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Village-Level Implementation of Supplementary Feeding and Nutrition Education Programs for Stunting Management

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ABSTRACT
Stunting remains a persistent public health challenge in Indonesia, especially in rural areas where access to nutrition and health services is limited. In response, the government has implemented supplementary feeding programs and nutrition education as key interventions in managing stunting. This study examines the implementation of supplementary feeding programs and nutrition education in addressing stunting at the village level, using Babakan Village as a case study. This research uses a qualitative case study design. Data were collected over two months through in-depth interviews, field observations, and document analysis. Informants were selected using snowball sampling techniques and included village government officials, Posyandu workers, health workers from community health centers, and families of children with stunting. Data validity was ensured through source and method triangulation, while thematic analysis was applied to interpret the findings. The findings show that the PMT program has been implemented in a relatively structured and coordinated manner, supported by the active involvement of the village government and health sector actors. Implementers at the field level demonstrate strong commitment and adaptive practices in responding to local social and cultural challenges. Although most children are still classified as stunted based on height-for-age indicators, gradual improvements are observed in weight-for-age indicators.

1 | Introduction
Stunting, characterized by impaired linear growth and cognitive development due to chronic malnutrition, remains a crucial and multidimensional public health challenge in Indonesia (Safitri et al., 2025; Agri et al., 2024; Martony, 2023). This condition is irreversible and most vulnerable during the first 1000 Days of Life (HPK), a critical window that begins at conception in the womb until the child reaches the age of two (Fahrepi et al., 2025; Hartini et al., 2023). The pathogenesis of stunting is not simple; it is the synergistic result of direct and indirect determinants. The main direct causes are inadequate nutritional intake (chronic malnutrition) and repeated exposure to infections, especially in early life (Safitri et al., 2025). Meanwhile, indirect factors such as household food insecurity, suboptimal parenting practices, limited access to health services and clean water, and poor environmental sanitation conditions form a complex causal chain (Darwin, 2025).

Operationally, stunting is diagnosed based on anthropometric measurements, where the child's height (length) for age (TB/U) is below minus two standard deviations (-2 SD) from the median standard growth of children according to the World Health Organization (WHO) (Amanda, 2024; Sukmawati, 2020). This diagnosis not only indicates physical deficiencies but also serves as an early indicator of a number of long-term and systemic negative impacts. Studies conducted by Mulyana (2025) and Achjar et al., (2024) at the individual level show that children who experience stunting are at risk of permanent developmental deficits, including impaired fine and gross motor function, impaired cognitive capacity, and learning difficulties that can reduce academic achievement. As adults, they tend to have shorter stature and are at higher risk of developing metabolic and cardiovascular diseases (non-communicable diseases) (Kurniati, 2022).

Archda & Tumangger (2019) explain that at the macro level, the burden of stunting has a serious impact on national development. Stunting contributes to decreased economic productivity, increased health costs, and widened social inequality (Fitriani et al., 2025). Therefore, efforts to accelerate the decline in stunting prevalence have become a strategic priority for the government, which is realized through various specific and sensitive interventions (Permanasari et al., 2020). Supplementary feeding programs combined with nutrition education are one of the main specific interventions expected to break the chain of direct causes of stunting (Tripuspita & Sihidi, 2024; Sachman, 2024). However, the effectiveness of these programs is highly dependent on the quality of implementation at the grassroots level, which involves multi-stakeholder synergy, distribution mechanisms, strict monitoring, and acceptance and compliance from target families (Widjaja & Dhanudibroto, 2025; Lawut & Jaftoran, 2025). Therefore, in-depth studies on the implementation of these programs at the community level, such as in villages, are needed to map achievements, identify contextual challenges, and formulate evidence-based policy improvement recommendations (Zunaidi, 2024; Nurhayati et al., 2025).

The prevalence of stunting in Indonesia remains at an alarming level, making it one of the most complex and multidimensional public health challenges (Putri et al., 2025; Yarmaliza et al., 2025). The impact of this condition is long-term and systemic, not only hindering the cognitive and physical development of individual children, but also potentially reducing the productive capacity and quality of human resources nationally in the future (Dahlia et al.,

2025; Maharani & Wulandari, 2025). Fundamentally, stunting is not only an indicator of nutritional failure, but also a reflection of economic and social inequality and unequal access to health services, clean water, sanitation, and nutritious food (Yarmaliza et al., 2025). Due to its nature, which is rooted in interrelated determinants—including biological, social, economic, and cultural aspects—any intervention effort must be designed holistically and integratively. This approach must be able to address the root causes of the problem, be sustainable in the long term, and be sensitive and adaptive to the diversity of socio-cultural contexts and local wisdom in each region. Without a comprehensive and participatory strategy, efforts to reduce stunting risk being only partial and ineffective in achieving transformative impact (Winarni, 2024).

Supplementary Feeding (PMT) is recognized as an essential specific nutritional intervention in strategies to combat malnutrition, especially among toddlers (Tripuspita & Sihidi, 2024). As a direct intervention, the PMT program aims to address deficits in energy, protein, and micronutrient intake, which are the main causes of growth disorders (Neherta, 2023; Kostania & Setiyani, 2025). Empirical evidence shows that structured and sustainable implementation of PMT has a significant positive impact on improving children's nutritional status, as seen in improvements in anthropometric parameters such as weight-for-age (WFA) and height-for-age (HFA) (Manik et al., 2025). However, the effectiveness of PMT is uneven and greatly influenced by the selection of food ingredients (Laili, 2024). This shows that PMT using local food ingredients tends to be more effective than those using imported ingredients or standard formulas (Kusfriyadi & Sulistiawaty, 2021; Paramitha et al., 2025). This advantage lies not only in their nutritional value but also in their sustainability, affordability, and higher socio-cultural acceptance in the target communities (Widowati & Nurfitriani, 2023). These factors collectively increase consumption compliance and reinforce the expected nutritional impact.

Therefore, a local food-based approach is a key principle in designing effective and sustainable nutrition programs. This strategy emphasizes the use of local food resources that are nutrient-rich, affordable, and in line with community consumption patterns, while also supporting food security and the local economy (Daulay et al., 2024; Azmi et al., 2025). The integration of nutrition science and local wisdom in PMT programs is a strategic step to optimize the results of nutrition interventions at the community level (Elfidayani, 2024; Rebianti et al., 2025).

Research in the field of public health shows an increasing focus on the relationship between PMT implementation and efforts to reduce the prevalence of stunting, especially in rural areas that are highly vulnerable to nutritional problems (Walidin, 2025; Adi & Andrias, 2016). Longitudinal studies show that systematic, structured, and sustainable PMT implementation can contribute to a reduction in stunting rates (Ipoel & Haris, 2025; Ramadhan & Sinaga, 2025). The success of this program's implementation depends not only on the availability of resources, but also on the active participation of the community and health workers at all stages of the policy, from planning and implementation to comprehensive monitoring and evaluation of the PMT program (Harefa et al., 2025; Mait et al., 2025). In addition, PMT program strategies need to be formulated with a contextual and responsive approach to the unique characteristics of each community (Tripuspita & Sihidi, 2024; Raesalat, 2024). This includes careful consideration of determining factors such as socioeconomic stratification, accessibility and availability of local foods, and the diversity of cultural norms and practices that exist in the community. Awareness of this complexity highlights that there is no universal intervention approach or methodology that can be applied uniformly in all locations. Therefore, flexibility and adaptability are key principles in designing effective, sustainable PMT programs that are relevant to the specific needs of the target population.

The success of PMT and nutrition education programs is not only determined by policy design at the central level, but also depends heavily on the implementation process at the local level. In the context of public policy, implementation is understood as a crucial stage that bridges policy formulation and the achievement of real impact in the community (Pressman & Wildavsky, 1984). Various studies confirm that the failure of social and public health programs is often not caused by weaknesses in the policy itself, but rather by implementation issues in the field.

This study is based on a theoretical framework of public policy implementation that emphasizes the importance of contextual factors and implementing actors in determining program success. The implementation model developed by Van Meter & Van Horn (1975) explains that policy implementation performance is influenced by six main variables, namely: (1) clarity of policy standards and objectives, (2) available resources, (3) characteristics of the implementing organization, (4) communication between organizations, (5) the disposition or attitude of the implementers, and (6) the social, economic, and political conditions of the implementation environment. This model is relevant for analyzing the PMT program because the intervention involves various cross-sector actors—ranging from village governments, community health centers, integrated health service post cadres, to beneficiary families—who operate in diverse socio-cultural conditions.

In addition, the bottom-up approach in implementation theory emphasizes the role of local actors and beneficiaries as active subjects in the policy process (Lipsky, 1980). In the context of PMT and nutrition education, health cadres and mothers of young children can be viewed as street-level bureaucrats who have considerable discretion in translating policy into daily practice. Their perceptions, understanding, and commitment to the program greatly influence the quality of implementation, consumption compliance, and sustainability of interventions. Therefore, analysis of PMT program implementation needs to consider not only technical and administrative aspects, but also social dynamics, cultural norms, and power relations at the community level.

By integrating the perspective of public policy implementation, this study views the PMT program and nutrition education not merely as nutritional interventions, but as complex, adaptive, and contextual policy processes, the outcomes of which are largely determined by the interaction between policy, implementers, and the target community.

A number of previous studies have evaluated the impact of PMT programs on the nutritional status of toddlers and the prevalence of stunting, both through quantitative approaches and evaluative studies based on anthropometric indicators. These studies generally emphasize the causal relationship between PMT and improved nutritional status, and highlight the importance of adequate nutrition, duration of intervention, and regularity of consumption in determining the effectiveness of the program (Iskandar, 2017; Ghodsi et al., 2018). Other studies have broadened the focus by examining the role of local foods as a strategy for increasing the sustainability and social acceptance of PMT programs (Kusfriyadi & Sulistiawaty, 2021).

Although these empirical contributions are significant, most studies still focus on program outcomes, while the implementation process at the community level receives relatively little in-depth analytical attention. In fact, implementation is a key stage that determines whether nutrition interventions can be carried out consistently, accurately, and sustainably, especially in

rural areas with limited resources and high socio-cultural complexity. Furthermore, research that explicitly integrates the public policy implementation theory framework into the analysis of PMT and nutrition education programs is still limited, especially in the village context. Many studies evaluate PMT as a technical health program, without examining how interactions between actors, coordination mechanisms, institutional capacity, and community responses influence the quality of policy implementation in the field. This gap highlights the need for a more holistic and theoretical approach to understand why PMT programs are successful in one region but less optimal in another.

In the local context, there is still limited empirical evidence documenting the implementation of PMT and nutrition education at the village level using a policy implementation lens, particularly in Babakan Village. In fact, villages are the main arena of implementation where national policies meet local realities, cultural values, and social practices of the community. Given the complexity of stunting, the importance of PMT and nutrition education interventions, and the identified research gaps, this study aims to analyze the implementation of the Supplementary Feeding Program and nutrition education in efforts to combat stunting in Babakan Village.

2 | Metode

This study uses a qualitative approach with a case study design. A qualitative approach was chosen because this study aims to gain an in-depth understanding of the implementation process of the PMT program and nutrition education in stunting prevention, including the dynamics of actors, the socio-cultural context, and the factors that influence the success and obstacles of program implementation at the community level. The case study design allows for contextual and holistic exploration of policy phenomena in a specific location, namely Babakan Village, as an arena for public policy implementation at the grassroots level. Case study research is appropriate when the boundaries between phenomena and context are not clearly visible (Yin, 2018).

Creswell & Poth (2018) define qualitative case studies as a research approach that explores in depth and detail a bounded system, which can be a program, event, activity, process, or individual, in a real-life context. Case studies emphasize a holistic understanding of phenomena by utilizing various data sources, such as interviews, observations, and documents, to obtain a comprehensive and context-rich picture. Furthermore, the main strength of case studies lies in their ability to answer the questions “how” and “why,” especially when researchers have no control over the events being studied and when the boundaries between the phenomenon and the context cannot be clearly separated.

This study was conducted in Babakan Village, which was selected purposively because it is one of the areas implementing the PMT program and nutrition education in an effort to combat stunting. Data collection was carried out over two months, allowing researchers to make repeated observations, build trust with informants, and gain a comprehensive understanding of the program's implementation practices in the context of everyday village life.

Informants were selected using snowball sampling. This technique was chosen because the implementation of the PMT program involved various actors with different roles and levels of involvement, not all of whom could be identified at the outset of the study (Noy, 2008). The process began with key informants, such as village officials or health workers, who then recommended other relevant informants based on their knowledge and involvement in the program. Informants in this study included: 1) village government officials involved in program planning and coordination; health workers (Puskesmas); Posyandu cadres as field implementers; mothers or families benefiting from the PMT program. The number of informants was determined based on the principles of adequacy and data saturation, namely when the information obtained was repetitive and did not produce any significant new findings.

Data collection was conducted using three main techniques to obtain rich and in-depth data, namely: 1) in-depth interviews, conducted in a semi-structured manner to explore the perceptions, experiences, and practices of actors involved in the implementation of the PMT program and nutrition education. The interview guide was developed based on the theoretical framework of public policy implementation, particularly the aspects of policy objectives, resources, communication between actors, implementers' dispositions, and the influence of social and cultural contexts. The interviews were conducted flexibly so that informants could freely express their views and experiences (Kvale, 2015); 2) field observations, which were conducted directly on program implementation activities, such as PMT distribution, Posyandu activities, and interactions between health cadres and target families. These observations aimed to capture actual implementation practices, patterns of social interaction, and the alignment between formal policies and practices in the field. Field notes were systematically compiled to document relevant observational findings (Spradley, 2016); 3) Documentation was used to supplement primary data through the examination of official and unofficial documents, such as PMT program guidelines, village activity reports, Posyandu records, and other supporting documents. Documentary data serves to trace the policy context, administrative mechanisms, and consistency of program implementation (Bowen, 2009).

To ensure the validity and credibility of the data, this study applied triangulation techniques, which included source triangulation, by comparing information from various groups of informants; method triangulation, by combining interviews, observations, and documentation; and time triangulation, by collecting data at different times during the research period. (Denzin, 2017; Lincoln, 1985). The application of triangulation aims to minimize researcher bias and increase the reliability of research findings.

Data analysis was conducted thematically (thematic analysis) using an inductive-deductive approach. This technique is considered most relevant for policy implementation research because it allows researchers to identify patterns and meanings. The stages of data analysis include: 1) Data Reduction, which is the process of selecting, focusing, and simplifying raw data from interviews, observations, and documentation; 2) Coding, which involves grouping data into initial themes that emerge from the field, as well as categories derived from the policy implementation theoretical framework; 3) Theme Development, linking empirical findings to policy implementation variables, such as resources, implementer dispositions, and social context; 4) Drawing Conclusions and Verification, through reflective interpretation of findings and testing the consistency of meaning across data sources (Braun & Clarke, 2006; Miles et al., 2014). This analytical approach allows for the integration of empirical data and theoretical frameworks, resulting in a comprehensive understanding of the dynamics of PMT program implementation and nutrition education at the village level.

3 | Result

3.1 | Program Implementation Context in Babakan Village

The seriousness of the impact of stunting has prompted the central government to make accelerating the reduction of stunting a national development priority. This is explicitly stipulated in Presidential Regulation No. 72 of 2021 concerning the Acceleration of Stunting Reduction, which emphasizes that stunting must be addressed in an integrated and convergent manner, involving all levels of government, from the central to the village level. Within this policy framework, stunting is no longer viewed solely as a health sector issue, but rather as a development problem that requires cross-sector and cross-level government collaboration.

The implementation of PMT is not solely the responsibility of one health agency, but requires cross-sector and cross-level government collaboration to create a significant and sustainable impact. This is where the role of the village government becomes important. Villages are the smallest government units that have direct proximity to the community and understand the social, cultural, and economic conditions of their citizens in greater detail than higher levels of government. Village governments are at the forefront in identifying target families that truly need nutritional intervention, facilitating access to health services at the community level, and mobilizing community participation in preventive activities such as PMT provision. The involvement of village governments in accelerating stunting reduction is reflected in the formation of stunting reduction acceleration teams, the allocation of a special village budget for PMT, and the assignment of village midwives and Posyandu cadres as program implementers.

In addition, the allocation of Village Funds (APBDes) is also an important source of funding that supports the implementation of PMT and other stunting prevention programs at the local level. The Village Fund allows villages to allocate resources flexibly according to the priority needs of the community, including the necessary nutritional interventions for toddlers and pregnant women in their area. This budgetary support is increasingly relevant, given the high rates of stunting that tend to be more prevalent in rural areas, making local, targeted, and sustainable interventions very important.

The active involvement of village governments in implementing PMT not only contributes to statistically reducing stunting rates, but also strengthens the legitimacy of the program in the eyes of the community. When villages respond to stunting as a shared challenge, rather than simply as an obligation of health centers or health agencies, community acceptance of the program is higher and its implementation can be carried out in a participatory manner. The integration of national policies, fiscal support from the central to village levels, and the involvement of village governments in the field make PMT more effective and sustainable as a concrete effort to ensure a healthier and more productive future for Indonesian children.

The results of the PMT program implementation in Babakan Village show that the PMT program implementation began with the identification of nutritional problems at the village level, particularly the high number of stunted toddlers, malnourished toddlers, and pregnant women at risk. The village government, together with village midwives and Posyandu cadres, collected data on the target population based on weighing results, nutritional status measurements, and health data collected through Posyandu and puskesmas activities. This data became the basis for the village to accurately determine the PMT target group.

Once the targets have been set, the village government plans an integrated PMT program with an accelerated stunting reduction agenda. At this stage, the village coordinates with the community health center, health office, and health cadres to determine the form of PMT, the type of supplementary food (generally based on local foods), the duration of provision, and the distribution mechanism. This planning is accompanied by budget allocation through the APBDes, both from the Village Fund and other legitimate sources of funding.

The next step is to socialize the program to the community. The village government plays an active role in communicating the objectives, benefits, and mechanisms of PMT to parents of toddlers and pregnant women through village forums, integrated health service posts (Posyandu), and direct assistance from cadres. This socialization aims to build community understanding and participation so that PMT is consumed as recommended and not misused.

PMT is implemented through Posyandu activities or direct distribution to target households, involving Posyandu cadres, village midwives, and village officials. Supplementary food is provided periodically according to a predetermined schedule (once a month), accompanied by monitoring of consumption and nutrition education for parents to ensure that the supplementary food is actually consumed by the target children or pregnant women.

During the program implementation, the village government and health workers routinely monitored target participation, PMT consumption compliance, and changes in the nutritional status of toddlers and pregnant women. The monitoring data was recorded and reported as program evaluation material. This evaluation was used to assess PMT progress, identify implementation obstacles, and serve as a basis for program improvement or continuation in the following period. Overall, the involvement of the village government made the implementation of PMT more coordinated, participatory, and sustainable, as the village acted as a link between national and/or regional policies, health sector support, and the real needs of the community at the local level.

3.2 | Understanding of Program Objectives among Implementing Actors

Understanding of the objectives of the PMT program is not only possessed by health workers and Posyandu cadres, but also by village governments as key actors in policy implementation at the local level. The village government plays an important role in translating the objectives of stunting prevention policies into program practices that are acceptable and feasible for the community. This understanding is reflected in the way the village government positions PMT as part of a continuous effort to help children overcome stunting, rather than merely as a short-term food assistance program.

The village government demonstrated a good understanding of the program's goals and objectives through its involvement in the process of determining PMT beneficiaries. Together with Posyandu cadres and health center staff, the village government was involved in verifying data on stunted children based on anthropometric measurements and health records. This involvement is not only administrative in nature, but also serves to ensure that the PMT program truly targets children who need nutritional intervention, so that the program's objectives can be achieved in a more targeted manner.

Understanding of the program's objectives is also reflected in the way implementing actors, including village governments, interpret PMT as part of a series of integrated interventions to address stunting. Posyandu cadres and health center staff are technically

responsible for identifying children's nutritional status and monitoring their growth and development, while village governments play a role in ensuring the sustainability of interventions through local policy support, facilitation of cross-actor coordination, and strengthening the participation of target families. This synergy of roles shows that the implementers have a shared understanding of the program's objectives, namely to encourage gradual improvement in children's nutritional status until they are no longer stunted.

Furthermore, understanding of the program's objectives is also evident in the follow-up mechanism implemented when PMT has not yielded optimal results. If children receiving PMT are still stunted after a certain intervention period, Posyandu cadres and village midwives will refer the families for further examination at the health center. The village government supports this mechanism by encouraging families to comply with health service referrals and facilitating access to follow-up services. In certain cases, children are then referred to hospitals, particularly to child growth and development services, to receive more comprehensive treatment.

Overall, these findings indicate that the actors implementing the PMT program in Babakan Village—including the village government, Posyandu cadres, and health workers—have a relatively consistent understanding of the program's objectives. The village government functions not only as an administrative organizer but also as an actor that ensures that the objectives of stunting prevention are understood, implemented, and followed up consistently at the community level. This shared understanding is an important foundation for the sustainability of PMT implementation and its integration with follow-up health services in stunting management in the village.

3.3 | Resource Availability and Utilization

The implementation of the PMT program in Babakan Village is supported by the availability and utilization of relatively adequate resources, both in terms of human resources, program logistics, and budgetary support. These three resource components complement each other and play a role in ensuring the sustainability of PMT implementation at the village level.

From a human resources perspective, the implementation of PMT involves various actors with complementary roles. Posyandu cadres play a role in data collection, PMT distribution, and monitoring consumption at the family level. Village midwives and health center staff are responsible for measuring nutritional status, monitoring child growth, and providing technical guidance related to toddler growth and development. Meanwhile, the village government plays a role in organizing the program, facilitating coordination between actors, and providing administrative and policy support at the local level. This division of roles enables the structured implementation of PMT, in which each actor performs their respective functions according to their authority. Collaboration between actors is also evident in their joint involvement in the PMT distribution process and target monitoring, so that the implementation of the program does not depend on one party alone, but is the result of collective work.

From a logistical standpoint, the PMT provided to stunted toddlers in Babakan Village is composed of local food ingredients that are readily available in the area. The use of local food ingredients facilitates the procurement, purchasing, and distribution processes, and allows for the adjustment of food types to the conditions and consumption habits of the community. The composition of the PMT package generally includes animal protein sources, such as chicken and eggs; energy sources in the form of rice; and sources of vitamins and minerals from infant formula (SGM), fruits, and vegetables. The PMT package is designed to meet the basic nutritional needs of stunted toddlers through a combination of macro and micro nutrients.

PMT distribution is carried out through two mechanisms. First, beneficiaries collect PMT packages directly at the village government office according to a predetermined schedule. Second, if PMT packages have not been collected, program implementers, particularly Posyandu cadres and village officials, voluntarily deliver PMT directly to the beneficiaries' homes. This mechanism is implemented to ensure that PMT is actually received by the target beneficiaries and is not delayed. The PMT storage and distribution mechanism is carried out directly, namely by purchasing foodstuffs and distributing them at the same time. This approach was chosen to minimize the risk of damage or spoilage of foodstuffs, given that most PMT consists of fresh food. PMT distribution is carried out regularly, once a month, according to a mutually agreed program schedule.

In terms of budgetary support, the implementation of PMT in Babakan Village is supported by funds allocated from the APBDes, particularly the Village Fund. The village government allocates this budget to support the procurement of PMT materials, distribution, and other supporting activities related to stunting prevention. In addition to the village fund, this study also found that there is funding support from other legitimate and non-binding sources. This support came from the involvement of the Environment Agency and contributions from universities, particularly IPB University, in the form of program and activity support for PMT implementation. The involvement of various parties strengthened resource support for the PMT program and enabled the village to implement the program more flexibly according to field needs. Overall, the availability and utilization of human resources, PMT logistics, and budgetary support indicate that the implementation of PMT in Babakan Village is supported by well-organized resources and collaboratively utilized by local implementing actors.

3.4 | Coordination and Communication Mechanisms

The coordination and communication mechanisms in the implementation of the PMT program in Babakan Village are carried out in stages and combine formal and informal communication patterns. This pattern enables connectivity between implementing actors at various levels of government and communities, while supporting the smooth operation of the program in the field. In the initial stage, PMT program coordination begins through structural relationships between health centers and village governments. The health center acts as the technical coordinator for the health sector, conveying program implementation directives, PMT technical standards, and target criteria to the village government. Communication at this stage is generally carried out through formal mechanisms, such as cross-sector coordination meetings, meetings at the sub-district or village level, and the delivery of circular letters and technical instructions that serve as a reference for program implementation at the local level.

At the village level, the village government functions as a coordination hub that bridges health sector policies and technical guidance with implementers at the community level. Information about the PMT program is conveyed to
Posyandu cadres and other village officials through regular village meetings, Posyandu meetings, and village deliberation forums. At this stage, communication is two-way. In addition to conveying program instructions and information, the village government also collects input from field implementers regarding the

conditions of the targets, implementation constraints, and the availability of resources. In day-to-day implementation, communication between PMT program implementers is mostly operational and informal. Posyandu cadres communicate directly with the village government and health workers to arrange PMT distribution schedules, monitor target attendance, and convey information regarding the compliance of beneficiary children with supplementary food consumption. Simple communication media, such as WhatsApp groups or text messages, are used as a means of rapid coordination between implementers, especially to convey schedule changes, logistical needs, and real-time reports on target conditions.

During the monitoring and evaluation stage, communication mechanisms are carried out more formally. Data on child nutritional status monitoring, target attendance rates, and PMT distribution implementation are compiled by Posyandu cadres and submitted to the village government and health center. This information is then discussed in periodic evaluation meetings held every three months at both the village and sub-district levels. These evaluation meetings provide a space to review program implementation, identify obstacles encountered, and formulate follow-up measures to improve PMT implementation in the next period. Overall, the coordination and communication mechanisms in the PMT program in Babakan Village demonstrate a layered, adaptive, and participatory pattern. The combination of formal bureaucratic channels and informal operational communication allows PMT implementation to remain aligned with health sector policies and standards, while also being responsive to the dynamics and needs at the field level.

3.5 | Roles and Commitment of Street-Level Implementers

The implementation of the PMT program in Babakan Village is largely determined by the role and commitment of field-level implementers, particularly Posyandu cadres and community health center staff. They are key actors who interact directly with the target community and serve as a link between macro-level health policies and the social reality at the community level.

Posyandu cadres play a fundamental role that is both technical and social in the implementation of the PMT program. On a regular basis, cadres are responsible for registering toddlers, weighing and measuring children's growth and development—including weight, height, and head circumference—as well as monitoring immunization status and early detection of children's health problems. These activities form the main foundation for determining the nutritional status of toddlers and setting appropriate PMT program targets. In addition to their technical role, Posyandu cadres also serve as health counselors and educators for the community. In this capacity, cadres convey information related to balanced nutrition, clean and healthy lifestyles, the importance of immunization, and proper child care practices. This education is not only conveyed during Posyandu activities, but also through informal interactions with parents of toddlers in their daily lives. The social closeness of cadres to the community makes health messages easier to accept and understand by target families.

Posyandu cadres also act as liaisons between the community and formal health workers from the community health center (puskesmas). They disseminate program information, facilitate access to health services, and help convey the conditions and needs of the community to health workers. In an administrative context, cadres act as recorders and reporters by documenting the results of Posyandu services in a register and compiling monthly activity reports that form the basis for program monitoring and evaluation at the village and puskesmas levels. In addition, cadres function as drivers of community participation by encouraging and motivating parents to actively bring their children to the Posyandu and to implement parenting patterns that support child growth and development, including in the implementation of PMT. The role of Posyandu cadres is strengthened by the active involvement of the puskesmas as a technical health institution. The health center acts as a supervisor and trainer of cadres, a provider of experts—especially nutritionists—and a technical implementer that ensures that the PMT program runs in accordance with health policy standards. The health center also provides nutrition education, assists in the early detection of nutritional problems in toddlers, monitors the implementation of PMT, and integrates the PMT program with other health services so that the nutritional interventions carried out are comprehensive and sustainable.

Field observations show that PMT program implementers are able to carry out their roles professionally and consistently. All actors clearly understand their respective tasks and responsibilities, so that program implementation runs smoothly without overlapping roles and is supported by good coordination between parties. The ability of implementers to adapt to the social and cultural characteristics of the local community is also an important factor in the successful implementation of the program. Since most of the implementers are part of the local community, they have a good understanding of the social dynamics, cultural values, and potential resistance of the community to the PMT program. In facing challenges in the field, including parental resistance to their children's stunting status or limited PMT consumption due to allergies and food preferences, the implementers showed initiative and flexibility in running the program. Various persuasive approaches are used to educate and engage target families, whether through adjusting the way information is conveyed, personal approaches, or providing alternative solutions that are still in line with the program's objectives. The implementers' commitment to service is evident in their daily practices. Posyandu cadres, for example, voluntarily delivered PMT packages to target households when parents were unable to attend the distribution location. Distribution times were also adjusted to accommodate the circumstances of beneficiary families. Flexibility in dealing with children who had allergies or refused certain foods showed that PMT implementation was not rigid, but rather tailored to the needs and circumstances of individual targets.

Overall, the role and commitment of street-level implementers in the PMT program in Babakan Village are key factors that support the sustainability and effectiveness of the program. Through a combination of clear roles, adaptability, and high personal commitment, field-level implementers are able to translate PMT policies into practices that are responsive to local conditions and oriented towards helping toddlers overcome stunting.

3.6 | Community and Family Responses to the Program

Target families in Babakan Village already have a fairly good level of initial awareness regarding the issue of stunting. The term stunting is not a completely foreign concept to the community, as most parents have learned about it through television reports, social media, and information provided by health workers and Posyandu cadres. This condition is an important social asset in supporting the PMT program socialization process and nutrition education. In various Posyandu activities, target families show relatively high participation, both in weighing and measuring their children's nutritional status and in receiving explanations about the objectives and mechanisms of the PMT program. At the initial stage of socialization, the majority of parents expressed their understanding that stunting is a serious health problem that needs to be addressed so that children can grow and develop optimally.

However, field findings also reveal complex social dynamics when the program enters the stage of determining children's nutritional status. Although parents generally understand the issue of stunting conceptually, different emotional responses arise when their children are officially categorized as stunted toddlers based on anthropometric measurements. In this situation, some parents show attitudes of rejection, anger, and non-acceptance of the stunting label attached to their children. These responses are not directed at the PMT program itself, but rather at the social meaning attached to stunting status in the local cultural context.

Researchers understand that in the social construction of local communities, stunting is not only perceived as a medical or nutritional problem, but also interpreted as a reflection of parents' failure to fulfill their parenting responsibilities. Children who experience stunting are often associated with parental negligence, lack of attention to food intake, or even extreme poverty. This perception makes stunting a symbol of social stigma and a "family disgrace" that is difficult to accept emotionally, even though in reality the condition can be influenced by various structural factors beyond the family's control. In this context, parental denial can be understood as a form of social defense mechanism to protect the family's dignity in the eyes of the surrounding community.

Although initially these emotional responses had the potential to hinder the implementation of the PMT program, the findings showed that the interpersonal approach taken by the posyandu cadres played a key role in managing family resistance. The cadres not only conveyed technical information about stunting and PMT, but also built empathetic and personal communication with parents. Through home visits, informal conversations, and ongoing assistance, the cadres gradually helped shift parents' perceptions that stunting is not a shame or individual fault, but rather a nutritional problem that can and needs to be addressed collectively through the support of families, communities, and the state.

This persuasive, non-confrontational approach proved effective in driving behavioral change among target families. Over time, parents began to show acceptance of their children's condition and became actively involved in the PMT program. All families with stunted children eventually expressed a willingness to cooperate, following the PMT distribution schedule, regularly attending integrated health post (Posyandu) activities, and receiving nutrition education from cadres and health workers. This high level of participation reflects a shift from initial resistance to more constructive and collaborative engagement.

Overall, the response of the community and families to the PMT program in Babakan Village shows that acceptance of the program is not only determined by the availability of assistance or the quality of nutritional interventions, but is also greatly influenced by social, cultural, and emotional dimensions. These findings confirm that the successful implementation of stunting prevention programs requires an approach that is sensitive to the local context, particularly in managing social stigma and building trust between program implementers and target families. Thus, the active involvement and humanistic approach of Posyandu cadres are crucial factors in bridging health policies with the social realities of communities at the community level.

3.7 | Perceived Program Outcomes in Stunting Management

The implementation of village-based PMT in Babakan Village has produced a number of initial outcomes that have been felt by program implementers and target families, although these achievements are still gradual and limited. These findings confirm that PMT functions more as a supportive intervention in addressing stunting, particularly in the early stages of nutritional status improvement, rather than as an instant solution for restoring children's linear growth.

Based on anthropometric data collected during the study period, most of the beneficiary toddlers were still in the stunting category, with height-for-age (HAZ) Z-scores predominantly below –2 standard deviations. This condition indicates that the stunting problem is chronic and has been going on for quite a long time. Therefore, the response to PMT intervention is not immediately reflected in short-term increases in children's height. This finding is in line with the understanding of program implementers that linear growth requires continuous, intensive intervention over a longer period of time.

Although the impact on linear growth remains limited, weight indicators show a more significant trend of improvement. Weight-for-age (W/A) and weight-for-height (W/H) data show that some toddlers are already in the normal weight category, while most are in the undernourished category, with a relatively small number of cases of severe malnutrition. The majority of toddlers receiving PMT experienced weight gain after participating in the program's monitoring series, although this increase is still relatively small and not enough to drive significant changes in overall nutritional status. These findings indicate that PMT has an initial positive impact on meeting children's energy and protein needs, which affects weight relatively more quickly than height.

The limited magnitude of outcomes achieved is also related to variations in the intensity of PMT intake, both in terms of quantity, frequency, and consistency of distribution. Program implementers acknowledge that PMT is supplementary and not intended to completely replace children's daily nutritional intake. Therefore, the impact is more protective, preventing further deterioration in nutritional status, rather than producing rapid and complete recovery. In this context, PMT serves as an initial buffer that helps maintain the nutritional stability of stunted toddlers.

At the family level, the PMT program's outcomes were more prominent in increasing parental awareness and involvement in monitoring child growth. Through active involvement in integrated health service post (Posyandu) activities and mentoring facilitated by the village government and Posyandu cadres, families gained a better understanding of their children's nutritional status, including the meaning of stunting and the importance of regular growth monitoring. This increased awareness was reflected in improved family compliance in bringing their children for regular weighing and measuring. Although significant changes in children's height were not yet visible, families began to observe positive changes in their children's weight, reinforcing the perception that nutritional improvement efforts were yielding results, albeit not instantaneous.

Furthermore, program-level outcomes are also evident in the increased legitimacy of PMT as a relevant and necessary intervention at the village level. The village government's role in coordinating growth monitoring, recording nutritional data, and strengthening family education contributes to the sustainability of PMT implementation. This support helps ensure more consistent monitoring of toddler weight gain, allowing even small changes to be detected and used as a basis for program evaluation.

Conceptually, the outcomes of the PMT program in this study can be understood as a multi-step process occurring at several levels simultaneously. At the child level, PMT serves as a protective intervention that helps prevent further decline in nutritional status. At the family level, the program encourages improvements in parental knowledge, attitudes, and behaviors regarding feeding practices and child growth monitoring. Meanwhile, at the program level, PMT provides empirical feedback that is crucial for improving the quality and sustainability of village-level policies. Therefore, despite limited outcomes, the village-based PMT program holds strategic value as a foundation for long-term interventions in addressing stunting, particularly when integrated with family nutrition education and ongoing growth monitoring.

4 | Discussion

4.1 | Policy Standards and Objectives

The PMT Program policy standards have been relatively clearly understood by implementing actors at the village level. This clarity is reflected in a uniform understanding of the program's targets, namely stunted and at-risk toddlers, and the program's orientation toward gradually improving children's nutritional status. This is in line with the view of Meter & Horn (1975), who emphasized that clarity of policy objectives is a crucial prerequisite for successful implementation. However, research results also indicate that the PMT policy objectives at the field level are understood more as short-term nutritional improvement efforts, specifically weight gain, rather than as interventions capable of rapidly reducing stunting. This understanding actually indicates a congruence between implementers' expectations and the supplementary nature of the PMT policy itself. Thus, although the national policy standards target accelerated stunting reduction, implementation at the village level realistically adapts these objectives to the program's limited duration and resources. This finding supports Meter & Horn (1975) argument that clarity of policy objectives and standards is a key prerequisite for successful implementation. When policy objectives are realistically understood by implementers, the policy is more likely to be implemented consistently, even if the final results are not fully achieved in the short term.

4.2 | Resources

The availability of resources is a crucial factor supporting the implementation of PMT in Babakan Village. Human resources, particularly integrated health post (Posyandu) cadres and community health center (Puskesmas) health workers, possess adequate technical capacity and are capable of carrying out complementary roles. This aligns with Meter & Horn (1975), who asserted that the adequacy and quality of resources significantly determine the success of policy implementation. From a logistical perspective, the use of local food in PMT packages has been shown to increase distribution efficiency and minimize the risk of food spoilage. Direct purchasing and direct distribution mechanisms also demonstrate the implementers' adaptability in managing limited storage infrastructure. Meanwhile, budget support from the Village Fund, as well as contributions from external parties such as other agencies and universities, strengthens the program's sustainability. These findings demonstrate that even when resources are scarce, flexible and contextual utilization allows the program to continue running smoothly. According to Meter & Horn (1975), resource limitations do not always hinder policy implementation if implementers are able to manage them efficiently and adaptively. The findings of this study indicate that the use of local food and flexible distribution are forms of resource adaptation that strengthen the sustainability of the PMT program at the village level.

4.3 | Inter-organizational Communication and Enforcement

The implementation of PMT in Babakan Village demonstrates a hierarchical and adaptive coordination pattern, involving the village government, community health center (Puskesmas), integrated health post (Posyandu) cadres, and other supporting actors. The village government acts as a local coordination node, bridging health policies with community needs. This pattern aligns with the concept of Meter & Horn (1975), which emphasizes the importance of inter-organizational communication in reducing policy distortions at the implementation level. The use of formal communication mechanisms (coordination meetings, written reports) combined with informal communication (WhatsApp groups, face-to-face communication) allows for a rapid response to field dynamics. These findings suggest that flexibility in coordination patterns actually strengthens implementation, particularly in the context of villages with administrative limitations.

4.4 | Street-Level Bureaucracy

The research findings strongly confirm the relevance of Lipsky (1980) street-level bureaucracy theory. Posyandu cadres and health workers act as field-level implementers with significant discretion in implementing the PMT program. This discretion is evident in various forms, such as adjusting PMT distribution times, delivering food to homes where targets are absent, and flexibility in dealing with children with food allergies or refusals. According to Lipsky (1980), field implementer discretion is not a policy deviation, but rather an inevitable adaptation mechanism in situations of limited resources and social complexity. In the context of this research, discretion is a key factor in maintaining the program's sustainability and increasing community acceptance of PMT.

4.5 | Disposition of Implementers

The attitude and commitment of the PMT program implementers are considered high. Posyandu cadres and health workers not only carry out administrative duties but also demonstrate a commitment to service through additional initiatives beyond formal obligations. This is reflected in their willingness to deliver PMT to target homes, take a personal approach to resistant families, and ensure that children are monitored despite facing social and cultural obstacles. The positive attitude and high commitment of program implementers align with the concept of policy disposition in the Meter & Horn (1975) model, which emphasizes that successful implementation is greatly influenced by the implementer's willingness to accept and implement the policy in accordance with its stated objectives. Meanwhile, Lipsky (1980) sees this commitment as part of the identity of field implementers who work under pressure and limitations, but still strive to fulfill policy objectives substantively.

4.6 | Social, Economic, and Political Environment

The sociocultural environment significantly influences the implementation of PMT. Although the community has become familiar with the term stunting through the media, resistance arises when stunting status is attached personally to children and families. The social stigma that views stunting as a family disgrace becomes an initial barrier to program acceptance. However, through a persuasive and personalized approach by Posyandu cadres, this resistance can be gradually managed. These findings indicate that the success of policy implementation is determined not only by program design, but also by the implementer's ability to understand and respond to the local sociocultural context. Meter & Horn (1975) also emphasize that the social and cultural environment can be a determining factor in the success or failure of policy implementation. In this study, the stigma against stunting presents an initial challenge, but it can be overcome through an

interpersonal approach by field implementers, as also explained in the street-level bureaucracy framework (Lipsky, 1980).

4.1 | The Meaning of Program Outcomes from a Policy Implementation Perspective

From a policy implementation theory perspective, the PMT outcomes in Babakan Village need to be understood realistically. The program's more rapid impact on weight indicators compared to height indicators indicates that policy implementation is proceeding according to the intervention's characteristics. Meter & Horn (1975) emphasized that implementation success is not always measured by the instant achievement of final goals, but by the extent to which the policy can be implemented consistently and produce gradual changes. Therefore, village-based PMT can be seen as the foundation for implementing long-term stunting management policies, where the role of village governments and field-level implementers is key to maintaining the program's sustainability and legitimacy. Therefore, PMT outcomes need to be understood as the gradual results of the policy implementation process, not solely as the achievement of final goals. This perspective is consistent with Meter & Horn (1975) view that implementation success is not always reflected in the achievement of immediate impacts, but in the consistency of the process and the sustainability of policy implementation.

5 | Conclusion

The implementation of the PMT Program and nutrition education in handling stunting in Babakan Village, by emphasizing the role of the village government and implementing actors at the field level, shows that the implementation of village-based PMT has been running relatively well in terms of the process, although the achievement of nutritional outcomes, especially the reduction in stunting status, is still gradual and limited.

From a policy implementation perspective, research findings indicate that clarity of program objectives, resource availability, cross-actor coordination mechanisms, and implementer commitment are key factors supporting the sustainability of the PMT program at the village level. Village governments play a strategic role as local coordination hubs, bridging national policies with the real needs of the community, while ensuring that the program can be implemented contextually and adaptively. This implementation pattern reinforces the view that the success of public policy at the grassroots level is highly dependent on village institutional capacity and its synergy with the health sector.

These results also confirm the relevance of street-level bureaucracy theory in the context of stunting management. Discretion exercised by integrated health post (Posyandu) cadres and health workers, such as flexibility in PMT distribution and a persuasive approach to target families, proved to be an important mechanism in overcoming resource limitations and sociocultural barriers. Rather than weakening the policy, this discretion actually strengthened the implementation process and increased program acceptance at the family level.

In terms of outcomes, village-based PMT (Food and Nutritional Supplements) made an initial contribution to improving the nutritional status of toddlers, particularly in terms of weight, although its impact on linear growth was still limited. These findings suggest that PMT functions more as a short-term protective and supportive intervention, halting the rate of child nutritional decline, rather than as a sole solution for stunting recovery. Therefore, program sustainability, improving the quality and consistency of PMT, and integrating it with family nutrition education and long-term growth monitoring are crucial prerequisites for achieving optimal impact.

Conceptually, this research contributes to the literature on public health policy implementation by demonstrating that stunting management at the village level is a gradual process influenced by the interaction between policy design, local capacity, and sociocultural dynamics. Village-based PMT programs not only produce nutritional outcomes but also build policy legitimacy, raise family awareness, and strengthen community capacity to address chronic malnutrition issues.

This study has limitations, including its focus on a single case study location and the use of a qualitative approach that was not intended to measure the program's quantitative impact. Therefore, future research is recommended to combine qualitative and quantitative approaches, expand the study locations, and explore the integration of PMT with other sensitive interventions to gain a more comprehensive understanding of stunting management at the local level.

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Conflicts of Interest

The authors declare no conflict of interest.

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