Perceptions and experiences of community-based social accompaniment for stunting prevention among vulnerable mothers in Garut, Indonesia: A qualitative study

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Abstract
Background: Stunting continues to be a multidimensional public health crisis in Indonesia. Conditional cash transfer (CCT) programs, such as the Family Hope Program (PKH), offer financial assistance, but their effect on reducing stunting is largely determined by the social support provided by the primary health care networks at the community level.
Objectives: To examine the perceptions and experience of social accompaniment among vulnerable mothers and primary healthcare actors in Garut Regency, a district that has been very successful in reducing stunting prevalence from 27.3% in 2022 to 14.2% in 2024, surpassing provincial and national targets.
Methods: This research is a qualitative case study which was conducted in Garut Regency from January 2025 to March 2026. The COREQ reporting guidelines have been followed. In-depth interviews and participatory observations were conducted with 13 informants consisting of PKH facilitators, primary healthcare workers and vulnerable beneficiary mothers. The data were analysed using a thematic analysis.
Results: Three main themes were identified. First, PKH facilitators act as cultural brokers by translating health communication into the local Sundanese cultural and religious context. This successfully bridges the gap between primary healthcare providers and the community. Secondly, social accompaniment is limited by significant structural and cultural barriers, including fragmented health data and entrenched sanitary myths. Third, the accompaniment process transforms perceptions of PKH from a financial assistance to a catalyst for behavioural change and health empowerment at household level.
Conclusions: Community-based social accompaniment is essential to translating national stunting policies into local practice and has been a major contributor to Garut's impressive stunting decline. Primary healthcare systems need to formally integrate social adaptive community accompaniment into stunting interventions. We recommend collaborative models between general practitioners, midwives and social facilitators to ensure culturally resonant and sustainable stunting prevention.
Stunting; Cash transfer; Social support; Primary health care; General practice; Qualitative study; Indonesia

Introduction
Childhood stunting, a condition of impaired growth and development due to poor nutrition, repeated infection, and inadequate psychosocial stimulation, is a critical global health challenge (Black et al., 2013; de Onis & Branca, 2016). Stunting remains a significant problem in low- and middle-income countries across the world, with profound consequences for cognitive development and future economic productivity (Black et al., 2013). Stunting in Indonesia is a national priority. Based on the 2024 Indonesian Nutritional Status Survey (SSGI), the prevalence of stunting in the country has decreased to 19.8%, and West Java Province has a prevalence of 15.9% [4]. Importantly, Garut Regency, a highland region with intricate socio-geographical difficulties, has shown impressive results, decreasing its stunting rate from 27.3% in 2022 to 14.2% in 2024, outperforming both provincial and national averages (Asnawi, 2024). However, to sustain this achievement, it is necessary to understand the mechanisms underlying community-based interventions, especially the role of social accompaniment in conditional cash transfer programs.
The determinants of stunting in Indonesia are very contextual, covering socioeconomic factors, maternal education, sanitation and cultural practices (Beal et al., 2018). The Indonesian government's reliance on the

Family Hope Program (Program Keluarga Harapan, PKH) is to address these multifaceted determinants. PKH, launched in 2007, is the national flagship CCT initiative that aims to break the intergenerational cycle of poverty. The program offers quarterly financial aid to vulnerable households subject to certain health and education requirements. The conditionality requires households with pregnant women, babies and toddlers to regularly go for health check-ups, immunizations and nutritional monitoring at integrated health posts (Posyandu) and community health centers (Puskesmas) (Hartarto et al., 2023; World Health Organization, 2025).

In 2018, the government strategically integrated PKH into the National Strategy for Stunting Acceleration, transforming it from a financial safety net to a convergent platform for behavioral and health interventions (Hartarto et al., 2023; World Health Organization, 2025). Programme implementers have been trained to deploy PKH facilitators to conduct regular Family Development Sessions (FDS) and home visits to ensure compliance. These facilitators are the main link between national health policies and vulnerable communities at the grassroots level, working in close coordination with primary health care workers including general practitioners, midwives, nutritionists and health promoters.

Although social assistance programs can offer essential economic relief, financial aid alone is not enough to change the underlying behavioral and cultural determinants of stunting (Munawaroh et al., 2024). Recent literature emphasizes the importance of community-powered pathways, social capital and open innovation for environmental and behavioral changes in semi-urban and rural Indonesia (Prayitno et al., 2025; Samsudin et al., 2023). Moreover, household social contexts and socio-cultural influences are strong determinants of child nutrition outcomes (Masthalina et al., 2025). The accompaniment process, in which PKH facilitators communicate, educate, and empower beneficiary families, thus becomes the critical mechanism for translating cash transfers into tangible health outcomes. However, empirical evidence on how this social accompaniment is perceived and experienced by vulnerable mothers and primary healthcare stakeholders remains scarce.

This study explored the perceptions and experiences of community-based social accompaniment for stunting prevention among vulnerable mothers and primary healthcare stakeholders in Garut Regency. The study offers practical insights to general practitioners and primary healthcare workers and policymakers to create more convergent and culturally adaptive stunting interventions by understanding these dynamics.

Methods

Setting and design of study

This research used a qualitative case study approach grounded in a constructivist paradigm, which holds that reality is socially constructed through ongoing interactions. The study was conducted in Garut Regency, West Java, Indonesia, and data collection was conducted from January 2025 to March 2026. The choice of Garut was based on its multifaceted socio-cultural landscape (dominated by Sundanese culture and Islamic religiosity), varied geographical conditions, and its outstanding success in decreasing stunting prevalence to 14.2% in 2024 [4]. This study was reported in compliance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist.

Participants

Participants were chosen through purposive sampling to obtain a full understanding of the social accompaniment ecosystem in the primary healthcare system. The total of informants involved was 13 consisting of three main groups: (1) PKH facilitators, (2) primary healthcare workers, and (3) vulnerable beneficiary mothers. Detailed characteristics of the participants are presented in Table 1.

Table 1. Characteristics of research participants

No.	Category	Code	Occupation / Role	Gender	Experience	Location
1	PKH Facilitators	F1	PKH Facilitator	Male	8 years (since 2016)	Cibiuk District
2	PKH Facilitators	F2	PKH Facilitator	Female	2 years (since 2022)	Pasir Wangi District
3	PKH Facilitators	F3	PKH Facilitator	Male	5 years	Cibatu District
4	PKH Facilitators	F4	PKH Facilitator	Female	6 years	Cisurupan District
5	PKH Facilitators	F5	Senior PKH Facilitator	Female	>10 years	Balubur Limbangan District
6	Primary Healthcare Workers	T1	Health Promoter	Male	5 years	Lembang Community Health Center, Leles District
7	Primary Healthcare Workers	T2	Nutritionist	Female	4 years	Lembang Community Health Center, Leles District

8	Primary Healthcare Workers	T3	Village Midwife	Female	7 years	Lembang Village, Leles District
9	PKH Beneficiaries	K1	Housewife	Female	4 years (since 2020)	Bojong Jambu Village, Leles District
10	PKH Beneficiaries	K2	Housewife	Female	3 years	Leles District
11	PKH Beneficiaries	K3	Housewife	Female	5 years	Leles District
12	PKH Beneficiaries	K4	Housewife	Female	2 years	Leles District
13	PKH Beneficiaries	K5	Housewife	Female	6 years	Leles District

PKH, Program Keluarga Harapan (Family Hope Program).

Gathering of data

Data were collected through in-depth semi-structured interviews and participatory observations. Interviews were conducted in the language of the participant's choice (Indonesian or Sundanese) and were audio-recorded and lasted between 45 and 90 minutes. The interview guide explored participants' perceptions of social accompaniment, cultural barriers, behavioural changes and collaboration with primary health care providers. Interaction dynamics in PKH family development sessions and Posyandu activities were observed. Field notes were taken to record non-verbal cues and contextual information.

Data analytics

Data were thematically analysed. Transcripts were transcribed verbatim, translated into English and coded inductively to identify recurring patterns related to experiences of social accompaniment, cultural barriers and behavioural changes. The transcripts were coded independently by two researchers, and discrepancies were resolved through discussion in order to establish credibility. Some of the participants were used to validate the findings through member checking.

Ethical considerations

The study was conducted in strict accordance with the ethical principles of the Declaration of Helsinki. Ethical approval was obtained from Research Ethics Committee of Universitas Padjadjaran, Indonesia (Approval No. 55/UN6.KEP/EC/2026 of 13 January 2026. All participants provided written informed consent prior to data collection. They were given full information regarding the purpose, procedures, possible risks and benefits of the study and were informed of their right to withdraw from the study at any time without any consequences. All personal identifiers were removed and pseudonyms or codes (e.g., F1, T1, K1) were used throughout to maintain confidentiality. The study was conducted in conformity with the principle of beneficence, so that the results could have positive contribution to the improvement of social and health programs.

Result

Thematic analysis of the interviews and observations produced three main themes and fourteen sub-themes, which are summarised in Table 2. These themes illustrate the multidimensional role of PKH facilitators in linking primary health-care services with community realities.

Table 2. Overview of themes, sub-themes, and illustrative quotations

Theme	Sub-theme	Illustrative Quotations	Code
1. PKH facilitators as cultural brokers in health communication	1.1. Dialogical and participatory approach	*"In the Family Development Sessions, my principle is not to lecture, but to discuss and learn together. Serious but relaxed. The most successful strategy is when the beneficiaries smile and laugh."*	F1
	1.2. Linguistic adaptation to local context	*"I use Sundanese when communicating with the beneficiaries to ensure the message is well-received. The biggest challenge is changing community habits related to parenting."*	F2
	1.3. Strategic involvement of religious leaders	*"Involving Islamic scholars (ajengan and kyai) has a positive impact. Compared to the village head, the kyai are more influential."*	F5
	1.4. Beneficiaries' appreciation of cultural adaptation	*"It is better to use Sundanese so we can understand more. If Sundanese is used, I understand better."*	K1
2. Navigating structural and cultural barriers	2.1. Fragmentation of data registries	*"We often have to match data from the Community Health Center about thin children... with the list of PKH beneficiaries."*	T1

	2.2. Deep-rooted sanitary myths and taboos	*"Changing the mindset is harder than giving the vitamins. Some families still have the habit of defecating in fish ponds, and there are local food taboos."*	T2
	2.3. Repeated simplified education	*"I explain about stunting not just once, but repeatedly... I use simple language, not medical terms."*	T3
	2.4. Empathetic and non-punitive accompaniment	*"If someone does not come to the Posyandu, I ask the reason first, maybe there is an obstacle, not immediately punished."*	F3
	2.5. Cross-sectoral coordination	*"PKH facilitators must coordinate with midwives, Posyandu cadres, and the Community Health Center. We cannot work alone."*	F4
3. From financial dependency to behavioral empowerment	3.1. Internalization of nutritional knowledge	*"Now I try to ensure there is nutritious side dish every day. Before, it was just rice and vegetables, now I try to include eggs or fish."*	K2
	3.2. Information consistency strengthening trust	*"Before, if I heard something slightly different from the midwife compared to the facilitator, I was confused. Now the explanations are the same."*	K3
	3.3. Transformation into self-responsibility	*"At first, I just waited for the money. Now, because the facilitator keeps asking about my child's height, I feel responsible."*	K4
	3.4. Ripple effect on household dynamics	*"After the Family Empowerment Meeting, I tell my husband. My husband obeys. So, my husband also understands the importance of eating nutritious food."*	K5

PKH, Program Keluarga Harapan (Family Hope Program).

Health communications: PKH facilitators as cultural brokers

Vulnerable mothers and primary healthcare workers saw PKH facilitators not just as administrative officers but also as cultural brokers. In Garut, which is rich in Sundanese cultural values and religious beliefs, there are times when standard medical instructions from primary healthcare workers are met with scepticism. Informants said that PKH facilitators are able to bridge this gap by adapting the communication style to local contexts.

"In the Family Development Sessions, my principle is not to lecture, but to discuss and learn together," said F1, a senior facilitator with eight years of experience, stressing his dialogical approach. Serious, not tense. The best strategy is when the beneficiaries smile and laugh. "If the beneficiaries are laughing, it means they are not tensed, as my mentor said" (F1). This participatory approach represents a move from top-down communication to collaborative engagement.

A relatively new facilitator, F2 emphasised the importance of linguistic adaptation: "I speak in Sundanese when I talk to the beneficiaries so that the message is well received. "The biggest challenge is changing community habits around parenting and feeding toddlers which are often at odds with modern nutritional knowledge" (F2). I know in Sundanese but there are still technical health terms that are difficult to translate," she added. Take the word 'stunting' itself – many beneficiaries do not know what it means, or how it differs from 'malnutrition' or 'being short'. "I have to explain over and over again with concrete examples" (F2).

Facilitators also strategically engage religious leaders to lend credibility to health messages. "Having Islamic scholars (ajengan and kyai) involved has a positive impact," said F5, the most senior facilitator with more than a decade of experience. The kyai are more powerful than the village head" (F5). This approach is successful in dismantling the cultural barrier by merging health activities with local religious beliefs.

This culturally adaptive communication is very much appreciated from the beneficiaries' perspective. "Better use Sundanese so we can understand more," said K1. Using Sundanese, I understand better. "If Indonesian is used, there are terms that I might not understand" (K1). This suggests that the success of health communication is significantly influenced by cultural and linguistic factors.

Structural and cultural barriers to overcome

The accompaniment process is full of many structural and cultural barriers. Regarding structure, informants mentioned the fragmentation of data between the social assistance registry and the nutritional registry of the

health sector, which led to delays in targeted interventions. “This is the challenge,” described T1, the health promoter, “we often have to match data from the Community Health Center on thin children or pregnant women with low energy, with the list of PKH beneficiaries. So if there is someone who has not been helped but their child is in danger, we propose them to the village” (T1). This shows the ongoing work to bring together data despite institutional silos.

Culturally, facilitators and primary health care workers have to work through deep-rooted myths and poor sanitary practices. T2, the nutritionist, said: “Changing the mindset is harder than giving the vitamins. Some families still defecate in fish ponds and there are local taboos on food for pregnant women. The PKH facilitator has to go to them again and again, build trust so they don't feel judged” (T2). She also emphasised the need to involve health professionals in empowerment meetings: “The participation of health workers in the Family Empowerment Meetings allows a deeper understanding of nutrition” (T2).

Village midwife T3 described her approach of education by repetition and simplification: “I explain about stunting not just once, but repeatedly every time a pregnant woman or toddler comes to the Posyandu. I use simple words, not medical terms. For example, “Mother, stunting is like a tree that cannot grow maximally without fertilizer’’ (T3). She also realised that beneficiaries responded differently: “Some use it right away and some take their time. For example, Ani is very disciplined. She always reports to the Posyandu what she has given to her child. But there are also those who are still struggling, particularly those influenced by myths or economic constraints. We can only guide and motivate, we cannot force (T3).

The facilitators also have a critical role to play in negotiating these barriers through empathetic and coordinated approaches. F3, who is known for his empathetic style, said: “I don’t only have to help, but also to accompany and educate. I have to ensure that the beneficiaries are aware of their responsibilities, such as bringing their children to the Posyandu and meeting nutritional requirements. But I must also understand their conditions, I cannot impose my will. For example if someone does not come to Posyandu, I first ask the reason, maybe there is an obstacle, not immediately punished” (F3).

F4 underscored the importance of cross-sectoral coordination: "PKH facilitators should coordinate with midwives, Posyandu cadres, and the Puskesmas. We cannot do it alone. For example, to see attendance at Posyandu, we need data from the midwife. We need the nutritionist’s inputs for nutrition education. “This collaboration is important so that the message delivered is consistent and does not confuse the beneficiaries” (F4). Hence, the social accompany is a negotiation in perpetuity between the modern medical guidelines and traditional practices.

Economic Empowerment as a Pathway to Behavioural Liberation

A major change had taken place in the perception of the purpose of the CCT. At first, vulnerable mothers saw PKH simply as financial aid. Nevertheless, constant social accompaniment, especially through the Family Development Sessions, enabled mothers to report a paradigm shift toward health empowerment.

K2 explained her changed behaviour: “Now I try to make sure that there is a healthy side dish every day. Used to be rice and vegetables, now I try to add eggs or fish. For fruit, I buy bananas or papayas. They're cheap and nutritious. “My toddler is healthier, not getting sick as frequently” (K2). Such a change implies that the knowledge has been successfully internalised and is part of the subjective reality that guides daily actions.

K3 stressed the importance of consistency of information: “Before, if I heard something different from the midwife and the facilitator, I would be confused. Now the explanations are the same so I feel more confident on which one to follow” (K3). Such consistency enhances the beneficiaries’ trust in the program and their compliance, an important foundation of a legitimate program reality.

K4 said she increasingly felt responsible: “At first I just waited for the money. Now I feel like I have to do something because the facilitator keeps asking me about how tall my kid is and what we ate yesterday. “I regularly go to the Posyandu, because I don’t want to get a soft scolding from the facilitator” (K4). The accompaniment translates the conditionality of the cash transfer into internalised health-conscious behaviour.

K5 also showed how empowerment can ripple through families: “Sometimes I cook vegetables and eggs. That's all. Sometimes meat, sometimes chicken, sometimes eggs, some vegetables. I tell my husband, after the Family Empowerment Meeting. My husband is a submissive. So my husband knows how important it is to eat healthy food as well. “My husband takes care of it too” (K5). This suggests that the accompaniment process extends beyond the mother and influences household decision-making and gender dynamics in childrearing.

Together, these accounts reveal that the PKH facilitators are not just cash dispensers, but behavioural change agents who empower vulnerable mothers to adopt sustainable health practices in partnership with primary healthcare service providers.

Discussion

This study shows that community-based social accompaniment is the key mechanism that translates conditional cash transfers into concrete stunting reduction results. The results are consistent with previous findings that

social assistance programs have a significant effect on stunting prevalence, but only when accompanied by adequate sanitation and behavioural interventions (Munawaroh et al., 2024). The extraordinary decline in the prevalence of stunting in Garut from 27.3% to 14.2% in 2 years (Asnawi, 2024) may be related to the intensive accompaniment process that is recorded in this study.

PKH facilitators as cultural brokers demonstrate the importance of socio-cultural influences in stunting prevention. Haniarti et al. (Haniarti et al., 2025) argued that the major contributors to undernutrition are food taboos and local care practices as culturally embedded factors. We extend this by showing that culturally adaptive communication, including use of local dialects and informal leaders, is highly effective in overcoming these barriers. This supports the idea that interventions need to include cultural competence and community engagement (Masthalina et al., 2025; Prayitno et al., 2025). Interestingly, the strategic role of Islamic scholars (kyai and ajengan) in Garut offers a local mechanism that has not been widely documented in any previous CCT studies in Indonesia such as the study by Hartarto et al. (Hartarto et al., 2023) in Bima City.

Findings from a primary healthcare perspective highlight the importance of PKH facilitators as links between the formal healthcare system and the community. The shift from financial dependency to behavioural empowerment is the essence of the CCT programs' goals. [7] found that external environmental factors and participative counselling are important for stunting prevention in Indonesia. This participative counselling is assisted by the social accompaniment of PKH facilitators, which ensures that vulnerable mothers do not just consume the cash assistance but invest it in their children's nutritional needs. These findings are consistent with the larger body of evidence that maternal knowledge and empowerment are critical to stunting reduction in the first 1,000 days of life (Pan et al., 2025; World Health Organization, 2025).

The fragmentation of data and the need for multisectoral convergence identified in this study are critical challenges to primary healthcare systems. Samsudin et al. (Samsudin et al., 2023) and Prayitno et al. (Prayitno et al., 2025) reported that stunting reduction needs community-empowered pathways and cross-sectoral cooperation. Primary healthcare centers (Puskesmas) and Posyandu cannot work alone. The PKH facilitator is the connective tissue, continuously accompanying social and medical advice provided by general practitioners and midwives at the household level. This result is in line with IFE-EFE matrix analysis by Samsudin et al. (Samsudin et al., 2023) that good coordination is a key strength of high-performing districts in reducing stunting. Furthermore, the ripple effect of social accompaniment on gender dynamics within households, where empowered mothers influence the nutritional decision making of their husbands, expands the understanding of the social context of households proposed by Masthalina et al. (Masthalina et al., 2025). This means that stunting interventions should not only focus on mothers, but also involve fathers as active partners in child nutrition.

The findings have a number of practical implications for general practitioners and family doctors. First, clinical consultations with families prone to stunting should be supplemented with referrals to PKH facilitators to accompany families at the household level on an ongoing basis. Secondly, primary healthcare workers should work together with Facilitators of the PKH to develop culturally relevant educational materials. Third, integrated data systems between health and social sectors should be strengthened so that interventions are timely and targeted. Fourth, general practitioners should be aware of the role of informal leaders (religious scholars, community elders) as allies in health communication, particularly in culturally conservative contexts.

Limitations

This study was limited to a particular cultural context (Sundanese community in Garut) so that the findings cannot be generalised to other ethnic groups in Indonesia. Future research should involve cross-cultural comparisons of social accompaniment models and quantify the impact of facilitator-mediated interventions on stunting outcomes through mixed-methods or longitudinal designs.

Conclusions

Community-based social accompaniment in the Family Hope Program is absolutely essential for the prevention of stunting among vulnerable mothers in Garut, Indonesia. PKH facilitators are cultural mediators, bridging the gap between national policy and the realities of the community by overcoming structural and cultural hurdles and supporting behavioural empowerment. This approach of accompaniment has a potential impact, as seen from the very significant decline in the prevalence of stunting in Garut to 14.2% in 2024 which is below the average in the province and nationally. The findings suggest that medical therapies for stunting should be linked with socially adaptive community accompaniment to general practitioners and primary healthcare institutions. Models of collaboration between health workers and social facilitators are advised to guarantee stunting prevention is not only scientifically sound but also culturally resonant and socially durable.

Declarations

Ethical approval and consent to participate

This study was approved by the Research Ethics Committee of Universitas Padjadjaran, Indonesia (Approval No. 55/UN6.KEP/EC/2026, dated January 13, 2026). Written informed consent was obtained from all participants prior to data collection.

Consent for publication

All participants provided written informed consent for the publication of anonymized quotations and findings.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request, subject to ethical considerations regarding participant confidentiality.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

Asaas Putra: Conceptualization, Methodology, Investigation, Formal analysis, Writing – Original draft preparation.
Jenny Ratna Suminar: Conceptualization, Supervision, Writing – Review & Editing.
Agus Rusmana: Supervision, Writing – Review & Editing.
Henny Sri Mulyani: Supervision, Writing – Review & Editing.
All authors read and approved the final manuscript.

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