programme is to improve the health status of children under five, particularly regarding nutrition, by providing education and inviting mothers and pregnant women to participate in games. One cadre also stated that the main aim is to change the knowledge and behaviour of caregivers in relation to child nutrition. Two informants mentioned that the programme seeks to decrease child malnutrition and ensure good growth of children.

When asked about messages, one cadre mentioned that emo demos focus on breastfeeding and complementary feeding for children under five, while another cadre stated that sessions are also devoted to issues related to pregnant women. A third cadre asserted that sessions focus on Community Based Total Sanitation and handwashing.

Three cadres maintained that emo demos use a different approach involving games to convey information, stating that games are more accepted and effective than conventional counselling. The final cadre argued that there were not many differences between emo demos and other approaches because, in essence, cadres continue to provide health and nutrition information to caregivers attending Posyandus. Two cadres mentioned that emo demos provide detailed information related to child nutrition and attempt to touch mothers' emotions through play and practice using props, while other programmes usually only involve one-way didactic counselling to share information.

One cadre stated that there are signs that mothers who have attended emo demo sessions are changing their behaviour, citing exclusive breastfeeding among newly-married adolescents, as an example. Another cadre mentioned that there is no substantive evidence of behavioural change, stating that she cannot monitor whether caregivers are practicing what they are taught during emo demo sessions and adding that many children in the area are still underweight.

Processes involved in implementation

Information collected on the props was quite variable and reflected the fact that cadres worked in different locations. One cadre mentioned that the props used in Posyandus are sometimes loaned to other Posyandus. If props are not available, the emo demo session will run without props, and she added that some modules do not involve props. While this informant stated that the props are critical to running emo demo sessions, she reported that the condition and availability of props was inadequate. Although this cadre had asked village officials to provide additional props, she was told that village funds are mostly being allocated for activities related to the COVID-19 pandemic. Another cadre mentioned that all props for the 12 modules were provided by STC and stored at the Posyandu. According to her, the condition of the props was good, and props were effective aides to carry out the sessions. A third cadre stated that she had not received any props after the emo demo training. To her knowledge, procurement of props would be carried out with assistance from the head of the Puskesmas and the village head. The village midwife procured props in the fourth cadre village, which were stored in Puskesmas. Cadres generally felt capable of using the props correctly.

Two cadres stated that STC staff used to visit the Posyandus, but since the start of the pandemic, visits became rare. They reported that midwives from the nutrition division in Puskesmas supervised

emo demo sessions and provided input if the cadre makes a mistake. Nutrition officers from the community health centre also supervised the emo demo sessions sometimes.

Two cadres mentioned that they completed a monthly Posyandu report for village officials which included emo demo activities. Another report, which also detailed emo demo activities, was submitted monthly to the village midwife. A third cadre stated that she submitted a report to STC via WhatsApp monthly but stopped sending the report after all the modules were completed. This report included photos and notes regarding the number of participants and themes covered. The final cadre mentioned that her Posyandu had no forms for the emo demo programme, but they sent photos to the village midwife every time a session was held.

Training

The first cadre reported that she was the only cadre in her Posyandu who attended the first emo demo training. She was not sent for the second training because another cadre in her Posyandu was chosen to attend. The training she attended lasted three days and included about 20 participants from different villages. It covered three modules, while the second training that she did not attend presented four modules. The training was led by a TOT village midwife, and the cadre praised the trainer, stating that after the training she felt competent to lead emo demo sessions in her Posyandu. The cadre mentioned that cadres learned about the other modules on their own, which they introduced to women attending the Posyandus.

A second cadre stated that she attended the first of two emo demo trainings in her area; each Posyandu in her area had sent two cadres for each training. The first training covered module one to six and the second training focused on modules seven to 12. The training she attended lasted two days – she indicated that she learned about the content of the modules and how to communicate with mothers, along with a general explanation of the emo demo programme. Trainers included STC staff, village midwives, and nutrition staff from Puskesmas. A third cadre mentioned that she attended a one-day training in December 2020 and another training in February 2020, which were led by STC; according to the informant, not all 12 modules were covered during the training. The final cadre attended two trainings, with each training lasting two days. Training participants were divided into four classes and three modules were covered each day, with a total of 12 modules introduced. In this case, trainers included facilitators from Puskesmas, nutrition midwives, and paediatric midwives.

The cadres interviewed did not talk specifically about cascade training; however, they mentioned that the trainers (Puskesmas nutrition officers or village midwives) who trained them on emo demos were trained by STC staff.

Funding

All the cadres mentioned that STC provided funding to initiate emo demos. They were not aware of any other organisations supporting emo demos in the area.

Emo demo sessions

Cadres mentioned that the target audience of the emo demo session were mothers of children aged under five and pregnant women who attended the Posyandus. One cadre added that husbands sometimes accompany their wives to emo demo sessions.

Conduct of the sessions varied according to the training received. One cadre mentioned that she usually conducted emo demo sessions twice a month during Posyandu mother and toddler sessions and pregnant mother classes. Topics followed the 12 module themes and were given in order. This cadre indicated that sessions are carried out after other Posyandu activities were completed and are

usually attended by five to six mothers of under five children and pregnant women. She also mentioned that sessions are assisted by the village midwife, who provided corrections at the end of the session. The second cadre said that she could only lead six modules because she had not received training on the remaining six themes. She reported that sessions last 10-15 minutes, are attended by 15-20 people, and held before Posyandu activities began. The third cadre admitted that she had led emo demo sessions only three times in the Posyandus. Participants comprised mothers and young children, and sometimes accompanying husbands, with the number of participants ranging from 5-20 people. The last cadre mentioned that the emo demo session was held in both the Posyandu and Dasa Wisma building a community centre (the centre provides services for 10 villages). She reported that the village midwife developed the session schedule and participants included mothers and their children.

Generally, cadres stated that emo demo participants were enthusiastic about the activities, although one cadre complained that participation of mothers in her Posyandu was low. This cadre felt that the fact that the Posyandu did not have a full set of emo demo props, and that she sometimes had to lead sessions without props, may have contributed to the low participation.

When asked about specifics regarding leading modules, cadres mentioned that Reckless Snacking and ATIKA had clear instructions and involved examples that were easy to guide. One cadre added that food ingredients promoted in the ATIKA module are accessible to participants. Modules considered tricky or more difficult to lead included Feeding Timeline, Imagining Your Future, and Child's Plate, with one cadre mentioning that sometimes mothers find it difficult to understand the latter.

Cadres underlined that it is critical to project confidence and demonstrate that they have mastered the materials and approach when leading emo demo sessions. One cadre mentioned that she was the only one in her Posyandu who led emo demo sessions, while other cadres refused due to lack of confidence. Another cadre highlighted that it is critical to create a pleasant, informal environment and use simple language that makes it easier for participants to understand the material presented. It was also suggested that the delivery of the materials be interspersed with jokes or humour and local languages be used to make participants more comfortable and messages easier to understand. One cadre stated that she sometimes visits caregivers' houses to repeat messages given during the sessions.

According to cadres, the strength of emo demos is that sessions provide new or complement existing information, and introduce new behaviours related to child nutrition. One cadre mentioned the enthusiasm of the cadres to teach mothers material in the modules and share information that allows mothers to raise their children to be healthy as a strength. Weaknesses included that it is challenging for mothers to apply the information due to conflicting perceptions and practices of family members including husbands, parents, or in-laws regarding childcare and feeding. We were told that caregivers sometimes request that cadres talk to their parents and in-laws about nutritional practices. An additional obstacle related to financial constraints that prevented some parents from applying the knowledge gained from emo demo activations. Another weakness centred on the varying ability of mothers to grasp and comprehend the messages. Specifically, cadres reported that some mothers understand messages quickly, while others require longer sessions and that messages be repeated. It was also mentioned that some caregivers are less responsive or indifferent to the information they receive, especially when conveyed by new cadres, who have less credibility. One cadre mentioned that missing props prevented the cadres from delivering sessions effectively. Another said that sessions can be crowded, causing some caregivers to get distracted and sessions to become chaotic.

The cadres expected more training on the modules, with some claiming that they led sessions irregularly, and much of the information acquired during the training had been forgotten. One cadre requested more materials to convey messages, particularly to enhance the understanding of pregnant women. Another requested a complete set of props which would allow her to lead sessions smoothly and effectively.

COVID and other contextual factors

The impact of COVID-19 on emo demo sessions varied. One cadre mentioned that services in the Posyandus stopped for several months but later resumed. Another cadre said that her Posyandu was closed for three months, and when the Posyandu activities resumed, activities were limited to baby weigh-ins and vitamin A administration. A third cadre reported that their Posyandu remained open and emo demo activities continued during the pandemic. Two cadres mentioned that the pandemic has impacted household finances, with one highlighting that financial constraints make it difficult for caregivers to provide essential nutritious foods to their children. All cadres emphasized that they strictly followed COVID-19 protocols in Posyandu, which involves restricting numbers of participants and wearing mask.

Village Level: Mothers (Sigi)

Background information

We interviewed four mothers who had been attending Posyandus between seven months and 15 years. The average age of the mothers was 35; two mothers had a high school diploma and two had a bachelor's degree in education. Women with high school degrees were housewives, while the other two women taught in local schools. Mothers had three children, on average. All mother informants had attended multiple (between three and 12) emo demo sessions.

Description of emo demo sessions

The first mother reported that the emo demo sessions were held at the Posyandu and a community building used for a variety of purposes such as village meetings or vaccination sessions. According to the informant, the goal of emo demos was to change dietary behaviours of mothers and pregnant women so that they eat healthy foods and provide a balanced diet for their children. It was also reported that emo demos teach the importance of exclusive breastfeeding up to six months of age. The second mother defined emo demos as an approach to share information on maternal and child health through counselling and games. Another mother mentioned that the last time she attended an emo demo session was in February 2020. According to the informant, emo demos provided instructions on how to prevent anaemia during pregnancy. The last mother said that emo demo sessions convey information on how to raise children properly and messages were transmitted while playing games. The emo demo sessions in her area were held at the 'Rumah Kencana', a multipurpose building next to the Posyandu. This mother added that sessions take place on the same day as the Posyandu service or on a different day.

We were told that emo demo participants are first requested to fill out the attendance sheet. Some sessions are held before Posyandu or maternity class activities, and some are held after services are completed. If held after Posyandu or maternity class activities, the cadres will instruct caregivers not to go home because there will be an education session. One informant mentioned that women are generally required to wait one hour after the Posyandu is finished for the session to start, adding that there is no waiting area. When sessions are led before Posyandu services, cadres generally wait about half an hour until ten to 15 caregivers arrive. One informant reported that Posyandus do not share emo demo schedules, while a second informant reported that announcements of the emo demo

calendar are made when Posyandu services take place or by cadres visiting caregivers' homes. Mothers reported that sessions usually last ten to 15 minutes; emo demo sessions are generally held once a month but can be more frequent depending on agreements made between the cadres and participants.

Three mothers reported that sessions start with a chant, mentioning several names for the chant including yel salam sehat, yel-yel, and Rumpi Sehat. The final mother remembered singing songs about handwashing and complementary feeding. Informants mentioned that sessions run more smoothly if the room is spacious and there is a playroom for accompanying children attending Posyandus. When children cry or become fussy, the mothers cannot focus on the material presented or the game.

Two mothers reported that the room where sessions take place is small, forcing some participants to stand or even observe from outside. Another mother stated that the room where emo demos are held was spacious and accommodated all participants. One informant mentioned that participants were not always the same caregivers, and informants admitted that they did not attend sessions monthly.

Mothers reported that the number of emo demo participants ranges from ten to 20 people depending on the Posyandus. Some Posyandus combine mothers of young children and pregnant women in the same session, and sometimes husbands or other family members attend. All mothers reported that the sessions are led by cadres and that village midwives are also generally present whose roles involve supervising the cadre, ensuring that mothers are actively engaged, and providing information, as needed. The midwife also makes corrections when the cadre makes an error and answers questions asked by participants.

One mother described caregivers as active and interested, mentioning that they raise questions during sessions. Two mothers reported that some mothers actively participate and ask questions, while others only listen to the cadres, particularly caregivers who arrive late or are new to the sessions. One mother added that it is particularly challenging to focus when the Posyandu is crowded and noisy. Another mother mentioned that sometimes the cadres hold a quiz at the end of the session to assess whether mothers had paid attention and understood the messages delivered.

Topics covered and most or least favourite session

Mothers reported that they attended Baby Tummy (4), Reckless Snacking (4), Wash Hands with Soap (3), ATIKA (3), Child's Plate (3), Getting Ready to Go Out (2), Feeding Timeline (2), and Creating Bonds (1). Favourite sessions included Feeding Timeline, Child's Plate, ATIKA, and Baby Tummy. The mother who preferred Baby Tummy claimed that the session encouraged her to exclusively breastfeed her last child. One mother mentioned that her least favourite session is Baby Tummy because she has flat nipples and is unable to breastfeed.

To see whether mothers retained messages, we asked them to describe the last emo demo sessions that they attended and other memorable messages. The first mother said that the key messages from the last two sessions [Feedling Timeline and Child's Plate] related to the importance of providing age-appropriate food, such as breastmilk for babies zero to six months of age. The informant reported that she learned about a balanced diet and appropriate feeding schedules for her young children. She said that she was surprised by the feeding guidelines and that these sessions have affected the way she feeds her children. She also reported that the sessions have made her more aware of when to provide snacks and the differences between healthy and unhealthy snacks. The second mother mentioned that the key message from the last session she participated in Child's

Plate related to providing diverse foods so that children can achieve ideal growth and development, adding that it encouraged her to change child feeding behaviours. The informant added that it is challenging to apply messages from the module 'Reckless Snacking' because children cry if they are not given snacks they desire, although she recognised that it is better to give homemade rather than processed snacks. This mother added that the module Creating Bonds raised emotions related to maintaining close relationships with her children. Another mother mentioned that the Feeding Timeline session improved her understanding of optimal feeding schedules and influenced her behaviour, adding that her child's feeding schedule is now more regular. In the Baby Tummy session, the informant learned that the size of a baby's stomach is different from an adult, and the size and age of the baby must be taken into consideration when feeding. She also appreciated messages given in the ATIKA module, which encouraged consumption of chicken liver, spinach, and kidney beans regularly during pregnancy to prevent anaemia, which she claimed to follow. The last mother said that the key message from the last session she attended related to the importance of handwashing with soap. The informant claimed to wash her hands more frequently, particularly since the start of the pandemic. She added that the 'Reckless Snacking' influenced her selection of snack foods for her children.

The cadres

All women stated that cadres led all emo demo sessions – one cadre facilitates the session while a second cadre helps to organise the props and support the facilitator.

Mothers said that most cadres led the sessions well, describing them as active and enthusiastic, which is reflected in the ability of the mothers to memorize the chants and capture key messages. Mothers also mentioned that cadres encourage that passive mothers take an active role in the sessions. One mother added that cadres make home visits to invite mothers to take part in the emo demo session. Mothers mentioned that some cadres lack confidence leading sessions, explaining that these cadre are generally new or shy and don't have experience. They also reported that some cadres refer to the guides when leading sessions, although they felt that this did not interfere with the sessions.

Criteria they provided for good cadres included that they are confident, active, persuasive, and able to create a relaxed atmosphere so that mothers participate actively. Informants recommended that cadres follow examples of the midwives, especially in terms of keeping participants engaged and interested in the session so they do not get bored quickly.

Informants reported that props included picture cards, posters, foods, blocks, balls of various sizes, beads, plates, banners, hand soap, and ultraviolet lamps. Mothers mentioned that the props were in good condition, adding that they were not faded, torn, or broken. Mothers felt that props brought clarity and facilitated participation in the games. According to the mothers, a few cadres were adept at using props, while many were confused and awkward using props, requiring additional training. Mothers recommended that the number of props should be increased so that all participants have an opportunity to use them during sessions.

Perceptions of emo demos

In general, mothers enjoyed emo demo sessions claiming that they gained new knowledge about maternal and child health which improved their capacity to provide proper care for their children. One mother mentioned that materials are easy to understand because messages are delivered using simple language and involve practice using props and games. Another mother added that the introductory *yel-yel* chant encourages mothers to participate in sessions. It was also mentioned that the relaxed and casual atmosphere makes it easier for mothers to understand and retain the material.

When asked about the opinions of friends and neighbours, they responded that people are generally positive, adding that some women find emo demos amusing due to the catchy chants and games. Mothers reported that there are also people who reject emo demo messages, with one mother mentioning that many women refuse to adhere to exclusive breastfeeding because they believe that breastmilk does not satiate hunger and children under six months require semi-solids. They added that some women feel that emo demos are time-consuming and interfere with work activities or household chores. Reasons for not attending or missing sessions included that their child was sick, fussy, or wanted to go home, or they had other obligations.

Information sharing

All mothers reported that they share information learnt from the emo demos to family members or neighbours, particularly about negative child feeding practices. One mother said that she talked to pregnant women in her neighbourhood about ways to prevent anaemia, while another woman shared the importance of handwashing with her husband and children, which she reported was especially important during the pandemic. Another mother reminded other women in her neighbourhood to attend emo demo sessions.

Recommendations to improve emo demos

One mother recommended that the venue be held in large open spaces, mentioning that the space in Posyandus or houses is often limited. It was also recommended that a waiting room is available for mothers and their children. Another suggestion was to give new information about childcare, such as how to care for a fussy baby; the same mother recommended that gifts or door prizes would make participants more enthusiastic. It was also mentioned that cadres' ability to present and lead sessions needs improvement, as well as their capacity to use the props. Some mothers recommended refresher training to remind cadres about how to open and conduct sessions and what the main themes are, emphasizing that this will improve their confidence when leading sessions and using props.

Provincial Level (PHO): East Java

Background information

We interviewed two informants in the Provincial Health Office – one informant worked in the public health division since 1997, and the second informant worked in the nutrition division, heading up the Family Health and Nutrition section from 2017-2020 before she was reassigned to the Communicable Disease Prevention and Control Section. Before and during the interview, the second informant reiterated that she may have forgotten aspects of the emo demo programme.

According to the public health division informant, several sections in the PHO are involved in emo demos, including health promotion, environmental health, and nutrition sections. Her role in emo demos involved ensuring that provincial funds – namely the special allocated funds (Dana Alokasi Khusus-DAK) – are available at city/district levels for emo demo implementation. She was also involved in developing the first set of modules and recommending that a new set be created. At the time of the interview, she was helping to establish the emo demo facilitator's association (ASFED) at the provincial level. The second informant mentioned that her role focused on monitoring and evaluation of emo demos.

Description of the emo demo approach

Informants reported that the Baduta programme started in 2017 in two districts and was progressively scaled up to all 38 provincial districts and cities. Informants stated that the aim of the Baduta programme was to address problems related to maternal and child health during the First

1,000 Days of life, and to change community health behaviours. They also mentioned that stunting reduction was a goal of the programme. One informant described emo demos as an educational tool that conveys messages in an interactive, easy-to-understand manner though the use of props. Both informants recognised that Baduta is the umbrella programme, which is comprised of various components including the LMKM (10 Steps to Successful Breastfeeding - 10 Langkah Menuju Keberhasilan Menyusui) and Most Significant Change (Cerita Perubahan paling Bermakna) approaches. One informant stated that there are 12 emo demo modules being implemented, adding that more modules are needed, but the pandemic interfered with the introduction of a second set of modules. This participant particularly praised the MSC approach due to the positive attention it draws to individuals who have changed behaviours and its power as an advocacy tool.

Informants commended the way messages are transferred, stating that conveying information through game-like activities provides clarity and enhances people's understanding. Plus, learning through doing is empowering, leading to behaviour change. One informant stated that emo demos are more interesting because sessions focus on current conditions and practices in communities, which makes messages more relatable. The second informant considered the props to be the strength of the approach, adding that props facilitate cadre-participant interactions and make the learning process easier for both the cadres and participants who readily understand why and how to change behaviour.

Processes involved in implementation

Informants said that GAIN provided the first props. Subsequently, the PHO received specifications from GAIN and procured the props by contracting a factory that manufactured and distributed the props to all areas. One informant added that costs for the props were covered through provincial funding (APBD 1 – Anggaran Pendapatan dan Belanja Daerah/Regional Revenue and Expenditure Budget).

Informants mentioned that all programmes funded by the provincial government must be supervised, and that routine supervision of emo demos is conducted from the PHO to Posyandu level, which examined how often activities are held, the number of cadres trained and leading sessions, and changes that have occurred since the introduction of the sessions. They mentioned that parallel supervision was carried out by GAIN.

Monitoring of emo demo implementation was incorporated into the routine reporting system. Informants reported that the PHO holds routine meetings with heads of health promotion teams across East Java two or three times a year when they review emo demo activities. Quarterly or biannual evaluation meetings attended by GAIN representatives; heads of health promotion teams; members of the family health and nutrition team; and representatives from several districts were held to examine the status of implementation of activities and outputs in GAIN supported districts.

Informants mentioned that the implementation of Baduta 1 involved media coverage, which enhanced dissemination of the programme. One informant added that several MSCs were aired on local TV stations. The East Java government also used a social media approach which transmits messages included in the programme through Instagram or using WhatsApp. One informant added that the Governor was involved in the programme launch, raising the profile of the Baduta programme.

From a regulatory standpoint, one informant mentioned that a Governor Regulation for the First 1,000 Days of life in East Java includes emo demos, suggesting that funding for emo demos can be used from the stunting budget in the First 1,000 days of life. She also reported that emo demos are supported by several provincial plans (for e.g., Provincial Strategic Plan (Rencana Strategis-Renstra), the Regional Medium-term Development Plan (RPJMD), as well as different stakeholders. However,

she expressed concern about the long-term funding to ensure sustainability of the programme, and the monitoring and evaluation to assess the impact of the programme, in relation to reduced maternal and infant mortality and stunting.

Training

It appeared that neither informant had participated in MOT or TOT training. One informant indicated that the GAIN team identified and oriented trainers at the provincial level, which included staff in health promotion and family health and nutrition sections. Subsequently, trainers at district level were identified, who led training at all service delivery points in the district.

Funding

Informants mentioned that funding for emo demo implementation is provided by the Health Operational Assistance (BOK) fund, which originated from the province's local government budget (APBD). This funding covers costs for the procurement of emo demo props. In addition, funding is provided by the district/city-level government. One informant added that an indicator of sustainability is when the district/city allocates funds.

Emo demo sessions

Informants reported that mothers were the main target audience. Government officials occasionally joined sessions and husbands were encouraged to participate, with informants underlining that maternal and child health involves both men and women, but male involvement is limited due to time constraints and social perceptions. Informants said that there are 12 modules – one informant preferred ATIKA while the second indicated that Baby Tummy was her favourite session. Both informants had observed several sessions carried out in the Posyandus. They noted that the cadres don't have to memorize messages, as is the case in traditional counselling, and that the props facilitate interaction with participants, and improves their confidence to lead sessions. Informants mentioned was that messages highlight inappropriate practices and how they can be rectified, providing a clear understanding without shaming or embarrassing mothers. Informants contended that sessions stimulate emotions and raise consciousness about the importance of improved nutritional practices and motivate women to follow behaviours, which are clearly illustrated during sessions, by reaching sensory perceptions related to smell, touch, and sight.

Reported strengths of emo demos is that mothers are engaged and enjoy the sessions, as opposed to traditional counselling. Another strength is that by evoking emotions, mothers are more likely to be stimulated to change behaviour. Weaknesses that were mentioned included that only 12 modules are available, which are expected to be completed in one year. Mothers are likely to attend the same module multiple times, which can cause boredom. One informant said:

> *I have told you a lot about the strength, how special emo demos are in behavioural change, how it could touch people [emotionally], how interesting the material was, how [the cadres] could improvise. But if the cadres only concentrate on 12 modules, the session will only go around in circles. That's why I requested them to add more modules… It should not just focus on the existing modules. If a mother with a child aged under five visits Posyandus regularly, then that means s/he would have visited the Posyandu 60 times. If there are only 12 modules being recycled every year, it will be boring.*

Another reported concern was that cadres might face challenges dealing with different cultural groups who may react differently to the modules, with some groups less likely to change behaviour. The informants suggested that delivering sessions to certain populations will require a lot of patience.

The price of the props, which informants agreed are critical, may be prohibitive for districts to cover. They added that training required funds, although one informant suggested online training as an alternative.

One informant advised providing guidance and mentorship to cadres in Posyandus that had resumed activities, suggesting that the quality of the session would be affected after passing such a long period without leading sessions. This informant also suggested that emo demos should be expanded to other health programmes to ensure sustainability. One informant pushed for innovative ways to conduct emo demos virtually during the pandemic. However, she underlined the challenges of making the messages interesting, touching emotions, and motivating behaviour change remotely.

COVID and other contextual factors

Like other programmes that required face-to-face interactions, implementation of emo demos had to be postponed due to the COVID-19 pandemic. Informants reported that all Posyandus were closed from the start of the pandemic to July 2020. Subsequently, only Posyandus in red zones in East Java remained closed. The Posyandus that did open offered limited activities and enforced strict health protocols.

District Level (DHO): Malang City

Background information

We interviewed two informants whose average age was 48. The first informant worked at the Malang DHO as head of Health Promotion and Community Development Unit for 1.5 years, and the second informant was a junior health administrator in the Health Promotion Unit in Malang City DHO. She had been working at the DHO since 2009.

The first informant mentioned that one of the roles of the Health Promotion Unit was to monitor emo demo sessions in the Posyandus, although she and her staff did not have any training on emo demos. The unit had created a schedule to supervise and monitor emo demos every month or whenever they visited Puskesmas. Unit members also went to the field to teach the cadres how to implement emo demos, although they learned about emo demos on their own by reading documents and other printed material. The second informant supervised the community-based health development programme (UKBM), which oversees Posyandus in her area. After participating in an emo demo outreach event sponsored by GAIN in the PHO East Java, she submitted a proposal to the head of the Health Promotion Unit in the DHO to adopt emo demos in Malang City. She also helped to organise capacity building refresher training for cadres at Posyandu, with assistance from her colleagues at the Puskesmas. In addition, she monitored Posyandus to examine where emo demo sessions were being held. Both informants observed emo demo sessions during regular Puskesmas or Posyandu visits.

Description of the emo demo approach

One informant reported that emo demos were initiated in Malang City in 2018; she applauded the methods used as a good alternative to traditional counselling and claimed that the approach enhances capacity building of cadres and serves to revitalize Posyandu activities in the area. The programme was already underway at the time that the second informant joined the Health Promotion Unit; as such, she was not certain about when it started.

One informant stated that the overall goal was to change community behaviours related to health, offering the example of handwashing behaviour, while the second informant mentioned that the main

objective was to eliminate or reduce stunting in children. Informants described the approach as an innovative counselling method that is more interactive than traditional approaches. They added that sessions are designed to arouse feelings and emotions, making information more memorable and easier to retain and producing behavioural change. One informant said:

> *Emo demos are an innovation in counselling, which encourages participants to be more active. This approach is new because we don't deliver messages through one-way [communication] — it improves participation and aims to reach participants' feelings and emotions. It is easier to bring about behavioural change compared to normal counselling.*

Informants emphasized that the approach differs from conventional counselling due to the active involvement of participants and the two-way exchange between cadres and women. Informants highlighted the inclusion of games as a novel approach. One informant stated:

> *In other programmes, we just educate — so it was more of a one-way [communication]. Emo demos are not like that — it's two-way communication. The main point is that the facilitator and participants communicate with each other and actively participate. The examples are also easier to understand because the programme uses local props.*

One informant mentioned that the approach enhances mothers' understandings about less-than-optimal nutritional practices commonly followed and corrective actions. Informants stated that since the introduction of emo demos, there has been an increase in Posyandu attendance of mothers with children aged under five.

Processes involved in implementation

Interest in implementation of emo demos was triggered when one of our informants attended an emo demo outreach event sponsored by GAIN at the PHO in East Java. After attending the event, the informant proposed adopting the programme in Malang City. While Malang City was not selected as an intervention site for Baduta 2, the informant submitted another proposal to GAIN requesting training in Malang. Cadre building capacity funds in the DHO budget was used to adopt the programme in Malang.

> *First there was a meeting at the province level where GAIN staff presented emo demos. GAIN also did community outreach in Malang City, and along with that meeting, we thought the programme was great. Only selected intervention areas implemented the [emo demos]. When we returned [from the meeting], [in the DHO budget] menu we have a capacity building for cadres' budget line that we needed to fill. So, we thought emo demos could be used for the capacity building. We were not a selected lokus (intervention area), so we used our own local government expenditure budget (APBD) to implement emo demo [training] for cadres.*

The first set of props was provided by GAIN during the emo demo cadres training in 2018. At the time, the DHO received three boxes of props – six sets of additional props were provided during subsequent refresher training. Props obtained from GAIN were stored in the DHO office. Using funds from the APBD, in 2019, the DHO reproduced printed materials. Other props, such as balls and marbles, were obtained by Posyandus. In 2019, Malang DHO used APBD funds to produce printed materials in large quantities and distribute them to Posyandus, where cadres had received emo demo training. However, other props involving objects could not be replaced due to budget constraints. One informant mentioned problems maintaining and monitoring the location of the props, reporting that over the past two or three years some props had been lost.

The Health Promotion Unit was responsible for supervising the cadres conducting the emo demos. Unit staff created a monthly visiting schedule for the Posyandus, along with a supervision form, which

informants indicated included emo demo activities. The second informant mentioned that she developed a checklist to use while observing emo demo activities. After the observations, the supervisor would provide feedback to the cadres and midwives.

Informants reported that there was no official monitoring or reporting system for emo demos. The cadre had no obligation to report emo demos to the DHO, although the Health Promotion Unit did follow up occasionally during visits to Posyandus or through WhatsApp to ensure that activities are still running. Informants mentioned that the DHO held an internal meeting every three months with the programme officer of the health promotion section to evaluate activities in Posyandus and that sometimes they discussed emo demos. Other than that, no meetings were scheduled for emo demo monitoring and reporting in the DHO.

Training

Neither informant received official training on the emo demo programme, although they indicated that they and other staff learned about the programme by reading the emo demo guidebook provided by the DHO. In addition, both informants were present during cadre trainings led by GAIN in Malang.

There was no cascade training system established in Malang City. One informant mentioned that the DHO planned to set up a cascade approach involving MOTs and TOTs like what was done in GAIN intervention areas but lacked adequate funding. Because Malang City is not a GAIN intervention area, funds for training of MOT and TOT had to come from Malang's APBD funds.

The first training in Malang City was led by GAIN and included cadres. The training, which was carried out in one of the Posyandus, lasted two days and introduced all 12 emo demo modules. Later, the DHO conducted a one-day refresher training to improve the capacity of cadres. For the refresher training, one cadre was selected from each Posyandu. Only those modules deemed to be most needed based on health indicators (e.g., exclusive breastfeeding, iron intake during pregnancy) in participating Posyandus were the focus of the refresher training, although other emo demo sessions were expected to continue. One informant mentioned that the cadres were expected to read printed materials to keep up to date on how to lead other sessions. Training participants were requested to transmit information they received during the refresher training to other cadres in their respective Posyandus. Refresher training was supposed to be conducted annually, with different cadres from each participating Posyandu invited to participate.

Funding

Funding for emo demos came from the local government expenditure budget (APBD), as well as some support from the Health Operational Assistance (BOK). No other organisations or groups financed the emo demo programme in Malang City. Funds from the APBD were limited. Furthermore, informants anticipated significant budget cuts as funds were shifted to focus on the COVID-19 pandemic.

Emo demo sessions

Informants reported that sessions were primarily conducted in Posyandus and led by the cadres, and that the target audience was pregnant women and mothers of children aged under five. One informant mentioned that Posyandu sessions are sometimes held in small, cramped quarters. The second informant added that sessions were also conducted as part of early childhood education (PAUD) in the under-five children's family building. Scheduling of emo demo sessions was usually prepared by Puskesma staff with input from the cadres. We were told that the cadres did not follow the module sequence but rather presented modules according to the specific needs of each Posyandu.

Informants claimed that the strength of the approach lies in the two-way communication between the facilitators and the participants, which enhances delivery of the messages. They cited many weaknesses – the first weakness related to the varied capacity of the cadres with informants stating that some lacked adequate confidence and refused to lead sessions, and others did not deliver the sessions appropriately. Informants specified that several senior cadres, who had limited capacity, did not want to be replaced by junior cadres, while junior cadres sometimes felt unable or hesitant to lead the emo demo sessions. Informants also observed that cadres in big cities tend to be less confident in leading the sessions; they assumed that this was because Posyandu participants in cities have higher education levels and tend to be more critical towards new methods or approaches. One informant said:

> *In some cases, the cadres — whom we had trained to deliver emo demos — weren't confident or hesitated to talk to the women. This became more apparent in bigger cities, I mean, women in a residency tend to have more education. This made the cadres nervous so they couldn't [talk to the participants]. On the other hand, [we observed] that cadres appointed in villages could do the work. So, cadres who were appointed at residencies seldom [talked about emo demos]. They hesitated since they [felt that] they are a mere Posyandu cadre.*

They also mentioned that since no health promotion staff are responsible for promoting the programme, and Puskesmas or Posyandu workers are busy with other tasks, emo demo sessions were not prioritized. Limited funding was also reported as a problem. Our informants mentioned that additional funding is needed to train more cadres, increase the capacity of existing cadres, and replace broken or lost props. Another challenge related to the inability to convoke enough mothers of children under five to participate. Informants believed that poor participation was a direct reflection of low cadre engagement and enthusiasm. They added that mothers living in more populated settings mothers may have less time to participate due to other obligations.

Since the start of the pandemic, no reports had been received regarding the status of the sessions. One informant mentioned that they planned to hold training with a limited number of cadres to refresh their understanding and capacity to lead sessions.

COVID and other contextual factors

Informants reported that the COVID-19 pandemic dramatically affected implementation of emo demos in Malang. Posyandus closed and sessions stopped in March 2020 at the start of the pandemic. In 2021, several Posyandus located in peri-urban centres started conducting emo demos occasionally while following government regulations regarding COVID-19, which limits the number of people attending Posyandus. At the same time, Posyandus adhered to the requirement that emo demo sessions must have at least five participants.

Posyandu Level: Cadre (Malang City)

Background information

We interviewed four cadres – three were head cadres of their Posyandu, with two located in *kelurahan* (urban villages). Their ages ranged from 28-55 years and the average age was 42 years; and the final informant failed to disclose her age. Two were high school graduates and one completed junior high school. The final cadre did not share her educational background. Experience as a cadre varied, one cadre worked in her position for 21 years. On average, informants had 11 years of experience.

All cadres shared the same role, which involved presenting emo demo sessions in the Posyandus or other venues where sessions are given; one informant mentioned that in her Posyandu, the cadres alternately lead sessions or assisted with props. Three cadres reported that they also taught emo demos to other cadres in their respective Posyandus or in other Posyandus in the same *kelurahan*.

One cadre also trained cadres in her community group (RW-Rukun Warga which is the lowest administrative level) to lead emo demos.

Three informants attended the emo demo training. Two said they were selected due to their status as heads of the Posyandu, and the third, who was the youngest informant, suggested that she was chosen to attend because she was considered 'fresh' and would be able to understand quickly. The final informant stated that two of her cadre colleagues attended the training.

Description of the emo demo approach

Cadres said the goal of emo demos is to improve the knowledge of the community and the health of children. One cadre elaborated that emo demos use games to shed light on deep-rooted misconceptions that influence beliefs and practices which negatively affect diets, and those sessions guide participants to draw conclusions about more optimal eating behaviours. Informants stressed that messages are simple and easy to remember, and that the games facilitate an active learning process that is fun and memorable, and in sharp contrast to lecturing used in traditional counselling. One cadre stated:

> *Emo demos convey simple messages. The target audience is invited to participate in playing, so it isn't just us lecturing and asking the others to listen. No, it isn't like that. Instead, mothers of under-fives are invited to participate in a game that will give them insights so that they realise that what they believe to be correct, is incorrect. So, they will come up with that revelation, not through our verbal messages, but through practical activities and fun games that enable women to draw a conclusion on their own.*

One informant highlighted that by 'demonstrating' key messages, participants do not feel offended or that it is patronizing, making the information more acceptable. Instead, the approach allows caregivers to see and experience the information being conveyed, making it more relatable. One cadre said:

> *While this is a game, it hits home, so that people can conclude, 'Oh yes, it's like this.' If we give counselling, 'Ma'am when you feed your child, please don't buy snacks, don't buy chiki (cheese balls),' people get offended. In emo demos, after the snacks are combined in water, the mothers can see, 'This is what the food will be like in the stomach.' That is one example.*

Another cadre said:

> *Emo demos provide the evidence, so people believe the information. For example, the Ready to go out module shows that women who use formula milk need more time to prepare things than women who breastfeed. The message resonates more, they can better relate to it.*

This cadre added that emo demos are fun and enjoyable for both the cadre and the participants, adding:

> *Usually when people instruct about something, the atmosphere is serious. In emo demos, we learn as we joke around, and when people answer a question incorrectly, we laugh, so it's just more enjoyable.*

While all cadres expressed enthusiasm about the approach and described anecdotal examples of modified behaviours, they emphasized that behavioural change is a process that occurs gradually.

Processes involved in implementation

All cadres had access to props which they either received during training or from the DHO or Head of the Paguyuban (Communal Society). We were told that materials received from the DHO consisted of the module manuals and other printed materials and stickers. Other props such as balls, marbles, balloons, and measuring cups had to be procured, or in one case, the cadre mentioned that they made the props. Some cadres mentioned that they did not have a full set of props. It was also reported that cadres from other Posyandus borrow their props to lead sessions. One informant remarked that sharing props prevents cadres from practicing emo demos in their own Posyandu.

All cadres considered the props to be essential, adding that props enable participants to visualize and remember key messages. The cadres reported feeling comfortable using the props while leading sessions. This informant said:

> *They (the props) are indeed very important. Without props, we can't do it … if we only say, 'Ladies, it's this size, the size of a marble,' they don't know how small a marble is. But if we have the item, 'Here's a marble, here's an egg,' then people know. So, props are indeed important.*

All cadres mentioned that Puskesmas staff, including health promotion, midwives, or nutrition staff, monitored the sessions held in the Posyandus, provided help when the cadre faltered, and gave feedback to the cadres after the sessions. Only one cadre mentioned that a DHO personnel had observed a session in the Posyandus. One cadre reported that she invites the Lurah (head of the *kelurahan*) and his wife and notifies PKK staff every time there is a session in the Posyandu.

Each cadre described a different emo demo reporting mechanism. One cadre said that she sends the report to Puskesmas, another said her Posyandu sends a report to the DHO, a third cadre mentioned that her Posyandu sends a report to the Head of the Paguyuban (Communal Society), and the final cadre admitted that her Posyandu does not report to either the Puskesmas or DHO. The three cadres who claimed that there is emo demo reporting mentioned that they include the total number of Posyandu attendees, the number of under-five children and their caregivers who participated in the emo demo, what module was presented, and questions asked by caregivers. One cadre described a recording book which also includes pictures taken during sessions.

Regarding participation, one cadre suggested that the number of Posyandus and emo demo participants remains constant, while another cadre claimed that monitoring data suggest that numbers are increasing.

Training

Cadre training was variable. One cadre participated in two emo demo trainings. The first was a two-day training and the second lasted around seven days. She recounted that 57 cadres participated in the second training. This cadre confessed that she was confused after the first training, but finally understood the emo demo approach and materials after the second training, which was of higher quality. However, she added that it would be helpful to participate in another emo demo training. Another cadre mentioned that cadres in her *kelurahan* participated in three separate one-day trainings. For each training, the *kelurahan* sent one cadre. The training she participated in covered three topics, including Baby Tummy, ATIKA, and the Child's Plate module. She recalled that the trainer was from a DHO and about 50 cadres attended. The training was divided into two classes--each class had around 25 cadres and was led by one trainer. According to the informant, the materials were presented clearly in a way that stimulated the audience. However, since she was only trained on three of 12 modules, she felt it was insufficient. Another cadre informant attended a two-day training that covered seven modules. The first day was devoted to theory and the second day focused on demonstrations and practice sessions. She viewed the trainer to be skilled at teaching the modules, which allowed her to understand the materials quickly and equipped her with the capacity

to carry out the sessions. She added that she is a teacher and is accustomed to explaining, demonstrating, and talking to many people, which gives her confidence. The last was the only cadre who had not received formal training. Instead, she studied the emo demo manual and received informal training from Puskesmas staff and other cadres in her Posyandu. This cadre explained that two cadres from her Posyandu attended formal emo demo training led by the DHO, but one of these cadres lacked confidence and had poor communication skills. It was decided that the cadre included in our interviews, who had not received formal training, would replace the less competent cadre.

There was no mention of cascade training. All three formally trained cadres stated that they train other cadres in their Posyandu and other Posyandus in their *kelurahan.* One cadre mentioned that many cadres in her Posyandu are old and reluctant to lead emo demos sessions.

Funding

Funding was not discussed during the cadre interviews.

Emo demo sessions

All cadres started implementing emo demos in their respective Posyandus in 2019, but Posyandu services were suspended for several months in 2020. Around the time of the interview, only two cadres had recently presented emo demos in the Posyandus.

Cadres reported that the primary venue was Posyandus – one informant mentioned that sessions are also held in conjunction with other services such as community groups (RWs) or during the Early Childhood Education (PAUD) programme, BKB (mentorship for families with under-fives) programme, and maternity classes. Target audiences included caregivers of children aged under two or five years, depending on the service offered, and pregnant women. When held outside the Posyandus, audiences extended to all parents of children under-five and pre-schoolers. Cadres reported that Posyandu do not follow a fixed schedule administrating emo demo session. For example, one cadre stated that her Posyandu held sessions twice a year, another cadre reported that her Posyandu rotated emo demo sessions with another education-counselling programme, and a third cadre admitted that her Posyandu had only scheduled two sessions.

When held in the Posyandu, sessions are usually conducted before Posyandu core activities and last from 15-20 minutes, with caregiver participants ranging from 10 to 20 people. During the session, the midwife or Puskesmas staff (nutrition staff, nurse, or health promotion staff) may assist cadres in responding to caregiver's questions.

Cadres suggested that in their respective Posyandu, they had presented anywhere from two to six modules and that certain cadre specialize in leading specific topics. The most effective module named by the cadres included Baby Tummy, and the least effective modules were Child's Plate (they said that mothers don't understand the meaning of one-third portion sizes) and Reckless Snacking. Regarding Reckless Snacking cadres reported that cadres leading this module failed to adequately engage participants and mothers continue to give children low quality snacks. There was agreement that the Getting ready to go out module was easy to lead and applied to caregivers' daily activities, whereas some modules focus on certain categories of mothers (pregnant or lactating) or children (breastfeeding, children consuming solids).

The strength of emo demos was that the interactive games facilitate understandings of key messages. The informants added that the materials and props enhanced caregiver's learning and the messages were easy to remember. One cadre said:

> *The use of games makes it easier for women to remember things since when we play games, we don't get bored. When it's only a conversation without any games, people get bored, but with games things become exciting, even when the game only involves two people, those who watch the game feel it's fun. People become energized when a game is involved.*

However, they reported challenges in the reception of messages by some caregivers. One cadre suggested that many women in Malang City, which is comprised of suburban neighbourhoods, are highly educated. These women tend to question the credibility of the cadres and undervalue the key messages shared, suggesting that they could look up the information online or ask their doctors. Other caregivers are disinterested in the topic matter or don't appreciate the activities. One cadre stated:

> *Its weakness is that when women are not interested, they're reluctant to participate. Those who are better educated will say, 'Meh, I can easily browse about this in this and that'… The community in my area is middle class.*

Another cadre said:

> *Young mothers who are relatively educated would say, 'Meh, this cadre has no health background, I'll just consult with my own doctor'. A lot of educated caregivers say this.*

One cadre mentioned that they face difficulties attracting women, adding that the cadres in her Posyandu provide food or children's games to convince participants to join session. She said:

> *We would like to hold sessions when we don't need to entice people with free food (cakes), or whatever. We asked each other, 'What should we provide so people would be willing to gather, what should we give them?' …Sometimes we prepare something for their children, we make photocopies of pictures for them to colour. People who participate are given children's games.*

The props and training were mentioned by all four cadres as a weakness of the programme. All cadres reported that they were not given complete sets of props (both modules and accompanying props), and some of the props listed in the module book had to purchased or made by the cadres. One cadre highlighted that the training needs improvement, adding that cadres do not have a health background and therefore lack certain insights about health and nutrition. Another cadre suggested that the reporting and monitoring systems should be improved. She said that it would be beneficial if DHO staff visited the Posyandus, observed the sessions, and reviewed the register books. This would make the cadres feel that staff at higher levels in the health system are paying attention to field level activities and motivate the cadres. She also suggested that DHO or Puskesmas staff provide feedback to the Posyandu reports and offer small rewards to Posyandus that report on time and submit complete reports. The same cadre added that some cadres in her Posyandu do not feel motivated to report emo demo activities because they are under the assumption that reports are not reviewed.

Our cadres informants reported that grandparents of children aged under two also pose a barrier to practicing key messages. Two cadres mentioned that caregivers' parents or in-laws must endorse exclusive breastfeeding before mothers can fully commit. In addition, working mothers often leave their infants in the care of grandmothers, and the grandmother may not be exposed to emo demos. This cadre explained:

> *There are a lot of young mothers who live with their mother or grandmother, and if the mother works, then the child is raised by the grandmother, this is where things get difficult. … Sometimes a woman would like to exclusively breastfeed her baby for six months, but the grandparents cannot accept that. They give the baby rice and banana. In this case, the barrier is the grandparents.*

Affordability and accessibility of healthy foods may also prevent caregivers from applying behaviours presented during emo demos. Cadres also suggested that women with lower educational levels may not value the information and be less willing to accept the messages.

One cadre mentioned the cadre must have the respect of participant caregivers so that they are attentive when she is leading sessions. Another cadre underlined that the facilitator must have a firm understanding of the module contents and how to use accompanying props and must prepare the props in advance. A third cadre emphasized that when presenting the module, the cadre must project confidence. She highlighted that studying the module guidelines, practicing leading the module, and preparing the props, as well as holding a trial run directly before the session, is essential preparation. Cadres suggested that they are still working towards maximizing their ability to lead sessions.

COVID and other contextual factors

Posyandu services were suspended for several months starting in 2020. At the time of the interview, Posyandus were open but only for certain services and not all Posyandus carried out emo demo sessions. Only two cadre informants had recently led an emo demo session in their Posyandu.

Another contextual factor is that caregivers in peri-urban areas, such as Malang City, are often busy with work or other engagements, and therefore reluctant to attend or to stay in the Posyandus for a long period. Cadres reported that caregivers sometimes leave the Posyandu session early and miss the emo demos.

Village Level: Mothers (Malang City)

Background information

We interviewed four mothers – their mean age was 29 and all mothers had completed high school. They all were housewives, although one mother also provided childcare for other families. Mother informants had an average of two children and attended Posyandus for an average of four years. On average, they had participated in three emo demo sessions.

Description of emo demo sessions

Mothers' descriptions of emo demo sessions varied. One mother stated that emo demos involve counselling carried out by playing educational games; a second mother reported that the cadre leads demonstrations on food, nutrition, and child growth and development; and a third mother stated that sessions convey lessons that enlighten mothers on issues they did understand before, and what they should and should not do when providing childcare.

Informants mentioned that sessions are held in the building where Posyandus are held either on the day of Posyandu services or the day after. Participants are requested to sign an attendance sheet – they generally wait from five to 30 minutes for sessions to begin, which our informants reported started with chants (*yel-yel*). One informant reported that the session will only start after a minimum of ten women have gathered. Two mothers mentioned that Posyandu staff provided toys for accompanying children to play with while caregivers attended the session or played with the children.

Informants reported that ten to 20 people participate in each session, including mothers and grandmothers of young children and pregnant women. One mother stated that fathers occasionally attend, but that they feel awkward and less willing to participate. Informants generally described mothers as engaged and active participants in the emo demo games, although one mother stated that some participants are less active or that some participants arrive late or even when the session is about to end. They also mentioned that some mothers ask permission to go home early, particularly if a child is fussy. Informants provided mixed reports on whether caregivers asked questions during the question-and-answer session; one informant added that some caregivers are scared to ask questions.

Informants reported that the props served as aids for the cadres to use when explaining emo demo activations. They noted that the props made it easier for participants to understand the messages and that cadres were generally proficient at employing the props. According to our informants, props are in good condition and include eggs, ping pong balls, oil, bottles, thermos, bags, diapers, and formula milk.

Topics covered and most or least favourite session

All mothers recalled the module name of the last session they attended and were able to relay the main message. Three mothers reported that they follow messages conveyed during the last session by reducing the portion size of the food provided during meals (Child's Plate) and exclusively breastfeeding (Baby Tummy) and (Getting Ready to Go Out) their young infants. Other lessons learned reported by the mothers interviewed included ideal portion sizes and appropriate mixes of foods that should be given to children during meals, the amount of breastmilk that should be given during breastfeeding sessions, appropriate complementary feeding practices, knowledge about the size of the baby's stomach, how to prepare for the baby's needs when leaving the household, and that breastfeeding is healthier and simpler than formula feeding. Favourite sessions included Baby Tummy, which they said enlightened them about the importance of breastfeeding the first six months of a child's life and Getting Ready to Go Out because the delivery is simple, and messages were easily understood.

The motivation for attending emo demo sessions was to gain new knowledge about childcare. One mother said that she is interested in participating in the games but stopped attending after three sessions. This woman noted that prior to emo demos caregivers were instructed about theories, but now mothers attending Posyandu can practice improved behaviours. Informants mentioned that they miss sessions when they have conflicting events – one mother reported that sometimes grandparents or other relatives take the child to Posyandus for weigh-ins, but do not attend emo demo sessions.

The cadres

Informants reported that either one or two of five cadres in the Posyandus led the sessions and others helped to prepare session materials. If two cadres were involved, they rotated taking the lead. In general, informants described cadres as adept at leading sessions, making it easy for caregivers to understand the main messages. Some reported that the cadre sometimes refer to notes or manuals when explaining the material, or if the cadre forgets something, requires assistance from other staff members in the room. Some cadres were considered more skilled in encouraging mothers to take an active role in sessions by joking to create a fun, relaxed atmosphere.

Informants stated that a midwife or another Puskesmas staff member is usually present during the emo demos. Their roles involved participating in the opening chant and observing the session; one mother mentioned that the midwife replies to questions from participants that the cadres cannot answer.

Perceptions of emo demos

Mothers believed that their knowledge about child health had increased through the emo demo sessions, noting that the friendly attitude of the cadres and easy-to-understand delivery of the sessions involving games and practice facilitated their understanding. An added benefit mentioned by one mother was that sessions convene caregivers and facilitate communication with one another. One mother mentioned that since the sessions are held occasionally (less than once a month) the activities are enjoyable, but if done regularly, she and the other mothers would likely get bored. One mother stated that when her or other children become fussy, it is difficult for mothers to concentrate.

Information sharing

Mothers suggested that they conveyed information attained during emo demo sessions to other people such as their husbands, neighbours, parents, and parents-in-law. Informants living with their parents or in-laws claimed that it is important to share messages regarding improved child feeding practices, so that older caregivers follow the practices when they oversee childcare. Informants said that family members generally receive information positively, while women of their generation sometimes discount the messages, with one informant specifying that some of her peers contend that formula is the same as breastmilk or they are too busy to change their behaviours. One woman mentioned that she is not comfortable sharing practices learned through emo demos with friends because they may feel that she is being patronizing and perceive her as a "smart aleck."

Recommendations to improve emo demos

Informants recommended that cadres should be more creative when presenting emo demo sessions. A specific suggestion was that props involving pictures be replaced with materials, such as actual food, that will better engage participants. This mother added that sometimes the cadre is keener about the messages than the caregivers. Another mother asserted that cadres should use local or regional languages that are easier to understand. Informants emphasized the importance of inserting jokes to make the atmosphere relaxed, prevent attendees from getting bored, and generally encouraging participation. One mother reported that sometimes the cadres become serious or tense, which demotivates participation and causes boredom. Another recommendation was to hold public sessions to make other community members aware of the emo demo programme and messages.

Discussion

The evaluation underlines the success of advocacy efforts employed to disseminate and promote the Baduta 2 programme, particularly emotional demonstrations, in the five programme target districts and across East Java and other provinces of Indonesia. Study informants consistently praised emo demos for their innovation and fun, interactive approach, which informants claimed captured the attention of participants. Implementation of emo demos confronted many challenges in both intervention and scale up areas. Most notably, our study results highlighted constraints ensuring adequate capacity of cadres to lead sessions as planned and maintaining high quality sessions. Scale up in the five districts faced funding and management constraints, negatively affecting training quality and capacity building of key implementors, particularly cadres, procurement and distribution of props, supervision, and monitoring and evaluation. Introduction of emo demos in districts outside of the Baduta 2 programme districts also met major funding and other obstacles, undermining execution of training and emo demos as originally planned. The COVID-19 pandemic disrupted implementation of emo demos across intervention, scale up, and government led districts. Informants reported that potential funding sources originally thought to be appropriate for emo demos were channeled to COVID-19 prevention and control measures.

GAIN personnel in Indonesia executed wide-ranging advocacy efforts to promote the Baduta 2 package of activities, involving emotional demonstrations, the MSC approach, and breastfeeding counseling in and beyond East Java Province. According to key informants, GAIN capitalized on its strong liaisons with national level government to endorse implementation of emo demos in East Java and elsewhere. The promotion of scale up of emo demos occurred at a time when the MOH was looking for promising activities to reduce the high rates of stunting in Indonesia. Government officials in East Java province were familiar with Baduta 1 interventions and the positive impact evaluation findings and were keen to implement Baduta 2. In addition, GAIN participated in provincial level outreach events, which included demonstrations of emo demos, to raise awareness about Baduta 2

interventions and the technical and funding support provided by GAIN, which DHOs found attractive and convenient. Similar events were held in the five selected districts to sensitize government officials about Baduta 2 interventions, particularly emo demos. These events helped to generate interest among health workers in non-intervention districts in and beyond East Java, and among institutions and organizations outside the government health sector including but not limited to NGOs, schools, universities, and various community groups. Introduction of emo demos in other sectors and organizations, and execution of the MSC approach, served to broaden exposure. In addition, emos demos were showcased to diverse audiences at different high-profile events, which fostered interest among health experts working in child nutrition programs in Indonesia and other countries. Our findings suggest that many government officials wrongly believed that emo demos were designed to reduce child stunting; as a behavioural change intervention, emo demos can support efforts to reduce stunting.

Informants generally expressed enthusiasm about the innovation of the emo demo approach and the focus on interacting with mothers, stimulating the senses, and triggering emotions. All types of informants underlined the participatory, fun, game-like approach; they also emphasized that the strategy allows participants to subconsciously realize that they had been employing suboptimal feeding practices and that learning through doing enhances participants' understandings and agency. Another mentioned strength was that messages focused on common conditions and practices, making them relatable. Informants emphasized that the underpinnings of emo demos are in sharp contrast to traditional one-way counseling, which they described as boring and showing little evidence of behavioural change related to child feeding and nutrition in the Indonesian context. Other advantages included that the appeal of emo demos increased Posyandu attendance, sessions enhanced social interactions and bonding among caregivers, and emo demos were being presented in other venues to a wide range of audiences. Challenges included that the Posyandu setting is often not big enough to accommodate active participation of mothers, children accompanying mothers to well-baby visits often become fussy and noisy, causing major distractions during sessions, and there is frequently a long wait before emo demos start. In urban areas and among better educated caregivers, informants reported that many mothers do not appreciate the game-like format, question the credibility of the cadres to convey health information, and prefer obtaining information from health experts. Informants stated that mothers living in urban centers frequently have other work or household obligations and send secondary caregivers to attend Posyandu sessions. Other obstacles included that mothers' parents or in-laws may refute the messages and impede mothers from changing feeding behaviours. In intensive intervention areas, the novelty of the approach and memorability of messages appeared to wane over time, particularly among caregivers participating in sessions more than once.

The biggest challenge related to the capacity of cadres to lead sessions with fidelity and maintain high quality demonstrations. All types of informants reported that many cadres, particularly those who are older and less educated, lacked the ability to guide emo demos effectively, although mother informants were more positive about cadres' abilities. Commonly reported deficits included that cadres are shy and often lack confidence to speak publicly, with some refusing to lead sessions, and that many cadres failed to master leading sessions proficiently, lacked spontaneity, and relied on guides. Informants reported that cadres' limitations impacted on caregivers' participation, the delivery of clear messages, the ability to evoke emotions, and the generation of a surprise or "ah hah" moment critical to the approach. Cadres' weaknesses are not surprising given that there are no set criteria for the selection of cadres, their roles had not previously involved public speaking, and they are volunteers and receive no incentive to lead emo demos. Furthermore, similar problems had been identified during Baduta 1 even when cadres received much more intensive mentoring and

oversight. GAIN leadership tried to identify solutions to overcome cadres' weaknesses, which became more pronounced with scale up. One solution involved selecting two, better qualified cadres in the Posyandus to participate in training and to lead emo demos. However, difficulties arose when the two trained cadres were absent, and those cadres not selected expressed jealousy towards their colleagues. In the intensive intervention areas, GAIN attempted to follow recommendations stemming from the Baduta 1 experience to introduce the modules gradually, ensure that cadres practice modules prior to Posyandu sessions, and have the midwife provide ongoing mentoring to rectify mistakes and give the cadres confidence to lead sessions. Unfortunately, a gradual training approach and adequate mentoring and supervision was not feasible in the scale up and government led (non-intervention) areas due to funding constraints, likely exacerbating the shortfalls of the cadres, whose capacity to lead sessions is paramount to participant engagement, message retention, and the overall effectiveness of emotional demonstrations.

In government led (non-intervention) areas, the number of training days was significantly reduced, and cadres were not consistently trained on the full set of modules, with some modules introduced by video, through printed materials, or by other trained cadres. Informants from Sigi and Malang City reported that cadres executed modules they felt more comfortable leading or according to local needs, not following the sequence or implementing the full set of 12 modules, and that Posyandus held sessions sporadically. The combination of inadequate training and irregular emo demo implementation caused cadres to forget key information. Informants also mentioned that language barriers between cadres and mother caregivers may have impeded participation and transfer of information during sessions. Our informants in government led districts highlighted difficulties keeping cadres enthusiastic and motivated, which they attributed to inadequate training and supervision. Another reported challenge in Malang City related to the inability to convoke enough mothers to participate, which informants believed reflected low cadre capacity and that mothers living in populated settings may have less time to participate.

Key informants working on Baduta 1 and in-depth interview informants emphasized that the availability of a complete set of props is essential to aiding the cadres to convey messages, engaging the senses needed to impart messages, and facilitating cadre-participant interactions. In the GAIN intervention areas, sets of props were procured and distributed to emo demo supervisors and facilitators. However, scale up and government led (non-intervention) areas lacked adequate funds to purchase full sets of props, forcing implementers to use partial sets, improvise by making props out of paper, or substitute props (e.g. a telephone in place of a baby bottle) with other items. When props got lost or broken, they lacked funds to replace missing items; in Sigi, some cadres led sessions without props. Lack of adequate and appropriate props in the scale up and government led areas likely affected the performance of the cadres and how messages resonated with mothers.

Informants in scale up and government led areas reported funding as a major constraint. Because emo demos are not linked to a specific MOH programme, the health sector does not have a budget line item to support emo demo expenses. Health officials had to be innovative in identifying funding and piecing together village funds to support activities. Securing village funds was challenging, resulting in a patchwork of funding which varied from one area to another and was often insufficient to support processes and systems involving cascade training, mentoring, supervision, coordination, monitoring and evaluation, and reporting essential to maintaining quality implementation. While there was general agreement that the success of emo demo implementation was dependent on the involvement of village midwives, lack of programme infrastructure and support systems compromised systematic mentoring and supervision by the midwives. Some informants reported that midwives and other Puskesmas workers considered emo demos as a burden to their work schedule. Lack of funding

and standard support systems likely contributed to the suboptimal adherence to the emo demo approach reported by our informants, such as the failure to make sessions participatory, to introduce the full set of modules and follow the module sequence (scale up area, Sigi, Malang City), and to hold sessions routinely (Sigi and Malang City), which informants insisted is essential for adequate practice and to maintain good skills. In Sigi District, it was also mentioned that, because there was no government policy to implement emo demos, Posyandu did not feel obligated to carry out sessions.

Other major constraints involved government turnover and vacant posts, which disrupted activities and required that training and outreach events be repeated. The pandemic forced the closure of Posyandus and had a major impact on training and emo demo implementation, also leading to the diversion of funds that may have been available for Baduta 2 activities.

Limitations

The COVID-19 pandemic prevented the evaluation field work to be carried out as originally planned. Due to the pandemic, the research team had to administer interviews remotely, which likely affected establishment of trust essential to carrying out high quality, in-depth interviews and impeded the researchers from gathering insights about informants that can only be gleaned during face-to-face interactions. Due to the closure of Posyandus and curtailing of emo demo sessions, the research team was unable to carry out observations of emo demo activities, which was a central component to the original evaluation design. In addition, at the time of the evaluation emo demos had not been carried out for months in the five target districts; as a result, the team was unable to collect data from midwives, cadres and mothers in the Baduta 2 intervention and scale up areas. While interviews with cadres and caregivers participating in emo demos were conducted in two government led districts where sessions were ongoing, the evaluation team had to rely on people in the field to select informants. Some of the cadres and mother informants were not accustomed to conversing by teleconference, which we suspect affected the quality of the interviews. Although the original plan was to administer focus group discussions with caregivers attending emo demos, this was not possible due to COVID-19 protocols and difficulties faced conducting group discussions remotely.

Conclusion

Study findings suggest that when implemented well, emo demos engage participants and are well liked due to their interactive and game-like approach. Study findings identified many constraints that interfered with the quality of implementation during Baduta 2, the most important being the capacity of cadres to lead sessions. Key informants reported that a key lesson learned from Baduta 1 was the time and effort needed for cadre training, which was supposed to be a gradual process, and that the cadres required regular practice and intensive mentoring and supervision. Yet, these recommendations could not be followed during scale up, jeopardizing the quality and effectiveness of sessions. Findings raise questions regarding the feasibility of maintaining high standards during massive scale up efforts. While the Baduta 1 impact evaluation showed that the package of interventions led to positive behavioral outcomes, evidence is needed to ascertain whether exposure to emo demos solely and not part of a package stimulates behavioral change. Before emo demos are promoted in other contexts, research is needed to understand whether use of social and emotional drivers in emotional demonstrations influences adoption of improved nutritional practices. Key informants raised concerns about the transferability of the emo demo approach and modules to other cultural contexts where caregivers may lack basic health information to understand the messages, a game-like approach may be inappropriate, and a massive system of volunteer health workers may not be available.

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