Indonesia is home to more than 6 million children under five suffering from wasting. Greater than 2 million of these children under five are severely wasted, putting them at a greater risk of death and disease in comparison to their healthy counterparts.

Trend data indicates a decrease in the prevalence of child wasting between 2007 to 2018. However, the resulting 2018 national prevalence (10.2%) is still classified as “high” by the World Health Organization (WHO). Regional disparities across provinces also exist, indicating a serious situation in some areas. For example, in 2019, the rates of wasting ranged from ‘very high’ (15.6% in Maluku) to ‘low’ (3.3% in Bali).

The key determinants of child wasting in Indonesia are multifaceted. While poverty is the fundamental bottleneck, inadequate dietary intake, suboptimal care practices, and high burden of infectious diseases lead to high rates of child wasting. Poor maternal health also plays a role, with suboptimal maternal dietary intake, and common practice of early marriage and pregnancy, collectively contributing to high incidence of low-birth-weight babies which is a strong risk factor for child wasting. Open defecation is still practiced by around 20% of households in Indonesia, leading to high burden of childhood diarrhea and subsequent wasting episodes. The positive trend in wasting prevalence may be related to healthy economic growth of over five per cent per year and improving the food security status but Indonesia still struggles to establish a healthy, sustainable, and productive nutrition and food system.

Between 2015-2018, Integrated Management of Acute Malnutrition (IMAM) programming was revealed to be an effective intervention for the treatment of acute malnutrition in the Indonesian context. In turn, IMAM was included in their national guidelines and a series of capacity building initiatives were launched, including online training options to mitigate against the Covid-19 pandemic interruptions.

The government of Indonesia has also made bold commitments in identifying food systems transformation as one of their national policy priorities. This commitment is further reflected in the Food Law No.18/2012 and Presidential Decree No.18/2020 on Mid-term Development Plan 2020-2024 that stated the food systems transformation has been designated as one, as the regulatory framework to ensure sufficient, affordable, safe, and balanced diets for all.

Finally, Indonesia has made impressive progress in the expansion of social protection systems since 2014. This includes a more nutrition sensitive focus and a multi-sectoral coordination group to facilitate the acceleration of the reduction of child wasting in Indonesia.

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**GEOGRAPHICAL PRIORITY AREAS**

*There are 10 provinces that are prioritized. Unicef is working in 7 (Aceh, Central Java, East Java, East Nusa Tenggara, West Nusa Tenggara, South Sulawesi, Papua). UNHCR is working in 4 (Greater Jakarta, West Java, Banten, Aceh) of these provinces and FAO in Greater Jakarta. Other UN agencies (WFP and WHO) target the national area.*

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**REACHING THE SDG TARGET BY 2030**

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**ANNUAL COST (USD)**

<table>
<thead>
<tr>
<th>Improved Birthweight</th>
<th>Improved Child Health</th>
<th>Improved Diets &amp; Practices</th>
<th>Improved Detection &amp; Treatment of Wasting</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,874,692.18</td>
<td>$2,176,945</td>
<td>$25,639,024.56</td>
<td>$14,925,000</td>
</tr>
</tbody>
</table>

**TOTAL ANNUAL COST (USD) = $53,615,651.74**

**TARGET POPULATION GROUPS**

TOTAL NUMBER OF PEOPLE REACHED = 30,081,557
**OUTCOME 1**

**REDUCE LOW BIRTH WEIGHT BY IMPROVING MATERNAL NUTRITION**

**SYSTEM** | **PRIORITY ACTION/SERVICE**
--- | ---
HEALTH | Strengthen existing maternal nutrition programs; (maternal iron/folic acid supplementation, maternal dietary counseling, fortification supplementation) through 1) capacity strengthening; 2) improving monitoring and information system; and 3) Social Behavior Change Communication
FOOD | Supporting supplementary food distribution program through 1) capacity strengthening; 2) improving monitoring and information system; 3) Social Behavior Change Communication

**OUTCOME 2**

**IMPROVED CHILD HEALTH BY IMPROVING ACCESS TO PRIMARY HEALTH CARE, WASH SERVICES AND ENHANCED FOOD SAFETY**

**SYSTEM** | **PRIORITY ACTION/SERVICE**
--- | ---
HEALTH | Strengthening the coverage and quality of essential nutrition services in the context of Covid-19 through 1) capacity building; 2) data management system; 3) social behavior change communication; 4) evidence generation; 5) guideline development

**OUTCOME 3**

**IMPROVED IYCF BY IMPROVING BREASTFEEDING PRACTICES AND CHILDREN'S DIETS IN THE FIRST YEARS OF LIFE**

**SYSTEM** | **PRIORITY ACTION/SERVICE**
--- | ---
HEALTH | Improve infant and young child feeding practices through 1) high-level advocacy; 2) strengthening capacity of health workers and community volunteers; 3) improving monitoring and information system; 4) implementing social behavior change communication activities

**OUTCOME 4**

**IMPROVED TREATMENT OF CHILDREN, PLW, PLWHIV WITH WASTING BY STRENGTHENING HEALTH SYSTEMS AND INTEGRATING TREATMENT INTO ROUTINE PRIMARY HEALTH SERVICES**

**SYSTEM** | **PRIORITY ACTION/SERVICE**
--- | ---
HEALTH | Strengthening and supporting food systems transformation with focusing on increasing the affordability of healthy diet for all including vulnerable population through 1) evidence-based policy; 2) advocacy and 3) capacity building to national and subnational government

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**By 2025**

- Reduce low birthweight to <10%
- Increase the rate of exclusive breastfeeding to at least 60%
- Increase the coverage of treatment services to 90% for severely wasted children
- Improve child health by achieving universal health coverage, including access to quality essential health-care services for 98% of the population

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