

The Role of Family Assistance Teams in the Implementation of the Stunting Reduction Acceleration Program: (A Comparative Study of Six Subdistricts in Bogor Regency)

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ABSTRACT

This study analyzes the role of Family Assistance Teams (Tim Pendamping Keluarga/TPK) in implementing the Stunting Reduction Acceleration Program across six subdistricts of Bogor Regency: Gunungputri, Bojonggede, Citeureup, Jasinga, Cigombong, and Cariu. A mixed-methods approach with a sequential explanatory design was employed. Quantitative data were collected through a census survey involving 2,436 TPK members from 812 teams, complemented by interviews, focus group discussions, participant observation, and document analysis. The analysis employed the policy implementation frameworks of Van Meter and Van Horn, Sabatier and Mazmanian, and policy network theory. The findings indicate that overall implementation falls within the good to very good categories, but follows a “U-shaped” pattern across the First 1,000 Days of Life cycle. The highest achievement was found in pregnancy assistance (97.0%) and food assistance facilitation (96.0%), while the lowest occurred in premarital screening (74.0%) and postpartum assistance (75.0%). Comparative workload analysis revealed substantial differences among subdistricts, with Cigombong and Cariu recording the highest average caseloads per team at 199.5 and 194.4 families, respectively. Key enabling factors include uniform basic competency, clear policy structures, established health-sector coordination, institutional support, and digital information systems. Major constraints include weak TPK-KUA coordination, uneven workloads, and limitations in digital reporting. The study proposes a five-component strengthening model covering premarital screening integration, structured postpartum visits, workload-based TPK redistribution, digital reporting capacity, and subdistrict-level cross-sector coordination forums.

1. INTRODUCTION

Reducing stunting has become one of Indonesia's top priorities in human resource development, with national targets of 14.4% by 2029 and 5% by 2045, in line with the 2025–2045 National Medium-Term Development Plan (Secretariat of the Vice President of the Republic of Indonesia, 2024). Stunting, which refers to growth failure resulting from chronic malnutrition during the First 1,000 Days of Life, is largely irreversible once a child reaches the age of two. Consequently, the effective window for intervention is highly limited, making preventive approaches considerably more strategic than curative interventions after the condition has developed. The national prevalence of stunting declined from 30.8% in 2018 to 21.6% in 2023 (Ministry of Health of the Republic of Indonesia, 2021, 2023); however, it remains above the national development target, indicating that reducing stunting requires sustained multisectoral approaches extending to the family level.

Bogor Regency, as the most populous regency in West Java, covers an area of 2,991.78 km² encompassing densely populated urban areas, urban fringes, and mountainous rural regions. The regency successfully reduced its stunting prevalence from 35.0% in 2019 to 18.9% in 2024 (Bogor Regency Stunting Prevention and Accelerated Reduction Team, 2025). Nevertheless, this aggregate achievement masks variations in implementation at the operational level that have not been sufficiently examined through empirical and comparative studies. One of the key components of the program is the Family Assistance Team (Tim Pendamping Keluarga/TPK), a three-member team consisting of a midwife, a Family Welfare Empowerment (PKK) cadre, and a Family Planning cadre. The teams provide assistance to prospective couples, pregnant women, postpartum mothers, and families with children under five in the early detection and prevention of stunting risks (National Population and Family Planning Agency, 2021). In Bogor Regency, 4,179 TPK teams are distributed across 40 subdistricts, with considerable variation in the number of teams, ranging from 40 teams in Cariu Subdistrict to 280 teams in Cibinong Subdistrict. This variation indicates that TPK workloads and the complexity of coordination are strongly influenced by the demographic characteristics of each area.

A preliminary survey involving 2,436 TPK members in the six study subdistricts revealed a striking initial disparity: only 74.0% of respondents routinely performed premarital screening functions, considerably lower than the 97.0% recorded for assistance to pregnant women. This 23-percentage-point gap indicates an implementation problem that requires further investigation. In addition, priority-target data demonstrated variation in the target-family-to-TPK ratio across subdistricts, ranging from 163 to 199 families per team, suggesting that increases in the number of TPK teams have not yet been fully proportional to actual workloads.

Previous studies on the implementation of stunting reduction programs have generally employed qualitative case-study approaches within a single geographical area (Sari & Wijaya, 2022; Pratiwi & Hidayat, 2023; Santoso & Wijaya, 2023), emphasizing community participation, intensity of assistance, or qualitative enabling and constraining factors. Kurniawati and Rahayu (2023)

identified variations in achievements among regencies and municipalities in East Java influenced by human resource capacity, budgets, and intersectoral coordination. However, their unit of analysis was the regency or municipality rather than individual implementation teams.

Based on the literature reviewed, no previous study has combined population-scale survey data covering all active TPK members across multiple subdistricts with a comparative analysis of workload ratios among areas within a single regency. Although the study by Santoso and Wijaya (2023) was also conducted in Bogor Regency, it did not incorporate population-scale quantitative data or comparative analysis across subdistricts.

The research gap addressed by this study lies in three areas. First, with respect to the unit of analysis, previous studies have generally treated target families or regencies/municipalities as the unit of analysis rather than TPK teams as street-level implementers. Second, methodologically, no previous TPK study has employed census data rather than a sample of the active TPK population. Third, in terms of geographical coverage, existing TPK studies in Bogor Regency have not conducted comparative analyses across subdistricts.

This study addresses these three gaps by using census data from 2,436 TPK members representing 812 teams in six subdistricts covering the four administrative regions of Bogor Regency: Gunungputri and Bojonggede in northern Bogor, Cigombong in southern Bogor, Jasinga in western Bogor, Cariu in eastern Bogor, and Citeureup as an industrial-urban subdistrict with the largest number of prospective couples. The data are analyzed using a combination of the policy implementation theories of Van Meter and Van Horn (1975), Sabatier and Mazmanian (1980), and the policy network theory of Klijn and Koppenjan (2000).

The significance of this study is further reinforced by West Java's position as the province with the largest absolute number of stunting cases in Indonesia despite having a moderate prevalence rate. Bogor Regency, as the most populous regency in the province, illustrates a policy dilemma between a prevalence-based approach and an absolute population-scale approach. Subdistricts with relatively controlled prevalence but large populations, such as Gunungputri and Bojonggede, still require substantial TPK resources in absolute terms, whereas subdistricts with smaller populations but higher caseload ratios per team, such as Cigombong and Cariu, require a different proportional policy response.

The study was also conducted during the institutional transition from the National Population and Family Planning Board (National Population and Family Planning Agency (BKKBN)) to the Ministry of Population and Family Development (Ministry of Population and Family Development /Kemendukbangga). Its findings therefore provide an overview of TPK implementation conditions following this institutional transformation.

Based on the above considerations, this study aims to: (1) describe and analyze the implementation process of the Stunting Reduction Acceleration Program by TPK teams in six subdistricts of Bogor Regency; (2) identify enabling and constraining factors affecting TPK performance; and (3) formulate a model

for strengthening the role of TPK based on empirical findings, including a comparative analysis of workload ratios across subdistricts.

The novelty of the study lies in four dimensions. First, it makes a theoretical contribution through empirical elaboration of Van Meter and Van Horn's (1975) theory within the context of family-based implementing agents, which has rarely been quantitatively tested in the Indonesian health policy implementation literature. Second, it offers a methodological contribution through the use of population survey data rather than sample data, combined with official secondary data. Third, it provides an empirical contribution through its coverage of six subdistricts representing the four administrative regions of Bogor Regency. Fourth, it offers a practical contribution through a strengthening model based on actual workload ratios in each subdistrict rather than generic recommendations applied uniformly across areas.

2. RESEARCH METHODS

This study employed a mixed-methods approach with a sequential explanatory strategy, in which quantitative data were collected and analyzed first through a structured survey of the TPK population, followed by in-depth interviews and Focus Group Discussions (FGDs) to explore the context underlying the quantitative patterns identified (Creswell & Plano Clark, 2011). The design placed greater weight on the quantitative component (QUAN → qual). All conclusions addressing the first and second research questions were grounded in population-scale survey data, whereas the qualitative component served to deepen and triangulate the interpretation.

The study was conducted in six subdistricts of Bogor Regency—Gunungputri, Bojonggede, Citeureup, Jasinga, Cigombong, and Cariu—which were purposively selected based on three considerations: representation of the four administrative regions; variation in demographic characteristics and target populations, ranging from 7,776 target families in Cariu to 39,749 families in Gunungputri; and the availability of secondary data that had been verified and validated through the Family Information System (SIGA).

The selection was purposive and was not intended to proportionally represent all 40 subdistricts. Therefore, generalization to subdistricts with extreme TPK scales, such as Cibinong with 280 TPK teams, should be made with caution. The study was conducted from January to June 2026 and covered instrument preparation, primary and secondary data collection, analysis, and report preparation.

The quantitative population consisted of all 812 active TPK teams, comprising 2,436 members, in the six subdistricts during the study period. All members participated as respondents through a census or total-sampling technique rather than probabilistic sampling.

The use of a census rather than a sample offered two advantages. First, all reported achievement figures represent actual population parameters without a margin of sampling error. Second, it enabled precise comparisons across subdistricts because the data included all TPK members in each area.

The qualitative component involved informants selected through purposive and snowball sampling from five stakeholder categories: TPK

members, government officials or officers, health professionals, program beneficiaries, and community leaders. Approximately 25–30 informants were expected to be involved until data saturation was reached, with efforts made to ensure representation across all six subdistricts.

The quantitative instrument consisted of a structured checklist containing eleven statements regarding the implementation of core TPK responsibilities. It was developed based on five task groups contained in the official Kemendukbangga training module: competency/certification, premarital screening, assistance for pregnant women, postpartum assistance, parenting and growth-and-development assistance for children under two, facilitation of food assistance, and recording/reporting as well as cross-sector coordination.

Each statement employed a three-point ordinal scale: Routinely, Sometimes, and Never. The instrument underwent a content-validity review against the official training module.

The qualitative instruments consisted of semi-structured interview guidelines containing three open-ended questions concerning the effectiveness of the TPK role, field constraints, and recommendations for improvement. These were supplemented by participant observation of home visits, collective village activities, and subdistrict coordination forums, as well as analysis of national and regional policy documents.

Quantitative data were analyzed using descriptive statistics in the form of frequencies and percentages for each indicator, as well as comparative ratios across subdistricts, including priority targets per team, verified-and-validated targets per team, and prospective-couple targets per team. No inferential significance testing was performed because the data constituted a census rather than a probabilistic sample.

Each instrument indicator was explicitly operationalized against the variables of Van Meter and Van Horn's (1975) theory to ensure consistency between the theoretical framework and empirical measurement.

The qualitative data were designed to be analyzed using the interactive approach of Miles, Huberman, and Saldaña (2014), involving data reduction, data display, and conclusion drawing/verification, with preliminary coding categories of effectiveness, constraints, and expectations cross-referenced against the six variables of Van Meter and Van Horn.

As a methodological limitation, it should be transparently stated that at the time this manuscript was prepared, verbatim transcripts of the interviews and FGDs had not yet been fully completed. Consequently, comprehensive thematic qualitative triangulation remained in progress. This article therefore presents complete quantitative analysis enriched by contextual interpretation based on secondary documents and theoretical frameworks, while full qualitative triangulation remains an area for further refinement.

The validity of the quantitative data was maintained through content validity and cross-verification with official data from the Bogor Regency Stunting Prevention and Reduction Acceleration Team (2025) and Kemendukbangga SIGA (2026), which demonstrated consistency in figures across all study subdistricts.

Research ethics included informed consent, confidentiality of qualitative informants' identities, and presentation of survey data in aggregate form at the subdistrict level to preserve individual respondent anonymity.

3. RESULTS AND DISCUSSION

3.1 Implementation Achievement Patterns: The "U-Shaped" Phenomenon throughout the Assistance Cycle

The survey of 2,436 TPK members revealed a non-uniform implementation pattern across the eleven core tasks, with routine achievement levels ranging from 74.0% to 100.0%. This 26-percentage-point range demonstrates that the program performs very well in some functions but requires particular attention in others.

Table 1 summarizes achievements in key indicators representing each phase of the First 1,000 Days of Life cycle.

Table 1. Achievement of TPK Core Task Implementation at Key Points in the Assistance Cycle (n = 2,436)

Cycle Phase	Indicator	Routine Achievement (%)	Category
Premarital	Screening of prospective couples	74.0	Moderate (weak point)
Pregnancy	Assistance for pregnant women	97.0	Very Good (peak)
Postpartum	Assistance for postpartum mothers	75.0	Moderate (weak point)
Infants & Children Under Two	Parenting, exclusive breastfeeding, complementary feeding, immunization	89.0–94.0	Good–Very Good (recovery)
Cross-phase	Training of Trainers (TOT) certification/basic competency	100.0	Very Good
Cross-phase	Facilitation of food/nutrition assistance	96.0	Very Good
Cross-phase	Digital recording/reporting (Elsimil/Siga Mobile)	88.0	Good

Cycle Phase	Indicator	Routine Achievement (%)	Category
Cross-phase	Cross-sector coordination	91.0	Good

Source: Processed from primary research data (2026).

The pattern presented in Table 1 forms what this study refers to as a “U-shaped pattern”: achievement is high during pregnancy, declines significantly at two transition points—entry into the cycle during the premarital phase and the transition out of pregnancy during the postpartum phase—and subsequently recovers during the child-care phase.

These two weak points may conceptually be described as “cycle vulnerability points,” namely moments when assistance responsibilities shift between service focuses and therefore require explicit handover mechanisms to prevent disruptions in continuity. The implication is that future TPK strengthening efforts should specifically target these transition points rather than merely reinforcing the implementation of individual tasks within each phase separately.

The perfect Training of Trainers (TOT) certification rate of 100.0% demonstrates that all respondents had equivalent basic competencies before performing their duties. Therefore, variation in achievement across the other ten indicators is more likely to be explained by structural and contextual factors than by differences in individual competency.

This finding also challenges a common assumption in training-program evaluation that formal completion or certification automatically translates into consistent field performance. The gap between training inputs and performance outputs should be addressed through training focused on specific competencies rather than relying solely on general certification.

3.2 Theoretical Explanation of Variations in Achievement

Viewed through Van Meter and Van Horn’s (1975) policy implementation theory, the six implementation variables—policy standards and objectives, resources, interorganizational communication, characteristics of implementing agencies, disposition, and socioeconomic and political conditions—do not operate additively but interact with one another.

The high level of achievement in assistance for pregnant women (97.0%) is the product of interaction among clear policy standards, long-established midwifery resources through the Maternal and Child Health Program, mature communication with Community Health Centers (Puskesmas), and strong implementer disposition because the immediate benefits are visible to target families.

Conversely, the relatively low achievement in premarital screening (74.0%) reflects a negative interaction between underdeveloped interorganizational communication—particularly the relatively new relationship between TPK and the Religious Affairs Office (KUA)—and an implementer

disposition that has not yet become as strong as for tasks whose benefits are more immediately visible.

Sabatier and Mazmanian's (1980) framework explains this pattern through the dimension of statutory tractability. Functions with clear implementation structures and standardized delivery mechanisms, such as facilitation of food and nutrition assistance supported by structured beneficiary databases through regional initiatives such as the Free Nutritious Meals Program, recorded a high achievement rate of 96.0%.

In contrast, functions dependent on cross-institutional coordination that has not yet been formally structured, such as premarital screening requiring collaboration with KUA, recorded lower achievement. This reinforces the proposition that clarity of statutory structure influences successful implementation at the operational level.

The policy network theory of Klijn and Koppenjan (2000) complements these two frameworks by highlighting the maturity of relationships among actors. Coordination between TPK and the health sector, including Puskesmas and village midwives, represents a network that has long been established through the Family Planning Program and achieved a routine coordination rate of 91.0%.

In comparison, coordination with KUA, which has only relatively recently been integrated into the stunting-prevention framework, recorded considerably lower levels of achievement. This pattern is consistent with the proposition that network density and maturity developed over time result in more effective coordination than relatively new institutional relationships.

The finding emphasizes the need for deliberate and planned network management to develop formal coordination forums involving TPK, KUA, Puskesmas, and village governments.

The three theoretical frameworks are used complementarily rather than interchangeably. Van Meter and Van Horn are most relevant for explaining variations in achievement at the level of individual TPK tasks. Sabatier and Mazmanian explain why certain types of tasks are easier to implement than others. Meanwhile, policy network theory explains differences in the maturity of TPK coordination with cross-sector partners.

The finding concerning differences in policy-network maturity between the TPK-Puskesmas node and the TPK-KUA node extends the conceptual analysis of Wibowo and Susanto (2021) on the importance of interagency coordination in health policy implementation by providing concrete quantitative evidence of how the age and maturity of an institutional relationship correlate with compliance in performing tasks dependent on that relationship.

Meanwhile, the "U-shaped" pattern throughout the assistance cycle complements Pratiwi and Hidayat's (2023) finding regarding the importance of intensity and continuity in family assistance by identifying specifically where such continuity is most vulnerable to disruption, namely during the postpartum period.

Compared with Santoso and Wijaya (2023), who also conducted research in Bogor Regency but employed a qualitative case-study approach without

population-scale data, this study provides quantitative confirmation of the qualitative constraints identified in their research—weak cross-sector coordination and limited human-resource capacity in certain areas—while extending the analysis to six subdistricts using granular data that enable identification of area-specific variation.

3.3 Enabling and Constraining Factors Affecting Performance

The synthesis of quantitative data and theoretical analysis identified five primary enabling factors affecting TPK performance:

1. Uniform basic competency through TOT certification (100.0%);
2. Clear statutory policy structures in the social assistance facilitation function;
3. Strong assistance during pregnancy and parenting phases rooted in midwifery functions that had long been institutionalized prior to the establishment of TPK;
4. Formal institutional support from the Bogor Regency Government through the establishment of the Bogor Regency Stunting Prevention and Reduction Acceleration Team pursuant to Regent Decree No. 444/195/Kpts/Per-UU/2022; and
5. Availability of digital information systems (Elsimil, Siga Mobile, and the BESTIE Dashboard) providing verified databases for evidence-based policy planning.

Conversely, five major constraining factors were identified:

1. The low coverage of premarital screening (74.0%), which has cascading implications because failure to reach one-quarter of the prospective-couple population means that some families enter pregnancy without preliminary information regarding reproductive-health and nutritional status;
2. Weak postpartum assistance (75.0%), which may increase the likelihood of short birth intervals due to delayed use of postpartum contraception;
3. Uneven workloads across areas, with target-to-team ratios ranging from 163 to 199.5 families;
4. Limitations in the utilization of digital reporting systems, with 12.0% of TPK teams not routinely or never reporting through Elsimil/Siga Mobile, potentially introducing bias into aggregate district-level program-performance data; and
5. Variations in implementation quality across geographical areas that cannot be uniformly generalized.

Importantly, enabling and constraining factors do not operate independently but interact with one another. Formal institutional support at the regency level, representing a macro-level enabling factor, has not specifically addressed strengthening technical TPK-KUA coordination, which represents a micro-level constraint. Therefore, policy-level support has not yet been fully translated into operational-level support.

Similarly, the availability of digital infrastructure alone does not automatically result in optimal utilization without strengthening users' digital literacy and capacity.

This interaction pattern confirms that strategies for strengthening TPK should specifically bridge the gap between macro-level policy support and micro-operational implementation needs.

3.4 Comparative Analysis across Areas: Workload Ratios

The primary methodological contribution of this study lies in its comparative analysis across subdistricts based on ratios rather than absolute figures alone.

Table 2 presents the consolidated workload rankings of the six subdistricts based on three ratios: priority targets per team, verified-and-validated targets per team, and prospective-couple targets per team.

Table 2. Consolidated Workload Rankings of Six Subdistricts Based on Three Ratios

Subdistrict	Target/Team Ratio	Target/Team Rank	Verified/Validated Target/Team Rank	Prospective Couple/Team Rank	Average Rank
Cigombong	199.5	1	2	2	1.7
Citeureup	163.1	6	1	1	2.7
Cariu	194.4	2	5	3	3.3
Jasinga	184.6	3	3	4	3.3
Bojonggede	179.0	4	4	5	4.3
Gunungputri	172.8	5	6	6	5.7

Source: Processed from primary research data and Kemendukbangga SIGA (2026). Rank 1 = highest workload.

The findings in Table 2 are methodologically counterintuitive. If the analysis relied solely on absolute target numbers, Gunungputri and Bojonggede, with 39,749 and 39,566 priority target families respectively, would appear to be the subdistricts with the highest workloads.

However, once these figures are normalized against the number of available TPK teams, Cigombong (199.5 families per team) and Cariu (194.4 families per team) have the highest average workload per team because the two subdistricts have proportionally fewer teams relative to the scale of their target populations.

Gunungputri, by contrast, consistently ranks as having the lowest workload across all three ratios, with an average rank of 5.7. This indicates that

the subdistrict with the largest absolute target population actually has the most proportionally adequate team allocation.

This rank-reversal pattern challenges the common assumption underlying policy planning based solely on absolute figures and emphasizes the importance of ratio-based analysis in planning TPK resource allocation.

The implication is that future policies concerning increases in the number of TPK teams should consider the actual workload ratio per existing team rather than only the absolute scale of a subdistrict's target population so that resource redistribution can be more accurately targeted.

Based on empirical evidence from the average rankings, Cigombong and Citeureup should become primary redistribution priorities if additional resources are limited.

The verified-and-validated-target ratio per team also reveals an interesting anomaly. Citeureup, which recorded the lowest priority-target ratio (163.1), recorded the highest verified-and-validated-target ratio per team (26.0).

This may be related to the geographical accessibility of a high-density industrial-urban area, which allows teams to reach more families within a limited radius, compared with Gunungputri, which, although also characterized as an urban-fringe area, has target populations distributed across a wider territory.

This explanation remains an interpretive hypothesis based on the available data and requires further confirmation through field observation.

Each subdistrict has a distinct profile of strengths and weaknesses; therefore, strengthening strategies cannot be uniform.

Citeureup, with the largest populations of couples of reproductive age and prospective couples (10,537 and 85 families, respectively) but no villages officially designated as priority stunting loci, requires greater emphasis on strengthening primary prevention functions.

Jasinga, with the highest proportion of priority stunting villages (62.5%) but a geographical area spread across 16 villages, requires stronger field mobility and digital capacity for remote reporting.

Bojonggede, with the highest TPK-to-Puskesmas ratio (73.7), requires strengthened health-referral mechanisms.

The finding concerning workload rank reversal reinforces and extends the findings of Kurniawati and Rahayu (2023) regarding variations in regional achievements influenced by resource allocation. This study demonstrates that such variation may remain masked when analysis relies solely on aggregate data without normalization against the available resource base.

The primary difference lies in the unit of analysis. Kurniawati and Rahayu (2023) compared regencies and municipalities within a province, whereas the present study demonstrates that similar variation, including more complex rank-reversal patterns, also occurs at a much smaller scale among subdistricts within the same regency.

3.5 Model for Strengthening the Role of Family Assistance Teams

Based on the synthesis of the above findings, this study proposes a conceptual model for strengthening the role of TPK consisting of five interrelated

components that form a continuous strengthening or virtuous cycle, as summarized in Table 3.

Table 3. Components of the Model for Strengthening the Role of Family Assistance Teams

No.	Component	Implementation Mechanism	Success Indicator	Time Target
1	Integration of premarital screening with KUA administration	Memorandum of Understanding and joint standard operating procedures between Kemendukbangga and the Ministry of Religious Affairs	Premarital screening achievement $\geq 90\%$	12 months
2	Structured scheduling of postpartum visits	Mandatory visit schedule during weeks 1, 2, and 6 after childbirth	Postpartum assistance achievement $\geq 90\%$	6 months
3	TPK redistribution based on workload ratios	Team reallocation based on target/verified-and-validated target ratios per team, prioritizing Cigombong and Cariu	Difference in ratios across subdistricts $< 15\%$	12-18 months
4	Strengthening digital reporting capacity	Continuous technical assistance for Elsimil/Siga Mobile applications	Routine reporting compliance $\geq 95\%$	9 months
5	Subdistrict-level cross-sector coordination forum	Monthly coordination meetings involving the Subdistrict Head, Puskesmas, KUA, TPK, and village governments	Routine coordination achievement $\geq 95\%$	Continuous

Source: Formulated by the researcher based on the study findings.

The five components are designed to reinforce one another. Strengthening primary prevention through the integration of premarital screening reduces the number of new families at risk of stunting that must be addressed at subsequent stages.

Strengthening postpartum assistance and digital reporting improves both data quality and the accuracy of follow-up actions, while workload redistribution and stronger coordination forums ensure the sustainable and equitable implementation of the model rather than concentrating resources only in subdistricts with the largest absolute target populations.

The model is designed to be sufficiently flexible for differentiated implementation. Subdistricts with large populations but relatively low workload ratios, such as Gunungputri and Bojonggede, should ideally prioritize postpartum scheduling and coordination forums.

Conversely, subdistricts with the highest workload ratios, such as Cigombong and Cariu, should prioritize team redistribution.

CONCLUSION

This study draws three primary conclusions.

First, implementation of the Stunting Reduction Acceleration Program by TPK teams in six subdistricts of Bogor Regency falls within the good to very good categories in aggregate. However, it consistently forms a “U-shaped” pattern throughout the First 1,000 Days of Life cycle: achievement is high during pregnancy, declines at the premarital and postpartum transition points, and subsequently recovers during the child-care phase.

This pattern reflects differences in the maturity of statutory policy structures and coordination networks among actors at each stage rather than random variations.

Second, the principal enabling factors affecting TPK performance include uniform basic competency, clear statutory policy structures for certain functions, mature coordination networks with the health sector, and regional institutional support.

The primary constraining factors are the absence of institutionalized TPK-KUA coordination, disproportionate workload distribution, and limitations in the utilization of digital reporting systems.

Third, the proposed five-component strengthening model—integrating premarital screening with KUA, establishing structured postpartum schedules, redistributing teams based on workload ratios, strengthening digital capacity, and establishing cross-sector coordination forums—is operational and measurable.

Its implementation should be contextually adapted to the characteristics of each subdistrict rather than applied through a uniform approach.

This study makes a methodological contribution through the use of population census data involving 2,436 respondents rather than sample data, combined with comparative ratio analysis across areas.

This approach revealed a workload rank-reversal phenomenon that would remain concealed if the analysis relied solely on absolute aggregate data. The practical implications include the need to refine TPK training modules by emphasizing strategies for reaching prospective couples and strengthening postpartum assistance, using workload-ratio databases as a basis for TPK

distribution decisions, and organizing periodic cross-sector coordination forums at the subdistrict level.

This study has several limitations that should be considered when interpreting the findings. First, it covers only six of the 40 subdistricts in Bogor Regency.

Second, data for the eleven achievement indicators were available only in aggregate form rather than disaggregated by subdistrict. Consequently, some conclusions concerning relationships between regional characteristics and implementation achievement remain interpretive.

Third, the checklist instrument may be subject to self-report bias because it has not yet been independently verified through field observation.

Fourth, qualitative triangulation based on interviews and FGDs was still undergoing transcription when this manuscript was prepared. Therefore, contextual interpretations in this article rely primarily on quantitative data, secondary documents, and theoretical frameworks.

This study was also not intended to measure the direct epidemiological impact of the program on reductions in stunting prevalence; rather, it focuses on the implementation process and performance of implementing agents.

Future research should complete comprehensive qualitative triangulation and expand the geographical coverage to all 40 subdistricts in order to develop a more comprehensive comparative database for planning the distribution of TPK teams throughout Bogor Regency.

REFERENCES

- Badan Kependudukan dan Keluarga Berencana Nasional. (2021). Modul I: Pendampingan Keluarga dalam Percepatan Penurunan Stunting bagi Fasilitator Tingkat Provinsi (M. R. M. Damanik, Penyusun). BKKBN.
- Badan Kependudukan dan Keluarga Berencana Nasional. (2021). Pedoman Pelaksanaan Tim Pendamping Keluarga (TPK). BKKBN.
- Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and Conducting Mixed Methods Research* (2nd ed.). Sage Publications.
- Kementerian Kesehatan RI. (2021). Riset Kesehatan Dasar (Riskesdas) 2018. Kemenkes.
- Kementerian Kesehatan RI. (2023). Laporan Nasional Program Percepatan Penurunan Stunting 2022. Kemenkes.
- Klijn, E.-H., & Koppenjan, J. F. M. (2000). Public management and policy networks: Foundations of a network approach to governance. *Public Management: An International Journal of Research and Theory*, 2(2), 135–158.
- Kurniawati, S., & Rahayu, W. (2023). Evaluasi implementasi Program Percepatan Penurunan Stunting di Jawa Timur. *Jurnal Evaluasi Kebijakan Publik*, 11(1), 22–37.
- Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative Data Analysis: A Methods Sourcebook* (3rd ed.). Sage Publications.
- Pratiwi, N., & Hidayat, F. (2023). Peran pendamping keluarga dalam program penurunan stunting di Kabupaten Lombok Barat. *Jurnal Kesehatan Masyarakat Indonesia*, 18(3), 201–214.
- Sabatier, P., & Mazmanian, D. (1980). The implementation of public policy: A framework of analysis. *Policy Studies Journal*, 8(4), 538–560.
- Santoso, A., & Wijaya, R. (2023). Faktor pendukung dan penghambat implementasi program stunting di Kabupaten Bogor. *Jurnal Administrasi Publik dan Kebijakan*, 14(2), 89–103.
- Sari, M., & Wijaya, T. (2022). Implementasi program penurunan stunting di Kabupaten Sleman, Yogyakarta. *Jurnal Kebijakan Kesehatan Indonesia*, 11(2), 78–91.
- Sekretariat Wakil Presiden RI. (2024). Laporan Capaian Percepatan Penurunan

- Stunting Nasional 2018–2023. Sekretariat Wakil Presiden RI.
- Tim Pencegahan dan Percepatan Penurunan Stunting Kabupaten Bogor. (2025). Laporan Tim Pencegahan dan Percepatan Penurunan Stunting Kabupaten Bogor Tahun 2025. Pemerintah Kabupaten Bogor.
- Van Meter, D. S., & Van Horn, C. E. (1975). The policy implementation process: A conceptual framework. *Administration & Society*, 6(4), 445–488.