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Street-Level Bureaucrats and the Production of Stunting Data in the Implementation of Indonesia's Stunting Reduction Acceleration Policy

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Abstract

This study analyzes how Indonesia's stunting reduction acceleration policy is implemented in subdistricts and villages, focusing on how frontline implementers produce, transmit, and communicate stunting data. Most Indonesian implementation studies stop at checking Edwards III's four factors; this article extends that model with street-level bureaucracy and performance-measurement literature. This qualitative case study in one West Java subdistrict drew on nine informants (a subdistrict official, a health-center nutritionist, two village midwives, one human development cadre, and four mothers of children under five), supplemented by Toddler Weighing Month records. All four factors appeared to be met, yet three hidden tensions emerged. First, data flowed up to the district health office before returning to the subdistrict and villages, leaving the subdistrict to supervise while waiting for data. Second, weighing coverage was recorded at 100% (2,154 children) with a prevalence of 5.48%, although informants reported low attendance; full coverage was achieved through sweeping by cadres. Third, because parents resisted the label "stunting", workers substituted "growth problem", so the label the data system requires was avoided face to face. The article shows that administrative success can coexist with field-level fragility and treats the gap between routine surveillance and survey figures as an implementation problem.

Keywords: *Policy Implementation, Street-Level Bureaucracy, Stunting, Nutrition Surveillance Data, Stigma*

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1. Introduction

Stunting, defined as length- or height-for-age below −2 standard deviations of the World Health Organization growth standards (World Health Organization [WHO], 2006), remains one of Indonesia's most serious human development problems, as early undernutrition is associated with educational attainment, productivity, and adult health (Victora et al., 2008). The 2024 Indonesian Nutritional Status Survey (*Survei Status Gizi Indonesia*, SSGI) recorded a national prevalence of 19.8%, down from 21.5% in 2023 but still above the 14% target set by Presidential Regulation No. 72 of 2021. West Java accounts for the largest number of stunted children under five among the six priority provinces, approximately 638,000 (Badan Kebijakan Pembangunan Kesehatan, 2025).

Presidential Regulation No. 72 of 2021 defines the acceleration of stunting reduction as specific and sensitive interventions "implemented in a convergent, holistic, integrative, and high-quality manner through multisectoral cooperation at the central, regional, and village levels" (Article 1 point 4). The lowest layer of this convergence, consisting of the integrated health post (*Posyandu*), village midwives, community health cadres (*kader*), and village governments, is where policy meets families (World Bank, 2018). It is also where the data underpinning the planning cycle, including the stunting consultation forum (*rembuk stunting*), village fund allocation, and target identification, are first produced.

Indonesia, however, has two kinds of stunting figures that often differ widely: sample-based survey figures (the SSGI and the Indonesian Health Survey, *Survei Kesehatan Indonesia*, SKI) and routine surveillance figures from integrated health post weighing, recorded in the electronic community-based nutrition recording and reporting system (*elektronik Pencatatan dan Pelaporan Gizi Berbasis Masyarakat*, e-PPGBM) and in regional applications. The Coordinating Ministry for Human Development and Cultural Affairs (Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan, 2023) acknowledged that the gap reaches "almost 5–10 percent", exceeding 10 percent in some regions, and attributed it to sample coverage, cadres' measurement competence, and measuring instruments. In Temanggung, e-PPGBM prevalence was 13.5% against 25.1% in the 2023 SKI (Mayangsari & Ashar, 2026). The district studied here shows a similar pattern: 27.6% in the 2022 SSGI, the highest in West Java (Annur, 2023), against 8.27% (6,316 children) in *by name by address* weighing data; and 14.4% in the 2023 SKI against 7.89% (5,791 children) in weighing data (Andriyawan, 2024).

Studies of stunting policy implementation in Indonesia using the Edwards III model generally conclude that communication, resources, disposition, and bureaucratic structure are "already fairly good", with some constraints. This approach treats implementation success as the presence of factors rather than as implementers' everyday practice, and it rarely questions how the figures that signal success are produced. Yet public organizations assessed by indicators tend to direct their effort toward what is

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measured (Bevan & Hood, 2006), and frontline implementers adapt policy to the constraints and pressures they face (Lipsky, 2010).

This article therefore asks: how is the policy to accelerate stunting reduction implemented at the subdistrict (*kecamatan*) and village levels, and how do frontline implementers' data production and communication practices shape the picture of implementation success? It makes three contributions. First, it traces the hierarchical flow of stunting data and its effect on the role of the subdistrict. Second, it shows how full weighing coverage is achieved amid low routine participation. Third, it documents implementers' language strategies for avoiding stigma and their tension with the labeling that the data system requires.

2. Literature Review

2.1 Policy Implementation and the Edwards III Model

Edwards III (1980) positions implementation as the stage between a policy decision and its consequences for target groups and proposes four interacting factors: (1) communication, the transmission, clarity, and consistency of policy information; (2) resources, meaning staff, information, authority, and facilities; (3) disposition, implementers' attitudes and commitment; and (4) bureaucratic structure, standard operating procedures and fragmentation. The model is a useful initial map but top-down: it assumes a clear policy and looks for impeding factors. A convergence policy involving many actors and cadres' voluntary work needs a complementary lens from below.

2.2 Street-Level Bureaucrats

Lipsky (2010) shows that frontline workers operate with inadequate resources, growing demands, and ambiguous goals, and cope by developing routines and simplifications that ultimately become the policy citizens receive. Village midwives, community health center (*Puskesmas*) nutritionists, human development cadres (*Kader Pembangunan Manusia*, KPM), and integrated health post cadres are the street-level bureaucrats of the stunting program: they weigh, record, counsel, cook supplementary food, and deliver news that parents do not want to hear.

2.3 Performance Measurement and Surveillance Data

Target systems in health services can drive measurable improvement while encouraging behavior that adjusts to the indicators (Bevan & Hood, 2006). At the integrated health post level, the main stunting indicators are weighing coverage (D/S, children weighed divided by target children) and prevalence. A Pulse Lab Jakarta (2023) assessment of e-PPGBM found no uniform weighing and recording standard across integrated health posts, one nutritionist overseeing around 50 posts, limited connectivity, and data entry piling up at month's end. Community health centers use about 30 platforms on average, 49% of which require redundant data entry (Aisyah et al., 2025),

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and the precision of cadres' measurements depends on training, which tiered training improves (Suyatno et al., 2024).

2.4 Stunting Stigma

Some families regard stunting as congenital or hereditary and believe that the child will "grow on their own" (Rahmadiyah et al., 2024). In Garut, mothers of stunted children experienced self-stigma in the form of shame and self-blame, and some refused supplementary food assistance (Putri et al., 2025). This matters for implementation because the "stunting" label is the entry point for intervention: an unlabeled child does not become a target, whereas a label that families reject can distance them from services.

3. Research Method

Design and setting. This descriptive qualitative case study was conducted in Sukasari Subdistrict, Sumedang District, West Java, which comprises seven villages covering 40.43 km^2, with a 2023 population of 35,142 (17,894 men and 17,248 women), or about 869 people/km^2; about 70% of the land is agricultural. Sumedang was chosen because it operates a regional stunting information system (SIMPATI) cited as a national and international reference (OECD Observatory of Public Sector Innovation, 2024) and because it shows a large gap between survey and weighing figures.

Regulatory framework. Implementation draws on Presidential Regulation No. 72 of 2021; West Java Governor Regulation No. 107 of 2020; and Sumedang Regent Regulation No. 82 of 2019 on the Integrated Acceleration of Stunting Reduction and Prevention, which establishes a Holistic, Integrative, Thematic, and Spatial (HITS) approach with five pillars of convergence intervention.

Informants. Informants were selected purposively and assigned codes (Table 1). Implementers were interviewed in two villages, Sindangsari and Mekarsari.

Table 1. Research informants

Code	Position	Interview date
P1	Head of the Community Empowerment Section, subdistrict office	28 May 2025
P2	Nutritionist, subdistrict community health center	28 May 2025
P3	Village midwife (Sindangsari)	5 July 2025
P4	Village midwife (Mekarsari)	14 July 2025
P5	Human development cadre (KPM) (Mekarsari)	17 July 2025
M1	Mother of a child under five, Sindangsari, 31 years old, child aged 1.5 years	17 July 2025
M2	Mother of a child under five, Mekarsari, 29 years old, child aged 2 years	14 July 2025
M3	Mother of a child under five, Mekarsari, 35 years old	14 July 2025
M4	Mother of a child affected by stunting, study village	July 2025

Source: Research data, 2025.

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Data collection and analysis. Data were collected through recorded semi-structured interviews, observation of integrated health post activities, and documents, mainly the 2024 Toddler Weighing Month (*Bulan Penimbangan Balita*, BPB) recapitulation from the subdistrict community health center and the district recapitulation of stunted children from SIMPATI. Analysis followed data condensation, data display, and conclusion drawing and verification (Miles et al., 2014). First-cycle coding followed Edwards III's four factors; second-cycle coding searched for cross-cutting patterns, namely the data flow, the way coverage was achieved, and the language used with families. Credibility was maintained through source triangulation (implementers versus recipients) and method triangulation (interviews versus documents) (Lincoln & Guba, 1985).

Ethics. Informants gave oral consent before the interviews, the study was authorized by the subdistrict government, and informants' names are not reported.

4. Results

4.1 The Numbers: A Consistent Decline in Weighing Data

District weighing data show the number of stunted children falling from 6,316 in February–August 2022 to 4,992 in August 2024–February 2025, a decrease of 1,324 children or 21.0% (Table 2). The 2022 and 2023 prevalences match those published by the district government (8.27% and 7.89%; Andriyawan, 2024). The survey figure was 3.3 times the weighing figure in 2022 and 1.8 times in 2023: the gap has narrowed but remains large.

Table 2. Two sources of stunting figures at the district level

Period	Number of stunted children (weighing data, SIMPATI)	Prevalence, weighing data	Prevalence, survey
Feb–Aug 2022	6,316	8.27%	27.6% (2022 SSGI)
Aug 2022–Feb 2023	6,253	–	–
Feb–Aug 2023	5,791	7.89%	14.4% (2023 SKI)
Aug 2023–Feb 2024	5,842	–	–
Feb–Aug 2024	5,120	–	19.8% (2024 SSGI, national)
Aug 2024–Feb 2025	4,992	–	–

Source: Number of children from the SIMPATI application, processed by the authors; weighing-data prevalence and 2023 SKI from Andriyawan (2024); 2022 SSGI from Annur (2023); 2024 SSGI national figure from Badan Kebijakan Pembangunan Kesehatan (2025). A dash indicates that no figure was published for that period.

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At the subdistrict level, the 2024 BPB recorded 118 stunted children out of 2,154 target children, or 5.48%, with 100% weighing coverage (D/S) in every village (Table 3). Prevalence varied more than twofold, from 3.38% in Genteng to 8.44% in Banyuresmi, the village with the fewest target children.

Table 3. Results of the 2024 Toddler Weighing Month by village

Village	Target (S)	Weighed (D)	D/S (%)	Stunted (n)	Stunted (%)
Sukasari	359	359	100.00	24	6.69
Genteng	385	385	100.00	13	3.38
Banyuresmi	154	154	100.00	13	8.44
Nanggerang	258	258	100.00	16	6.20
Sindangsari	372	372	100.00	20	5.38
Mekarsari	258	258	100.00	12	4.65
Sukarapih	368	368	100.00	20	5.43
Subdistrict	2,154	2,154	100.00	118	5.48

Source: UPTD Puskesmas Sukasari (Sukasari Community Health Center technical implementation unit), processed by the authors.

Implementers read these figures as evidence of success, and the initial assessment in this study likewise judged communication effective, "evidenced by the decline in stunting figures" from 162 cases in the previous weighing recapitulation to 118 in the 2024 BPB.

4.2 Edwards III's Four Factors: The Surface Picture

Communication. Outreach used many channels: the prospective-bride-and-groom program, adolescent integrated health posts, monthly counseling at schools and integrated health posts, classes for pregnant women and for mothers of children under five, and home visits (P1, P3, P5). M1 learned from integrated health post counseling and the mothers' class "that stunting isn't just about a child being short, it can also affect their intelligence." M2 received home visits "once or twice a month", including training in making nutritious food from simple ingredients.

Resources. All integrated health posts had standard anthropometric equipment (scales, length and height boards, and mid-upper-arm circumference tapes), "on loan from the [district health] office" (P2). Supplementary feeding (*Pemberian Makanan Tambahan*, PMT) was funded from the Village Fund Allocation (*Alokasi Dana Desa*), the community health center's Health Operational Assistance (*Bantuan Operasional Kesehatan*, BOK), and the district population control and family planning office; it could be provided up to four times a year, and the community health center's program ran for 56 consecutive days (P3). Cadre and KPM training was budgeted by the village through the stunting consultation forum (P1). Mekarsari had 26–28 cadres, including KPMs, whereas some integrated health posts had only four, "helped by active volunteers even though they are not registered as official cadres" (P4).

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Disposition. Implementers went beyond minimum duties. The community health center formed peer cadres in schools to monitor iron supplement consumption, mobilized adolescent cadres to reach out-of-school adolescents, and asked village cadres to sweep for children who had not attended (P2). Cadres cooked supplementary food daily to a set menu, and the village head was described as "going down personally to monitor the program" (P4).

Bureaucratic structure. The subdistrict acceleration team was chaired by the subdistrict head (*camat*), assisted by the subdistrict secretary, and worked with the community health center (P1). Evaluation took place every three months through cross-sectoral mini-workshops (*lokakarya mini*) (P1, P4). Anthropometric data were entered into an integrated nutrition application that classified nutritional status automatically (P1, P3, P4), whereas KPMs reported monthly through e-HDW (P5).

Read separately, these findings suggest "fairly effective" implementation. Cross-factor analysis revealed three tensions that this checklist misses.

4.3 First Tension: Data Flow Up Before Coming Back Down

The community health center nutritionist explained the data flow after the BPB:

"The data we collect are processed first at the community health center. After that, we send the validated results to the District Health Office. From there, we can't immediately inform the village or the subdistrict, because we have to wait for official information from the office first. [...] Once all that is done, then we pass the information on to the subdistrict and the villages in our working area." (P2)

The subdistrict official described the receiving end: "the data are processed first by the community health center, and only after they've been processed … do we receive the data" (P1). Centralized processing keeps official figures consistent, but it leaves the subdistrict, which formally leads the acceleration team, waiting; in practice it "mostly acts only as a supervisor" (researcher's observation notes). Villages that fund supplementary feeding and cadre training from their own budgets receive official figures about their own areas only after district validation and cross-unit dissemination, and the BPB itself is held only twice a year, in February and August (P3).

Beneath this official flow, implementers work with several systems at once: the integrated nutrition application, e-HDW, and e-PPGBM for national reporting. e-PPGBM often suffers from slow servers, unstable networks, and limited operator skills, so "manual recording is still used as a backup" (P2), consistent with the national picture of platform fragmentation and data-entry burden (Aisyah et al., 2025; Pulse Lab Jakarta, 2023).

4.4 Second Tension: 100% Coverage Amid Low Attendance

Despite 100% coverage in every village, the nutritionist identified the main challenge in the under-five phase as "parents' low participation in bringing their children to the

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integrated health post regularly" (P2), and low attendance was also the first barrier identified in this study. Both hold because of how coverage is achieved:

"On the other hand, cadres in the village are also asked to do sweeping for children who don't come to the integrated health post, or at least make sure the child's growth and development data are recorded from other health services such as the village midwife, private practices, or hospitals." (P2)

Full coverage thus reflects cadres' additional work, visiting homes, measuring outside the integrated health post, or collecting records from other facilities, rather than voluntary family participation. This has two implications. First, a D/S of 100% conceals the cadres' workload; some are volunteers "not registered as official cadres" (P4), and others were recently replaced and "have not been properly trained to operate the equipment" (P1). Second, measurements taken at home or obtained elsewhere are made under more varied conditions, widening the scope for inaccuracy. This is one source of the gap noted by the Coordinating Ministry (Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan, 2023), and one that measurement training can reduce (Suyatno et al., 2024).

Without microdata, and with national surveys not designed for subdistrict estimation, this study cannot test whether the 5.48% prevalence is too low. What it shows is that the figure emerges from a process heavily dependent on cadres, and that the corresponding district figures are consistently lower than survey figures (Table 2).

4.5 Third Tension: A Label the System Needs but Conversation Avoids

The subdistrict official admitted:

"However, the biggest challenge is still the community's low awareness, including some parents' reluctance to accept information that their child is stunted." (P1)

One mother whose child was affected explained: "maybe the reason [my child] is not tall enough and his weight is low is that it's been there since birth; [he] eats well, too" (M4), although she attended the integrated health post regularly and received assistance. The nutritionist instead framed the problem as parenting, with parents "too busy watching TikTok, so the child gets less attention" (P2). Implementers and families thus held different causal explanations.

Implementers responded with a language strategy. Cadres and health workers were trained not to call a child "stunted" but to say "growth problem" or "the child has not yet reached the ideal height for their age", with an approach that is "culturally and psychologically sensitive, without making parents feel offended or ashamed" (P2). The strategy is reasonable, given that mothers ashamed of the label may refuse supplementary feeding (Putri et al., 2025). Yet it creates two languages: inside the system, the application classifies the child as "below −2 SD" and counts a case; in front of the family, the condition is softened. This gap risks reinforcing the belief that the condition is congenital and will improve on its own (Rahmadiyah et al., 2024).

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4.6 Operational Barriers

Informants also mentioned four operational barriers. (1) Cadre turnover: new cadres had not been trained to use anthropometric equipment (P1). (2) Low compliance among target groups: adolescent girls' iron supplement consumption was hard to monitor because it depended on schools, and some pregnant women avoided supplements because of nausea (P2). (3) Unstable supplementary feeding: M3 received it "four times, so once a week", but "in some months the supplementary feeding is only twice, especially when the food stock from the village or the community health center isn't available yet" (M3), consistent with financing from several budget sources with different schedules (P3). (4) Uneven knowledge of supplementary feeding management: a village midwife said its technical management "needs to be confirmed directly with the village" (P4), indicating that health implementers did not fully know their villages' nutrition programs.

5. Discussion

Read only through Edwards III's (1980) four factors, this case appears fairly successful. The findings indicate that such a checklist needs to be supplemented by questions about how the factors work in practice and for whom.

First, bureaucratic structure concerns not only procedures but also the direction of information flow. Edwards III discusses fragmentation as a barrier; this case shows a different form, centralized validation, in which data produced in the village are validated at the district and then returned. This yields uniform official figures, which matter for rankings and awards. As a consequence, the actors closest to the problem wait for data about their own areas even though they are expected to lead convergence and finance interventions, and with the BPB held twice a year the feedback cycle is long. The regional digital innovation claimed to produce real-time data (OECD Observatory of Public Sector Innovation, 2024) has not yet fully changed implementers' experience at the subdistrict level; an earlier study of the same platform likewise found information management not yet well integrated (Husni, 2023).

Second, success on indicators is achieved through unrecorded frontline work. Full coverage amid low attendance illustrates how organizations direct effort toward what is measured (Bevan & Hood, 2006). The data give no indication of manipulation; they show cadres' extra work to meet the indicator. In Lipsky's (2010) terms, sweeping is a coping routine that ensures every child is "recorded" even when the family does not come, at a cost borne by cadres, some unofficial volunteers and others new and untrained. Highly complete weighing figures should therefore be read as a measure of cadre effort, not of family participation.

Third, surveillance and survey figures measure different things, and the difference is institutional. The district gap (8.27% versus 27.6% in 2022; 7.89% versus 14.4% in 2023) resembles findings elsewhere (Mayangsari & Ashar, 2026). Beyond the technical causes already acknowledged by the central government, namely cadre competence,

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equipment, and coverage, this article adds administrative causes: measurement conditions vary because of sweeping, cadres turn over, and implementers have an incentive to show improvement. Because surveys are meant to evaluate prevalence and e-PPGBM to monitor individual growth (Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan, 2023), regional claims comparing baseline-year survey prevalence with current-year weighing prevalence should be read with caution.

Fourth, policy communication faces a dilemma between legibility and acceptance. The data system needs a clear-cut label for a child to become a target; families need language that does not shame them so that they keep coming. Frontline implementers resolve this by using two languages, which maintains relationships with families and follows recommendations not to disclose a child's condition in public (Putri et al., 2025). However, it can blur the message that stunting requires changes in caregiving practices and is not congenital. Communication that is clear and consistent in Edwards III's sense is hard to achieve when implementers deliberately soften the message.

Policy implications. (1) Read both figures side by side: district governments should present weighing and survey figures together in performance documents and explain the gap, rather than choosing the most favorable figure. (2) Speed up feedback: village- and child-level weighing data should be accessible to the subdistrict and villages once the community health center has validated them, while district validation continues to apply to official figures. (3) Provide tiered, periodic measurement training, especially for new cadres and volunteers, using the train-the-trainer model already proven effective (Suyatno et al., 2024), and recognize sweeping work in cadre incentives. (4) Develop, together with cadres, a stigma-sensitive yet honest communication protocol that explains causes and corrective steps without shaming families.

Limitations. (1) Interviews with village implementers covered only two of the seven villages and excluded the village with the highest prevalence. (2) Few mothers were interviewed, all active integrated health post participants; non-attending families, precisely the targets of sweeping, were not represented. (3) Without microdata, measurement accuracy could not be tested, and the quantitative data were limited to administrative recapitulations. Future research could compare cadre measurements with those of trained personnel on the same children and interview families who do not attend the integrated health post.

6. Conclusion

Implementation in the subdistrict studied met Edwards III's four factors and produced steadily improving weighing figures, yet three tensions lie behind this picture: (1) a hierarchical data flow leaves the subdistrict and villages waiting for information about their own areas; (2) 100% weighing coverage is achieved through cadre sweeping amid low routine participation; and (3) implementers avoid the stunting label with families, while the data system depends on it.

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Implementation success therefore cannot be judged from the presence of factors and administrative figures alone; an assessment must also consider who carries the work behind the figures and what is lost when they are read without a comparison figure. Theoretically, the article shows the value of combining the Edwards III model with the street-level bureaucracy perspective and the performance-measurement literature when studying convergence policies that rely on data and cadres.

Declarations

Manuscript origin. This article was developed from the undergraduate thesis of Rendi Aji Ramdhani, "Implementasi Kebijakan Percepatan Penurunan dan Pencegahan Stunting di Kecamatan Sukasari Kabupaten Sumedang" [Implementation of the Policy to Accelerate Stunting Reduction and Prevention in Sukasari Subdistrict, Sumedang District], Public Administration Study Program, Universitas Al-Ghifari (2025). The analysis of data flow, coverage, and stigma, and the comparison with survey figures, were developed for this article.

Author contributions. Kurhayadi: conceptualisation, methodology, supervision, writing (review and editing). Rendi Aji Ramdhani: data collection, formal analysis, writing (original draft). Dudung Ahmad Suganda: validation, writing (review and editing). Jamaliah Said: public sector accountability and data governance perspective, writing (review and editing).

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Conflict of interest. The authors declare no conflict of interest.

Ethical considerations. The study was conducted with authorization from the subdistrict government, and all informants gave oral informed consent before the interviews. Informants' names are not reported.

Data availability. Interview transcripts are not publicly available to protect informant confidentiality. The administrative recapitulations used in Tables 2 and 3 are available from the corresponding author on reasonable request.

Use of generative AI. Generative artificial intelligence tools were used to assist in restructuring the thesis into an article draft, in language editing and translation into English, and in literature searching. The authors reviewed all data, quotations, and interpretations and take full responsibility for the content of this article.

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