Nutrizione
Nawala Education
https://jurnal-ilcaagam.com/index.php/JN/index
Volume 3 Issue 1, 2026
e-ISSN: 3048-4138
DOI : https://doi.org/ 10.62872/jn.v3i1.635

Community-Based Sensitive Nutrition Assistance Strategy to Accelerate Stunting Reduction in Disadvantaged Areas

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ARTICLE INFO

Accepted:
01 March 2026
Revised:
18 March 2026
Approved:
25 May 2026

Keywords:
sensitive nutrition; community-based assistance; stunting; locus areas; social capital; Family Support Team

ABSTRACT

Stunting remains a challenge for human development in Indonesia, despite a decline in national prevalence from 21.5% in 2023 to 19.8% in 2024. This narrative and thematic review synthesizes policy documents and literature on nutrition-sensitive services, community facilitation, and village governance to develop a conceptual assistance framework for disadvantaged stunting-priority areas. Official policy and survey materials and relevant scientific publications from 2020–2026 were interpreted using social ecology, social capital, and collaborative governance perspectives. The synthesis suggests that nutrition-sensitive measures are more consistently associated with improved dietary diversity than with linear growth when implemented alone. It identifies frontline facilitators as potential links between at-risk families and cross-sectoral services, while noting constraints related to skills, incentives, social norms, budgets, and leadership continuity. Six proposed strategies integrate participatory diagnosis, household plans, facilitator support, behavior-change communication, collaborative governance, and participatory monitoring. The framework is a conceptual proposal derived from heterogeneous secondary evidence, not a tested intervention; its effectiveness in reducing stunting requires prospective evaluation.

INTRODUCTION

Stunting is a disruption in children's linear growth rooted in chronic malnutrition and recurrent infections, particularly in the first 1,000 days of life. Its impact extends beyond low height. Stunting is associated with stunted cognitive development, lower educational attainment, decreased adult productivity, and an increased risk of non-communicable diseases later in life (Vaivada et al., 2020; Victora et al., 2021). Therefore, stunting is now viewed not solely as a child health issue, but as a human development issue intertwined with intergenerational poverty. Studies of countries that have successfully reduced stunting on a large scale show that progress is driven by a combination of expanding nutrition and health services with improvements in determinants outside the health sector, such as household well-being, maternal education, and water and sanitation (Bhutta et al., 2020).

Indonesia has made significant progress. The prevalence of stunting among children under five has decreased from 37.2 percent in the 2013 Basic Health Research

How to cite:
Example: Tasya. A (2026). Community-Based Sensitive Nutrition Assistance Strategy to Accelerate Stunting Reduction in Disadvantaged Areas. *Journal Nutrizone,* 3(1), 22-32. DOI: 10.62872/jn.v3i1.635

(Riskesdas) to 30.8 percent in 2018, 21.5 percent in the 2023 Indonesian Health Survey (SKI), and 19.8 percent in the 2024 Indonesian Nutritional Status Survey (SSGI) (Ministry of Health, 2023, 2024, 2025) (Figure 1). The 2024 figure equates to approximately 4.48 million children under five (Coordinating Ministry for Human Development and Culture [Kemenko PMK], 2025). However, the 2025–2029 National Medium-Term Development Plan (RPJMN) targets a prevalence of 18.8 percent in 2025 and 14.2 percent in 2029, with a long-term target of 5 percent by 2045 (Ministry of Health, 2025). Moving from 21.5 percent in 2023 to the 14.2 percent target in 2029 implies a decline of 7.3 percentage points over six calendar years. This review uses the officially released 2024 SSGI estimate as its national prevalence benchmark; the reporting period and survey instrument are specified because successive survey designs are not directly interchangeable (Ministry of Health, 2025).

The national average masks disparities. The prevalence of stunting is higher in the poorest economic groups, at around 29.8 percent in the lowest quintile (Coordinating Ministry for Human Development and Culture, 2025), and in rural areas (22.7 percent compared to 17.8 percent in urban areas) (Directorate General of Fiscal Balance, 2025). The 12–36 month age group shows a rising prevalence trend, requiring special attention (Coordinating Ministry for Human Development and Culture, 2025). Distribution between provinces is also wide. In the 2023 SKI, the highest prevalence was recorded in Central Papua (39.4 percent), East Nusa Tenggara (37.9 percent), and Highland Papua (37.3 percent) (Ministry of Health, 2024).

To focus resources, the government has designated focal locations (loci) for intervention. At the district/city level, the scope of loci expanded from 260 in 2020 to 360 in 2021 (Stunting Reduction Acceleration Team [TP2S], n.d.). At a lower level, district/city governments designate locus villages/sub-districts based on a situational analysis, which is Action 1 of eight convergence actions (TP2S, n.d.). Local practice shows that locus determination typically takes into account the number of families at risk of stunting, the number of cases, prevalence, service coverage, and the availability of drinking water and sanitation (Rembang District Government, 2025; Purworejo District Bappeda, 2025). In other words, loci are areas where the burden of stunting and gaps in basic services overlap. It is precisely in these areas that the inadequacy of specific nutrition interventions delivered by health workers is most evident when implemented alone.

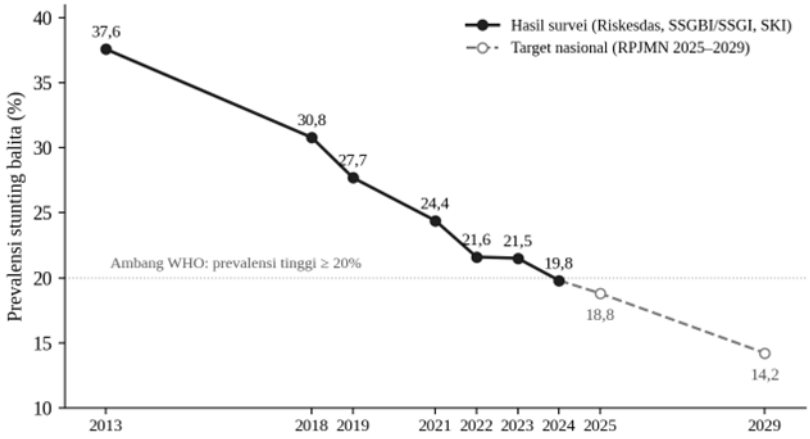


Figure 1 Trends in toddler stunting prevalence in Indonesia, 2013–2024, and national targets

Source: Ministry of Health (2023, 2024, 2025); targets according to the 2025–2029 RPJMN. Methods across surveys are not fully comparable (Riskesdas, SSGBI, SSGI, SKI).

Global evidence confirms this. Even if ten specific, evidence-based nutrition interventions reach 90 percent coverage, the resulting reduction in stunting is estimated to be only about one-fifth (Bhutta et al., 2013). Acceleration therefore requires nutrition-sensitive interventions that target indirect causes (Ruel & Alderman, 2013). A recent synthesis of 260 quantitative studies concluded that sensitive programs outside the health sector, such as cash transfers, nutrition-sensitive agriculture, and water, sanitation, and hygiene (WASH), consistently improve dietary diversity and have the potential to have small but positive impacts on anthropometric indicators (de Hoop et al., 2025).

The problem is that sensitive interventions are spread across multiple ministries, institutions, and regional apparatuses, while families most in need often face barriers to accessing them, including information, costs, administration, and social norms. This is where community-based assistance comes into play: who ensures that at-risk families actually receive safe drinking water, healthy latrines, social assistance, health insurance, and good parenting? The government has prepared institutional frameworks, including Family Assistance Teams (TPK), Integrated Health Post (Posyandu) cadres, and Stunting Reduction Acceleration Teams (TPPS) at various levels, as well as pillars of behavior change communication and community empowerment outlined in Presidential Regulation Number 72 of 2021 and the National Strategy for the Acceleration of Stunting Prevention and Reduction (Stranas P3S) 2025–2029. However, field evaluations show suboptimal implementation: facilitators struggle to convince families, budgets are limited, and community participation often stops at attendance (Alexandra & Yusran, 2024; Iriany et al., 2024; Sasmito et al., 2026).

Existing Indonesian studies frequently examine cadre counseling and nutrition knowledge, while analyses of water, sanitation, social protection, and village governance often address these determinants separately (Alexandra & Yusran, 2024; Arief et al., 2025; Sasmito et al., 2026). As a result, the practical mechanism through which community facilitators identify unmet household needs, connect families to services delivered by different sectors, and follow up on unresolved barriers is less clearly specified. Unlike a stand-alone education or food-assistance program, this article develops an integrated, household-to-village facilitation framework that assigns explicit liaison, behavior-change, governance, and monitoring functions to existing local institutions. The framework is a conceptual synthesis rather than a demonstrated intervention model. It addresses three questions: (1) which nutrition-sensitive determinants and service gaps characterize priority areas; (2) how do facilitators connect families to services, and what constrains their work; and (3) which operational components could be integrated into a feasible village-level support strategy?

METHODOLOGY

This study employed a qualitative narrative literature review combined with thematic policy analysis. This design was chosen to integrate heterogeneous evidence national survey findings, policy instruments, evidence syntheses, and qualitative implementation studies whose objectives and methods are not sufficiently uniform for a single quantitative meta-analysis. The study used no primary participant data and was not conducted as a formal systematic review. Three source groups were considered: (1) national policies and statistical materials, including Presidential Regulation No. 72/2021,

the 2025–2029 national stunting strategy, the 2024 SSGI and 2023 SKI, and relevant program guidance; (2) studies and syntheses from 2020–2026 on nutrition-sensitive interventions, family assistance, community participation, and local governance; and (3) foundational theoretical works on social ecology, social capital, participation, street-level implementation, and collaborative governance, retained regardless of publication year. Policy documents were used to identify formal mandates and program instruments; empirical publications were used to assess reported mechanisms, barriers, and outcomes; and conceptual works provided interpretive lenses. The resulting framework was derived by comparing these source types, not by treating policy commitments as proof of effectiveness.

The literature search was conducted in September 2026 using Google Scholar, PubMed Central, and Indonesian journal and official-government portals. Search phrases included "sensitive nutrition," "nutrition-sensitive," "Family Support Team," "stunting locus village," "stunting social capital," and "community participation stunting Indonesia," together with Indonesian-language equivalents. Priority was given to materials directly addressing nutrition-sensitive determinants, community-based assistance, or implementation in Indonesia, and to relevant syntheses from low- and middle-income countries. Sources concerned solely with clinical nutrition treatment were outside the review scope. Screening consisted of checking topical relevance, study or document type, and access to sufficient text to assess its claims. Because the original search log and deduplication records were not retained in the source manuscript, reliable counts of records identified, screened, excluded, and included cannot be reconstructed; no numerical screening flow is claimed. This omission limits reproducibility and should be addressed in a future registered or systematic review.

The synthesis followed four descriptive themes: priority-area conditions, nutrition-sensitive service domains, facilitator roles, and contextual enablers or barriers. For each theme, policy provisions were compared with findings in research articles and evidence syntheses. Interpretation then proceeded through social ecology (levels of influence), social capital (trust and access across networks), and collaborative governance (coordination and shared problem-solving). Higher-weight support was assigned to national surveys and systematic evidence syntheses for descriptive prevalence or broad intervention patterns; local qualitative case studies were used to explain plausible mechanisms rather than to estimate population effects. Proposed program components were identified separately from documented findings, and indicator definitions were formulated as recommendations for future piloting. The non-systematic selection process may introduce selection bias; the retrieved literature is heterogeneous, some local studies have limited transferability, and the proposed framework has not undergone field validation.

RESULTS AND DISCUSSION

Results

Situation of locus and policy direction

The policy foundation for community support is already strong. Presidential Regulation 72/2021 establishes five pillars of the National Strategy for Accelerating Stunting Reduction: leadership commitment and vision, communication for behavior change and community empowerment, convergence of specific and sensitive interventions, food and nutrition security, and strengthening systems, data, information, research, and innovation (State Secretariat, 2022). The 2025–2029 National Strategy for

P3S expands this to six pillars, which, according to socialization materials published by local governments, include political commitment and leadership, communication for behavior change and community empowerment, program convergence and partnerships, food and nutrition security, increasing program management capacity, and monitoring and evaluation (Metro City Government, 2025). Two of these pillars—communication for behavior change and community empowerment and convergence—serve as the policy framework for sensitive nutrition support.

In 2025–2026, a new platform emerged outside the National Strategy document, namely the Free Nutritious Meals (Makan Bergizi Gratis; MBG) program for pregnant women, breastfeeding mothers, and non-PAUD toddlers (group 3B). As of August 18, 2026, this program reached 10.8 million recipients, consisting of 964,000 pregnant women, 2.4 million breastfeeding mothers, and 7.4 million non-PAUD toddlers, through 24,606 Nutrition Fulfillment Service Units (ANTARA, 2026). Its technical guidelines emphasize nutrition education, consumption monitoring, food safety, and the involvement of cadres and Integrated Health Posts (Posyandu) (TP2S, 2026). This program straddles the line between specific and sensitive interventions. For mentors, it presents both an opportunity and a challenge. It provides a rationale for routine visits and a gateway into households, but without nutritional mentoring, food packages can be perceived by families as mere food assistance, rather than as part of changes in parenting and feeding practices.

The situation within the loci themselves is not uniform. Tabanan Regency, for example, designated 18 priority loci villages for 2026 and monitored 31 indicators of converged services, ranging from services for pregnant women, infants, toddlers, adolescent girls, and prospective brides, to the provision of safe drinking water and proper sanitation, JKN participation, population administration, family assistance, and the use of yards as a source of nutritious food (Puspawati, 2026). Purworejo Regency faced a different dilemma. Analysis of the situation showed that many villages remained red-status, but these villages had become loci in 2021–2024. Therefore, a coordination meeting selected 34 new villages that had never been loci (Bappeda Purworejo Regency, 2025). This decision is understandable from an equity perspective, but it leaves a sustainability issue: villages that still face challenges could potentially lose intensive assistance before their local capacity is self-sufficient.

Two structural constraints are also worth noting. First, the 2025 spending efficiency policy, which calls for savings of IDR 306.7 trillion, has prompted the government to discuss its impact on the program to accelerate stunting prevention and reduction and to focus on the utilization of Village Funds (TP2S, 2025a). Second, e-PPGBM surveillance data cannot yet be used to measure prevalence due to various limitations (TP2S, 2025a), which limits the ability of regions to accurately assess their own progress. Overall, the locus can be understood not simply as an administrative label, but as a social configuration: poverty, distance to services, limited infrastructure, parenting norms, and village government capacity are intertwined. This configuration is what mentoring must interpret.

Anatomy of sensitive nutrition interventions at the locus and role of mentoring

The first question is what needs to be ensured to reach families at the site. Table 1 summarizes the five most relevant nutrition-sensitive domains for community support, along with typical barriers, support roles, and examples of process indicators. The domain selection was based on the SSGI sensitive indicators (Ministry of Health, 2023), the

sensitive intervention groups in the National Strategy for Sustainable Development (Stranas, 2025b), and the reviewed evidence.

Table 1. Sensitive nutrition intervention domains, typical family barriers at the locus, and the role of community mentoring

Domain	Typical barriers in the locus family	The role of community mentoring	Examples of process indicators
Drinking water, sanitation and hygiene	Unsafe water sources; unsanitary toilets; poor hygiene practices	Mapping households without access; triggering behavioral change at the hamlet scale; facilitating assistance or self-help; monitoring usage	Percentage of priority families with safe drinking water and healthy toilets
Family food and nutrition	Limited purchasing power; low access to animal foods; children's diets are less diverse	Local food cooking demonstration; yard assistance; ensuring that the MBG 3B package reaches and is consumed by the target	Toddler food diversity; percentage of 3B targets who received and consumed the package
Social security and population administration	Out-of-date data; administrative barriers; aid not linked to nutrition messages	Verifying family data; assisting with JKN, birth certificates, and social assistance; linking assistance to nutritional recommendations	Percentage of priority families with active JKN and receiving the assistance they are entitled to
Parenting, early childhood education, and reproductive health	Extended family norms; low paternal involvement; readiness of adolescent girls and prospective brides	Parenting classes and the first thousand days; mentoring prospective brides and young women; connecting with family planning and early childhood education services	Family participation in parenting classes; father involvement; premarital visits
Access to integrated basic services	Incomplete immunization; irregular Posyandu visits; referrals not followed up	Visit reminders and assistance; referral follow-up; connecting health centers and village governments	Complete basic immunization; regular Posyandu visits; completed referrals

Source: synthesized by the author from the Ministry of Health (2023), TP2S (2025b), Arief et al. (2025), de Hoop et al. (2025), and Sasmito et al. (2026).

Water, sanitation and hygiene. The use of water from unsafe sources is associated with stunting in Indonesian children (Arief et al., 2025). Global evidence suggests that the impact of WASH on growth is greater when water, sanitation, and hygiene components are combined and integrated with specific nutrition programs, provided community coverage is sufficiently high (de Hoop et al., 2025). The implications for mentoring are clear: a single home visit is insufficient if neighboring homes remain

without safe latrines. Mentoring needs to work at the hamlet or neighborhood level, for example through joint mapping and triggering collective behavior change, and not stop at the family level.

Family food and nutrition. Food garden programs and nutrition-sensitive agriculture increase dietary diversity, but their impact on stunting is small on their own (de Hoop et al., 2025). Community studies in rural Indonesia report that stunting prevention programs are well-received but hampered by social attitudes that conflict with program objectives and a low understanding of nutritious food security (Yusriadi et al., 2024). In the context of MBG 3B, facilitators play a role in ensuring that packages reach the right targets, are consumed by the intended mother or child rather than shared equally within the family, and are integrated with education on menus and the use of local foods. This reading is analytical and needs to be monitored in the field.

Social protection and population administration. The finding that Social Protection Card recipients are at higher risk of stunting (Arief et al., 2025) does not necessarily imply that social assistance is failing. It suggests that assistance is reaching more vulnerable families but is not adequately packaged with nutrition messages and services. Evidence from Jember aligns. Unconditional cash transfers improve nutritional intake in the short term, but their sustainability is limited without nutrition education and access to quality health services (Putra et al., 2024, as cited by Sasmito et al., 2026). Global synthesis supports this, as cash transfers accompanied by behavior change communication have a greater effect on dietary diversity (de Hoop et al., 2025). Facilitators are strategically positioned to connect assistance with nutrition messages, while also assisting families with managing JKN membership, population documents, and accurate data collection.

Parenting and family norms. In Jember, informants described the belief that giving eggs could make babies "hot," leading to delays, and that feeding decisions were held by husbands or in-laws, while mothers were not free to challenge them (Sasmito et al., 2026). Although mothers regularly attended Posyandu (Integrated Health Post) visits, the cadres' recommendations were overridden by the authority of their extended families. These findings highlight that access to services and information does not automatically change practices. What is needed is work on norms and power relations within families, with culturally sensitive communication strategies (Marni et al., 2021).

Access to integrated basic services. Children who do not receive immunizations show a significant association with stunting (Arief et al., 2025). Companions can reduce this gap through schedule reminders, accompanying visits, and following up on referrals, so that Posyandu (Integrated Health Post) and community health centers (Puskesmas) become part of the family plan, rather than occasional visits. The synthesis of these five domains yields four main functions of mentoring. First, the diagnostic function: identifying sensitive obstacles for each family, not just the child's nutritional status. Second, the liaison function: ensuring families access to cross-sectoral services. Third, the function of changing behavior and norms. Fourth, the accountability function: reporting service gaps to village and district governments. These four functions are rarely covered simultaneously in the currently evaluated mentoring role, which is more prominent in counseling and record-keeping.

Mentoring actors and institutions

At-the-spot mentoring is carried out by a network of actors with different mandates. The Family Assistance Team (Tim Pendamping Keluarga; TPK), consisting of midwives, Family Welfare Movement (PKK) cadres, and family-planning cadres, assist target

groups ranging from adolescents to toddlers (Martina & Effendy, 2025). The TPK's role, as reported in the literature, includes counseling or communication, information and education, facilitating referrals and receiving social assistance, and recording and reporting mentoring results (Alexandra & Yusran, 2024). Posyandu cadres spearhead growth monitoring and counseling, village governments control local budgets and regulations, and religious and informal leaders influence norms. An evaluation in Nagari Kandang Baru, Sijunjung Regency, concluded that the implementation of the TPK's role was suboptimal. Counseling was not well-run, mentors had difficulty convincing families, and the available budget was deemed insufficient (Alexandra & Yusran, 2024). Family rejection manifests in various forms, ranging from disbelief in a stunting diagnosis, embarrassment in admitting a child's condition, to reluctance to participate in mentoring, which the authors attribute to low human resource capacity, economic and educational conditions. Another evaluation in a target village in South Konawe Regency examined the TPK program from the perspective of input, process, and output (Martina & Effendy, 2025). Both are consistent in their general outline: an institutional framework is in place, but the quality of implementation relies on local capacity, support, and acceptance.

From a social capital perspective, the facilitator's role is dual. They are local residents close to the target families (bonding) and also serve as extensions of state programs, delivering messages and reporting (linking). Social proximity is both a capital and a burden, as reprimanding or correcting the practices of neighbors and relatives demands a high price of trust. The author's reading, which needs to be tested, is that the facilitator's credibility depends on their ability to deliver something concrete: water, assistance, referrals, or food. Facilitators who only deliver messages without a path to services risk losing trust, and facilitators who only deliver services without a message fail to change practices.

From a governance perspective, “symbolic compliance” behavior in low-performing villages can be understood as coping with uncertainty and reporting pressure, rather than simply individual negligence (Lipsky, 2010; Sasmito et al., 2026). Informants in these villages described activities undertaken out of obligation, with documents prepared, photographs taken, and reports submitted, with activity tapering off after district monitoring concluded. In contrast, in high-performing villages, village heads brought stunting issues to village meetings, reviewed data and budgets, even participated in family visits, and cross-sectoral forums involving midwives, schools, and religious leaders met regularly (Sasmito et al., 2026). This pattern aligns with Ansell and Gash’s (2008) emphasis on facilitative leadership and collaborative processes: villages that thrive are those that transform meetings and forms into collaborative problem-solving.

Determinants of success and obstacles

Table 2 summarizes six recurring factors in the evidence reviewed, along with their implications for strategy design in the following subsections.

Table 2.Determining factors for success and obstacles to mentoring in the locus area

Factor	Primary evidence	Implications for strategy
Symbolic participation	Citizen participation is limited to manpower (Iriany et al., 2024); voiceless presence in decisions in low-performing villages (Sasmito et al., 2026)	Participatory diagnosis and monitoring by citizens (Strategies 1 and 6)
Cultural norms and maternal autonomy	Beliefs about feeding, the influence of the extended family, and the limited power of mothers (Sasmito et al., 2026; Yusriadi et al., 2024; Marni et al., 2021)	Norm and figure-based communication (Strategy 4)
Capacity, incentives, and family acceptance	TPK has difficulty convincing families; rejection and shame arise; budget is limited (Alexandra & Yusran, 2024)	Strengthening companions (Strategy 3)
Leadership and institutional continuity	Active village heads differentiate high-performing villages; leadership changes disrupt programs in low-performing villages (Sasmito et al., 2026)	Collaborative governance and handover documentation (Strategy 5)
Budget flexibility and efficiency pressures	Rigid budgets hamper responses to urgent needs (Sasmito et al., 2026); 2025 spending efficiency impacts the P3S program (TP2S, 2025a)	Mobilization of local resources (Strategy 5)
Data quality and utilization	e-PPGBM cannot yet be used to measure prevalence (TP2S, 2025a); data is collected but rarely used for village decisions (Sasmito et al., 2026)	Village data-based diagnosis and monitoring (Strategies 1 and 6)

Source: author's synthesis.

Functional versus passive participation. In high-performing villages, mothers were involved in determining parenting class topics and helping organize them, while in low-performing villages, mothers were invited to listen and sign attendance lists (Sasmito et al., 2026). This difference concerns ownership. Without a sense of ownership, attendance tends to be dependent on incentives and ceases when they disappear. Findings in Garut, which showed participation was limited to labor, without ideas, group discussions, expertise, or other contributions (Iriany et al., 2024), reinforce that mobilization is not the same as participation.

Cultural norms and stigma. An approach that blames the mother risks reinforcing resistance. Labeling a family as a "stunting family" can be stigmatizing, while Alexandra and Yusran (2024) note that shame is one source of resistance to mentoring. This reading suggests framing stunting as a shared concern and highlighting the family's assets, not just its shortcomings. In high-performing villages, nutrition messages are delivered through religious leaders, for example, during Friday sermons, without making families feel blamed (Sasmito et al., 2026).

Leadership and sustainability. Sasmito et al. (2026) noted that village regulations on stunting were often not enforced after a change in village head, while high-performing villages maintained institutional memory through documentation, retained actors such as

cadres and secretaries, and orderly handovers. For the locus, this means that the continuity of mentoring should not depend on a single figure or a single term of office.

Budget and data. In high-performing villages, informants described mechanisms for rapid budget adjustments for urgent needs such as clean water or nutritious food, as well as the integration of Village Funds with other sources such as village-owned enterprises. In contrast, in low-performing villages, the health budget is locked in at the beginning of the year, with any remaining funds after infrastructure and traditional events allocated to stunting (Sasmito et al., 2026). Childhood measurement data is also collected but not analyzed for local decision-making in these villages. The role of Village Funds and administrative capacity in stunting reduction has also been the subject of empirical research at the national level (Indra & Khoirunurrofik, 2022).

These factors reinforce each other. Active leadership expands budgetary space, flexible budgets enable facilitators to truly connect families with water or food, and fulfilled service promises foster trust that strengthens participation. Conversely, passive leadership, rigid budgets, and unused data create a cycle of symbolic compliance. Most of the evidence in this subsection is qualitative studies with small samples in limited areas, so the patterns are read as working hypotheses, not general laws. Sasmito et al. (2026) themselves emphasize that the findings from six villages in one district are not intended to be generalized.

Framework of six community-based sensitive nutrition assistance strategies

Based on the evidence reviewed, and as an untested program-design proposition, this article proposes a Community-Based Nutrition-Sensitive Assistance (PGS-BK) framework consisting of six strategies. This framework is designed to operate within an annual locus cycle and is embedded within existing instruments, namely situation analysis and eight convergence actions, stunting consultations, village TPPS, and TPK visits, thus not adding new structures. The sequence of strategies follows a cyclical logic: diagnosing (Strategy 1), planning assistance (Strategy 2), preparing assistance (Strategy 3), changing behaviors and norms (Strategy 4), consolidating governance and resources (Strategy 5), and monitoring and learning (Strategy 6). In practice, Strategies 3 and 5 operate throughout the cycle. Table 3 summarizes the core activities, actors, and indicators for each strategy.

Table 3.Summary of the Community-Based Sensitive Nutrition Assistance (PGS-BK) framework

Strategy	Core activities	The main actor	Monitoring indicators
1. Participatory social diagnosis	Mapping of assets and obstacles; hamlet tracing; sensitive determinant profiles for each priority family; stunting discussions	Cadres, TPK, village midwives, village government, residents	Percentage of priority families with complete profiles; involvement of mother representatives and figures in deliberations

Strategy	Core activities	The main actor	Monitoring indicators
2. One family support plan	Specific and sensitive needs plan; primary care provider; referral pathway; regular visits	TPK, family, health center	Percentage of priority families with plans; visits on schedule; sensitive needs met
3. Strengthening companions	Practical training; supportive supervision; incentives and operational costs; peer learning forum	Community health centers, family planning counselors, village government	Percentage of trained companions; supervision implemented; availability of operational support
4. Behavior change communication	Dialogue and joint practice; targeting fathers and extended families; messages through religious figures; peer groups	Cadres, religious figures, mothers' groups	Toddler dietary diversity; father involvement; recommended feeding practices
5. Collaborative governance and local resources	Routine village TPPS; village regulations and plans; rapid budget adjustments; handover documents; light post-locus assistance	Village head, TPPS, BUMDes, local partners	Frequency of TPPS meetings; portion of village budget for sensitive activities; program sustainability across leadership changes
6. Participatory monitoring	Community scorecard; village data board; monthly review; service gap report	Residents, cadres, village TPPS, services	Convergence service coverage; completion of service gap reports; prevalence trends from district/city level surveys

Source: author's formulation based on synthesis in subchapters 4.1 to 4.4.

Evidence status of the proposed strategies. The need for integrated nutrition-sensitive support, the relevance of behavior-change communication, and barriers relating to household norms and village governance are supported by the reviewed literature. In contrast, the particular six-step sequence, designation of a single household contact, specific supervision arrangements, community scorecards, budget-adjustment procedures, and post-locus follow-up arrangements are the author’s design recommendations. Their feasibility, cost, acceptability, and impact have not been empirically tested in this study.

Strategy 1. Participatory social diagnosis of families and villages. District/city situation analysis remains the basis for determining loci, but at the village level, it needs to be supplemented with a community-based diagnosis. This includes mapping assets and constraints (water sources, latrines, yards, mothers' groups, community leaders, nearby

services), transect walks to assess sanitation and the environment, and a seasonal food calendar. Cadres and the Community Empowerment Team (TPK) compile a profile of the sensitive determinants of each priority family based on family census data and Posyandu measurements, and the results are presented to the village stunting discussion as the basis for determining priorities. The goal is twofold: to obtain more precise data and to shift participation from mere presence to contributing to problem-solving (Arnstein, 1969; Rifkin et al., 1988). The diagnosis also captures local resources to ensure the approach does not focus solely on deficiencies.

Strategy 2. One family mentoring plan. Convergence is often discussed at the program level, but the meeting point is the household. For each priority family, the facilitator and the family develop a simple plan that outlines specific and sensitive needs, steps, responsible parties, referral pathways, and deadlines. A single facilitator serves as a single point of contact for the family, avoiding multiple staff with conflicting messages. This plan packages assistance and services with behavior change communication, as evidence synthesis shows a greater effect on dietary diversity when transfers are combined with behavioral components (de Hoop et al., 2025). MBG 3B drop-off visits can be used as contact points, provided they do not replace mentoring visits. The criteria for priority families are openly agreed upon, and the term "priority family" is chosen to avoid stigma.

Strategy 3. Strengthening capacity and support for facilitators. Evaluations of the Family Assistance Team (TPK) indicated that difficulties convincing families and budget constraints hampered performance (Alexandra & Yusran, 2024). This strategy included practice-based training in counseling, non-blame communication, and cross-sectoral service tracking. Supervision was supportive, conducted by midwives, community health centers, and family planning counselors, and extended beyond reviewing reports. Incentives and operational costs were transparent and budgeted through village mechanisms, caseloads were maintained at a reasonable level, and peer-learning forums were provided. Because frontline implementers interpret policies according to their own beliefs and discretion (Lipsky, 2010), facilitators also needed certainty about what was permitted and protection when undertaking local initiatives, as fear of making mistakes is a source of waiting for instructions (Sasmito et al., 2026).

Strategy 4. Communication of behavior change based on norms and figures. The messages target not only mothers but also fathers, grandmothers, or in-laws, and other figures who influence feeding decisions. The methods chosen include dialogue, shared cooking practices, successful family stories, mothers' peer groups, and the use of religious spaces such as religious studies and sermons. The messages are designed collaboratively with community members to align with local foods and beliefs, while respectfully addressing misconceptions without denigrating the experiences of previous generations. This approach aligns with a review of cultural communication strategies for behavior change in stunting prevention (Marni et al., 2021) and with the experience of high-performing villages that work through figures as cultural translators (Sasmito et al., 2026).

Strategy 5. Collaborative governance and local resource mobilization. The village TPPS is activated as a collaborative forum that meets regularly and involves village heads, midwives, cadres, representatives of the Family Welfare Movement (PKK), schools or early childhood education institutions (PAUD), religious leaders, and family representatives. Village regulations and work plans include concrete, sensitive activities, such as improving water access, toilets, food gardens, and supporting incentives, with a

mechanism for rapid budget adjustments for urgent needs. Local resources such as village-owned enterprises, business support, and community kitchens are linked to the implementation of MBG 3B. To maintain continuity, each village prepares a handover document containing data, plans, and role allocations, and retains key actors across leadership changes (Sasmito et al., 2026). Addressing dilemmas like those in Purworejo, the authors propose that villages that "graduate" or move off the list of locus villages continue to receive light assistance and act as learning partners for new locus villages, so that achievements are not lost when program intensity decreases. This proposal is the authors' untested idea.

Strategy 6. Participatory monitoring and social accountability. Progress is monitored at three indicator levels. Process indicators include visit coverage, developed family plans, and ongoing TPPS meetings. Intermediate indicators include dietary diversity for toddlers, access to safe drinking water and healthy latrines, JKN participation, complete basic immunizations, and recommended feeding practices. Outcome indicators include stunting prevalence, referenced from district/city-level surveys, and new cases detected at Posyandu (Integrated Health Posts). Progress is reviewed during monthly Posyandu meetings and periodic stunting discussions. Community members assess service quality, for example through simple community scorecards and village data boards that display service coverage without listing family names. Companion feedback on missing services, such as no running water or undisbursed aid, is reported to the village and district TPPS to prevent structural problems from being passed on to families. Because surveillance data is not yet reliable for measuring prevalence (TP2S, 2025a), villages use process and intermediary indicators that can be verified locally.

Proposed indicator definitions and data sources. Family-plan coverage = number of priority families with a dated, jointly agreed plan divided by all eligible priority families recorded in the village register, assessed monthly. Scheduled-visit completion = completed documented visits divided by visits due during the reporting period, assessed monthly from TPK logs. Referral completion = referrals confirmed as received by the target service divided by referrals issued, assessed monthly from facility and facilitator records. Safe-water and improved-sanitation coverage = priority households meeting locally adopted service definitions divided by all assessed priority households, checked through household verification at baseline and follow-up. Minimum dietary diversity should follow the applicable WHO age-specific indicator and be assessed from caregiver interviews for eligible children, rather than treated as an interchangeable measure across all toddler ages. Participation should record the proportion of priority households represented in deliberations and whether their suggestions were documented in decisions. These indicators are suggested monitoring measures; data quality, denominators, privacy safeguards, and staff workload require pilot assessment. Village registers, Posyandu records, TPK visit logs, and service-referral records are proposed local sources; nationally representative survey estimates, rather than routine e-PPGBM counts, should anchor population-level stunting prevalence comparisons.

Conceptually, this unvalidated framework positions mentoring as a node that integrates three lenses. From a social ecology perspective, it works simultaneously at the family, community, and policy levels. From a social capital perspective, it leverages bonding for trust, bridging for outreach, and linking for service access. From a collaborative governance perspective, it demands facilitative leadership and a continuous shared process. The limits of this framework also need to be clarified. Mentoring cannot replace service provision. In areas lacking adequate water, toilet, or health services, the

role of mentors shifts to advocacy and social accountability, while the responsibility for provision remains with the government. Furthermore, without adequate compensation and support, this framework risks burdening cadres and TPKs, who already shoulder many responsibilities.

Policy implications and research agenda

For policy, there are four implications. First, the behavior change communication and community empowerment pillars in the National Strategy for the Acceleration of Stunting Prevention and Reduction (Stranas P3S) need to be translated into operational guidelines for sensitive assistance that integrate TPK (Tim Pendamping Keluarga), Posyandu (Integrated Service Post) cadres, and MBG services for pregnant women, breastfeeding mothers, and non-PAUD toddlers (3B) with the task of connecting families to services, not just counseling. Second, village budget norms need to provide clear space for sensitive activities and incentives for assistance, along with a mechanism for rapid adjustment. Third, locally verifiable village data needs to be strengthened and effectively used in stunting discussions. Fourth, continuity of locus needs to be regulated so that expansion of coverage to new villages does not interrupt assistance in villages that are still vulnerable.

For research, the future agenda includes six areas. First, testing the PGS-BK framework through a quasi-experimental design or a stepwise cluster test across multiple locations. Second, mixed-methods implementation research to understand the mechanisms that work and don't, given that global syntheses note the scarcity of mixed-methods studies on sensitive interventions (de Hoop et al., 2025). Third, measuring social capital (bonding, bridging, linking) as a mediator of outcomes. Fourth, analyzing the costs of mentoring and incentives. Fifth, a longitudinal study across village leadership changes. Sixth, an ethical review of stigma and family privacy in data collection and monitoring.

CONCLUSION

The reviewed literature identifies interconnected nutrition-sensitive conditions in disadvantaged stunting-priority areas, including limitations in safe water and sanitation, food security, social protection, caregiving, and access to basic services. Evidence syntheses suggest that some nutrition-sensitive measures improve dietary diversity, while effects on linear growth are generally more limited and depend on implementation context and integration with other services. Indonesian implementation studies also describe how facilitators may connect households with cross-sectoral assistance, although their work is affected by capacity, incentives, resistance, stigma, and participation that sometimes remains procedural. These observations are associations and interpretations drawn from secondary studies, not causal effects established by this review.

The proposed six-component framework integrates participatory diagnosis, household mentoring plans, support for facilitators, culturally responsive behavior-change communication, collaborative village governance, and participatory monitoring. It offers an operational hypothesis for future program testing rather than evidence that the framework reduces stunting prevalence. Pilot implementation should establish indicator baselines, document feasibility and costs, protect family privacy, and assess service coverage and feeding practices before undertaking adequately designed evaluations of longer-term nutrition outcomes.

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