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# STRENGTHENING MULTISECTORAL GOVERNANCE FOR STUNTING REDUCTION IN INDONESIA: A COMPREHENSIVE POLICY ANALYSIS AND INTERNATIONAL COMPARATIVE REVIEW

**Syed Agung Afandi[1], Muslim Afandi[2], Rizki Erdayani[3]**

[1,2,3]Universitas Islam Negeri Sultan Syarif Kasim Riau
Panam Jl. HR. Soebrantas No.15, Kota Pekanbaru, Riau, Indonesia
*Corresponding author: muslim.afandi@uin-suska.ac.id*

## *ABSTRACT*

*Multi-level governance deficits and fiscal asymmetries within the decentralized framework constitute primary barriers to accelerating stunting reduction in Indonesia. This study deconstructs subnational institutional matrices and political economies using historical institutionalism (path dependency) and collaborative governance theories. Findings explicitly reveal that a pervasive curative bias within community health centers and the diversion of Village Funds by local elites causally fracture intervention convergence pathways, resulting in household-level nutrient absorption failure. Analytically, an international comparative review of Rwanda's Imihigo system and Vietnam's vertical command chain offers novel regulatory benchmarks to overcome localized bureaucratic fragmentation. Core policy recommendations urge binding accountability reforms through mandatory performance contracts for regional leaders and strict fiscal earmarking on central transfer funds conditioned rigorously upon real ground-level nutritional convergence metrics.*

*Keywords: Multisectoral Governance; Stunting; Indonesia*

## ABSTRAK

Defisit tata kelola multi-level dan asimetri fiskal di era desentralisasi menjadi hambatan utama percepatan penurunan stunting di Indonesia. Studi ini mendekonstruksi matriks kelembagaan dan ekonomi politik subnasional menggunakan teori institusionalisme (*path dependency*) dan tata kelola kolaboratif. Temuan secara jelas membongkar bahwa bias anggaran kuratif di Puskesmas serta penyelewengan Dana Desa oleh elite lokal secara kausal memutus konvergensi intervensi, yang berujung pada kegagalan penyerapan zat gizi di tingkat rumah tangga. Sebagai kontribusi analisis, tinjauan perbandingan internasional terhadap sistem *Imihigo* Rwanda dan komando vertikal Vietnam digunakan untuk

menawarkan tolok ukur regulasi baru dalam mengatasi fragmentasi birokrasi lokal. Rekomendasi kebijakan utama mendesak adanya reformasi akuntabilitas mengikat melalui pelembagaan kontrak kinerja mandatori bagi kepala daerah serta penguncian anggaran (*strict fiscal earmarking*) pada dana transfer pusat berbasis target konvergensi gizi riil di lapangan.

Kata Kunci: Tata Kelola Multisektoral; Stunting; Indonesia

## INTRODUCTION

Stunting eradication in Indonesia has exposed a fundamental structural reality, child growth failure is not merely a biomedical or dietary deficit, but an institutional crisis rooted in systemic governance friction across a highly decentralized state. While conventional public health paradigms treat stunting as a clinical issue solved by nutrient delivery, its persistence in Indonesia indicates that the crisis is deeply embedded in broader political, social, and institutional structures that dictate everyday access to resources. Despite a decade of intense national mobilization, which successfully drove stunting prevalence down from 37% in 2013 to 21.6% in 2022, the policy regime faces massive institutional bottlenecks. This structural drag places immense strain on Indonesia's highly ambitious national target of 14%, demonstrating how top-down technocratic mandates run the risk of fracturing when decoupled from subnational administrative readiness and local political will (Afandi & Afandi, 2025; Victora et al., 2021; World Bank, 2023).

Existing literature has extensively documented the proximate clinical, socio-economic, and dietary determinants of malnutrition across the archipelago (Agustina et al., 2019; Kementerian Kesehatan Republik Indonesia, 2023; Kurniasi et al., 2024; UNICEF, 2022). However, there remains a critical research gap in understanding how multi-layered policy frameworks and intergovernmental friction actively disrupt or enable intervention convergence at the frontline. This study directly addresses this gap by shifting the analytical lens away from individual biomedical inputs toward a systemic, multidisciplinary policy and governance analysis. Stunting is a multidimensional development failure; its resolution demands synchronized, coherent governance that spans across health, social protection, water and sanitation, and local administration.

The operationalization of this multisectoral approach was formalized

through the launch of the National Strategy for Stunting Reduction (*Stranas Stunting*) in 2018, establishing a high-level governance model across 23 ministries and agencies. The core objective of *Stranas Stunting* is convergence, the systematic alignment of nutrition-specific and nutrition-sensitive interventions. However, national evaluations reveal that convergence remains highly volatile and heavily uneven (Afandi et al., 2026; Bappenas, 2021; Khairunnisa & Putri, 2024; Tim Nasional Percepatan Penurunan Kemiskinan, 2022). Because Indonesia utilizes a decentralized governance model, the statutory burden of implementation falls squarely upon district and village governments. Consequently, robust national policy frameworks are frequently undermined by localized policy discontinuity, rigid sectoral silos, and bureaucratic inertia, making stunting reduction a highly volatile political-administrative process.

This interplay between decentralization and multisectoral coordination directly drives severe implementation inequality across regions. While the post-2001 decentralization reforms granted districts substantial planning and fiscal autonomy, they also transformed local political alignment into the primary determinant of child health outcomes. This institutional variability has created a landscape of stark contrasts: for example, progressive districts in Central Java have successfully leveraged village funds (*Dana Desa*) and integrated real-time digital infrastructure through the Stunting Management Information System (SIPS) to achieve rapid, data-driven convergence. Conversely, underserved districts in parts of Sulawesi and Papua remain trapped in systemic stagnation, paralyzed by severe health workforce shortages, weak data interoperability, and a reliance on fragmented, purely curative spending (Erdayani et al., 2023; Tim Nasional Percepatan Penurunan Kemiskinan, 2022; UNICEF, 2022).

Grounded in these systemic challenges, this study analyzes the governance landscape of stunting reduction in Indonesia through an institutional lens, evaluating how multisectoral coordination, digital transformation, fiscal policies, and community engagement interact to shape policy outcomes. By drawing on global best practices and integrating theories of social determinants of health, multi-level governance, and the whole-of-government (WoG) approach, this paper identifies structural gaps in the current

regime. Ultimately, this multidisciplinary analysis contributes to a more nuanced understanding of stunting reduction not as a static medical target, but as a dynamic, non-linear policy process mediated by competing institutional logics, shifting political cycles, and diverse socio-cultural contexts.

## THEORETICAL FRAMEWORK

The theoretical framework of this study seeks to explain the complexity of stunting reduction in Indonesia through a multidisciplinary approach. This approach integratively synthesizes the social determinants of health (SDH), multisectoral nutrition governance, multi-level governance within a decentralized context, as well as the concepts of policy coherence and the WoG approach. This combined framework is essential because stunting is not merely a medical or nutritional problem but a social phenomenon shaped by structural, institutional, political, and behavioral factors across multiple levels of governance (Fajar & Nurrahman, 2025; Victora et al., 2021). A comprehensive understanding of stunting therefore requires an analytical lens linking social determinants, governance arrangements, intersectoral coordination, and institutional capacity at both national and subnational levels.

The first conceptual foundation is the SDH perspective, which posits that child nutrition outcomes are influenced by socioeconomic status, education, physical environment, access to essential services, food security, sanitation, and gender norms. SDH emphasizes that health outcomes are shaped by broader social structures, not merely individual behavior or clinical interventions. In the Indonesian context, this perspective helps explain the geographic clustering of stunting in areas with high poverty rates, low maternal education, inadequate infrastructure, and limited access to primary care (Agustina et al., 2019; UNICEF, 2022). The SDH framework therefore underscores the need for stunting reduction policies that extend beyond the health sector to address structural determinants of wellbeing.

The second framework is multisectoral nutrition governance, which highlights the importance of integrating nutrition-specific and nutrition-sensitive interventions supported by robust governance, including political leadership, cross-sectoral coordination, adequate financing, performance accountability, and integrated monitoring systems (Fanzo et al., 2021; Food and

Agriculture Organization, 2020). This aligns with evidence showing that successful nutrition programs depend on the capacity of government institutions to collaborate effectively across sectors (Reich & Balarajan, 2020). In Indonesia, the National Strategy for *Stranas Stunting* represents a major attempt to institutionalize multisectoral governance ; however, studies indicate that coordination remains inconsistent due to fragmented budgets, uneven regional capacity, and siloed data systems (Bappenas, 2021; Overseas Development Institute, 2018). The multisectoral governance framework therefore helps assess institutional opportunities and constraints in achieving effective stunting reduction.

The third theoretical pillar, multi-level governance and decentralization is highly relevant in Indonesia's decentralized system, where public policy outcomes are shaped by interactions among national, provincial, district, and village governments (Bossert, 2016; Rodden, 2018). This framework emphasizes that policy success depends on local bureaucratic capacity, political leadership, vertical relationships between central and local governments, and horizontal coordination across local agencies (Lieberman et al., 2022). In Indonesia, districts with strong political commitment, adequate technical capacity, and coherent inter-agency collaboration have demonstrated faster declines in stunting, while others stagnate despite national mandates (Hadna & Dwimawanti, 2020; Prakasa & Riyanto, 2022). Multi-level governance therefore helps explain subnational variations in stunting outcomes.

The final conceptual foundation is policy coherence and the whole-of-government approach. Policy coherence emphasizes aligning objectives, instruments, and incentives across sectors and administrative levels (OECD, 2018). WoG frameworks argue that cross-sectoral issues, such as nutrition, require integrated planning, synchronized budgeting, and harmonized monitoring systems to ensure aligned implementation. In the context of stunting, coherence is crucial because interventions span health, water and sanitation, agriculture, education, social protection, and village development (Kieny et al., 2017; World Bank, 2023). Without such alignment, stunting policies risk remaining fragmented and sector-bound, undermining overall effectiveness.

Integrating these four theoretical approaches enables the study to

conceptualize stunting as a multidimensional problem. SDH explains its structural roots; multisectoral governance highlights institutional and coordination needs; multi-level governance accounts for decentralization-driven variation; and policy coherence and WoG emphasize the need for aligned, cross-sectoral policies. Together, these perspectives offer a comprehensive analytical lens for assessing governance challenges and opportunities in Indonesia's stunting reduction efforts, and for identifying pathways to more sustainable policy impact.

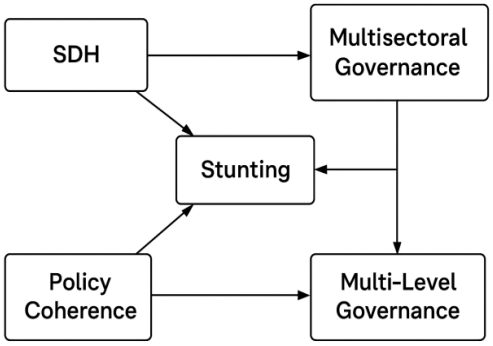


**Figure 1. Theoretical Framework Flowchart**
Source: Compiled by the researcher (2026)

The dynamic interactions, interdependencies, and causal linkages among these four theoretical pillars are explicitly mapped out in the Theoretical Framework Flowchart in Figure 1. Based on this visual model, the structural analysis initiates from the SDH block as a macro-structural determinant with two distinct causal pathways. The first pathway is a direct arrow pointing toward Stunting, positioning the empirical reality of stunting as a direct consequence of upstream social determinant deficiencies. The second pathway moves from SDH toward Multisectoral Governance, analytically demonstrating that the multivariate nature of health determinants forces the emergence of cross-sectoral governance; a single sector is intrinsically incapable of disentangling the complexities of SDH.

The diagram illustrates a conditional relationship wherein the outputs of Multisectoral Governance must descend vertically through the capacity filter of Multi-Level Governance at the decentralized level before being directed horizontally toward the reduction of Stunting. The Policy Coherence block acts as an integrative systemic anchor at the base, directing two critical intervention arrows. The horizontal arrow pointing toward Multi-Level Governance indicates that WoG approaches are required to mitigate localized bureaucratic friction and bridge fragmented regional departments. Meanwhile, the diagonal arrow moving directly from Policy Coherence toward Stunting reinforces the conceptual argument that substantive synchronization of policy instruments,

such as strictly linking social protection mechanisms to primary nutrition counseling is a prerequisite for generating direct and sustainable impacts at the household level.

## METHODS

This study adopts a systematic integrative review design, an approach that enables the synthesis of findings from diverse forms of research, including qualitative, quantitative, mixed-methods studies, policy analyses, program reports, and grey literature to construct a comprehensive understanding of stunting reduction policies in Indonesia. This approach is appropriate because stunting is a multidimensional phenomenon in which public health determinants intersect with governance structures, health system capacity, socioeconomic conditions, intersectoral intervention design, and policy actor dynamics. Thus, only an integrative method is capable of capturing the complexity of these interrelated factors, as recommended by Snyder (2019).

A systematic literature search was conducted across five major international databases, Scopus, Web of Science, PubMed/MEDLINE, ScienceDirect, and Google Scholar, and supplemented by three leading national databases: SINTA, Neliti, and Garuda. Search keywords were constructed using Boolean operators enhanced with MeSH terms, including "stunting," "child growth failure," "undernutrition," "nutrition policy," "health policy implementation," "Puskesmas," "BKKBN," "specific nutrition intervention," and "sensitive nutrition intervention". These terms were combined in search structures such as: ("stunting" OR "child undernutrition") AND ("policy" OR "intervention" OR "governance") AND ("Indonesia").

The publication period was explicitly restricted from 2013 to 2025 based on critical milestones in Indonesia's contemporary health policy trajectory. The year 2013 serves as a vital baseline because it marks the release of the National Health Research (*Riskesdas 2013*) data, which revealed a shocking national stunting prevalence of 37%. This empirical turning point catalyzed widespread political awareness and triggered the foundational planning that led to the pre-implementation phase of the National Strategy for *Stranas Stunting* launched in 2018. The timeline extends to 2025 to critically capture the comprehensive policy lifecycle, including the operational phase where the National Population and Family Planning Board (*BKKBN*) was appointed as the leading

sector, as well as the immediate post-evaluation of the 2024 national target milestone (14%). To minimize publication bias, national policy documents, ministerial reports, WHO-UNICEF publications, and donor agency reports were also included, consistent with the recommendations of Paez (2017).

To maintain objectivity and methodological transparency, selection criteria were established before the screening process. Table 1 summarizes the specific inclusion and exclusion criteria utilized in this review.

**Table 1. Inclusion and Exclusion Criteria**

| Criterion | Inclusion Criteria | Exclusion Criteria |
|---|---|---|
| Geographic Focus | Conducted within the administrative territory of Indonesia. | Studies outside Indonesia or broad regional studies without specific Indonesian country-data. |
| Topic & Scope | Focusing on stunting, child nutrition interventions, and systemic policy/governance implementation analysis. | Studies reporting solely epidemiological prevalence data without policy, institutional, or governance contexts. |
| Study Design | Empirical studies using quantitative, qualitative, or mixed-methods, alongside formal institutional policy reports. | Opinion pieces, editorial letters, commentaries, or theoretical reviews lacking empirical evidence. |
| Data Source Type | Peer-reviewed journal articles and verified grey literature (government, ministerial, and international agency reports). | Non-verified blogs, conference abstracts without full naskah text, and student assignments. |
| Accessibility | Studies written in English or Bahasa Indonesia with accessible full-text documents. | Documents without accessible or retrievable full texts. |

Source: Compiled by the researcher (2026)

All search results were imported into Mendeley for duplicate identification. Screening rigorously followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) workflow, moving sequentially from initial identification, title and abstract screening, full-text review, to final eligibility assessment. The detailed step-by-step selection process and article attrition are mapped out in Figure 2.

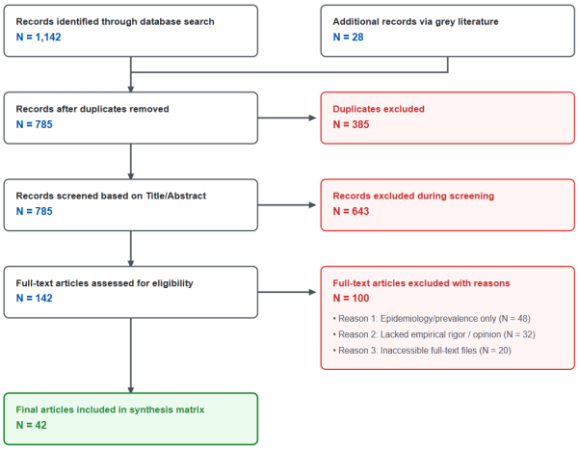


**Figure 2. PRISMA Flowchart of the Selection Process**

Source: Compiled by the researcher (2026)

As illustrated in the PRISMA workflow (Figure 2), the initial multi-database search yielded a total of 1,142 records, supplemented by 28 documents

from grey literature sources. After eliminating 385 duplicate records through Mendeley, 785 unique titles and abstracts were screened independently by two reviewers to reduce subjective bias, resolving disagreements through consensus. This phase resulted in the exclusion of 643 records that failed to meet basic thematic requirements. Subsequently, 142 full-text articles were rigorously assessed for eligibility against the strict criteria in Table 1. A total of 100 full-text articles were excluded with explicit justifications: 48 focused strictly on medical prevalence without policy context, 32 were opinion pieces or lacked empirical rigor, and 20 lacked retrievable full texts. Ultimately, 42 final articles and policy documents met all criteria and were included in the systematic synthesis matrix.

Data from these 42 eligible studies were extracted into a synthesis matrix capturing author, year, study location, methodological approach, policy indicators, types of interventions assessed, actors involved, and key findings. Coding was performed using thematic content analysis guided by the Braun & Clarke (2016) framework, allowing themes to emerge inductively while incorporating deductively derived categories aligned with national policy structures, such as specific and sensitive nutrition interventions. Policy analysis employed a combination of three theoretical frameworks: the Health Policy Triangle to examine actors, context, processes, and content; a systems thinking approach to map cross-sectoral causal relationships; and the Consolidated Framework for Implementation Research (CFIR) to assess determinants of implementation success. Triangulation of academic literature, government documents, peer debriefing, and reflexive note-taking ensured search saturation and high validity in accordance with global standards in health policy research.

## RESULTS AND DISCUSSION

### 1. Indonesian Health Policy Landscape

An analytical synthesis of national policies, institutional reports, and empirical data reveals that the trajectory of Indonesia's health policy over the past two decades has been profoundly shaped by a complex interplay of macro-political shifts, economic dynamics, bureaucratic reforms, and public sector decentralization. Since the onset of the *Reformasi* era in 1998 and the subsequent implementation of radical decentralization in 2001, the Indonesian health system has evolved within a

political environment that is visibly more open yet increasingly fragmented.

These structural transformations have simultaneously enabled localized opportunities for policy innovation while generating persistent vertical and horizontal coordination challenges between central and subnational governments. Numerous empirical studies describe Indonesia as one of the most rapidly decentralized countries in Asia in terms of both fiscal and administrative authority, a condition that has triggered significant reconfigurations in the governance structure of the health sector (Agustina et al., 2019; World Bank, 2021). These shifts do not merely alter administrative maps; they fundamentally dictate regional policy formulation capacity, frontline program implementation, and the objective effectiveness of monitoring and evaluation frameworks.

Over the past two decades, Indonesian health policy has systematically moved beyond a narrow focus on basic service delivery toward a more comprehensive, system-wide reform agenda encompassing universal health financing, primary care strengthening, digital health transformation, and multi-level governance. These domestic reforms did not occur in isolation; they were heavily influenced by global health developments, such as the worldwide push for Universal Health Coverage (UHC), global health security concerns, the necessity for robust epidemiological surveillance, and the growing integration of digital technologies into health systems. Literature demonstrates that these external and internal pressures reflect a critical paradigm shift from fragmented, curative service delivery to a more integrated, data-driven system of health governance (Kickbusch & Gleicher, 2023; World Health Organization, 2019).

In the realm of health financing, the implementation of the National Health Insurance (*Jaminan Kesehatan Nasional* - JKN) in 2014 marked one of Indonesia's most monumental health reforms. Empirical studies note that the JKN framework has successfully expanded population healthcare access, increased the utilization of public and private health facilities, and significantly reduced financial barriers for vulnerable households (Agustina et al., 2019; Mahendradhata, 2017). However, researchers also highlight that profound geographic disparities and severe variations in facility performance remain rampant, factors closely linked to varying

subnational capacities in regulating service providers and managing capitation-based payments. This structural reality illustrates how decentralization operates as a double-edged sword: it successfully enables localized innovation while simultaneously generating wide, unregulated variations in service quality across the archipelago. In low-capacity jurisdictions, such as several regions in eastern Indonesia, the JKN referral system becomes highly inefficient due to restricted primary care capacity, causing systemic bottlenecks.

Progress in health governance has been distinctly uneven across administrative tiers. While the central government has attempted to resolve fragmentation through national development plans, the 2021 health system transformation agenda, and the strengthening of the six pillars of health reform, actual implementation depends heavily on subnational government capacity, health worker availability, data quality, and regional alignment with national mandates. Consequently, health policy literacy and execution vary considerably across regions; advanced provinces such as West Java, Yogyakarta, and Bali have seamlessly integrated health planning with digital information systems, whereas many districts in eastern Indonesia still struggle with severe structural constraints, including limited digital infrastructure, insufficient human resources, and weak data recording systems (Bappenas, 2022).

Digital health development has similarly become a central element in national health policy discourse. Indonesia began addressing this issue through the 2010 e-Health Blueprint and subsequently strengthened its structural commitment through policies on electronic medical record (EMR) interoperability between 2022 and 2023, with literature indicating that digitalization enhances service effectiveness, accelerates referral processes, and improves real-time health data collection. However, multiple empirical studies emphasize the persistent challenges of weak interoperability, siloed datasets, and inadequate data utilization for evidence-based decision-making. The core challenges are primarily institutional rather than technological, revolving tightly around weak data governance, deficiencies in cybersecurity, lack of platform standardization, poor digital literacy among health workers, and varying levels of regulatory compliance by subnational health facilities.

Decentralization has thus produced substantial, uncoordinated variations in health policies across provinces and districts. Regions backed by robust fiscal baselines and high capacity, such as Jakarta and West Java, have successfully developed real-time health dashboards, leveraged big data for epidemiological surveillance, and integrated JKN with local service delivery systems. Meanwhile, regions with lower fiscal capacity still rely heavily on central transfers and face persistent challenges in basic health data management, the implementation of promotive and preventive programs, and meeting standard primary care service benchmarks. The literature on multi-level governance strongly underscores that policy success in decentralized states is highly dependent on the quality of coordination between national and subnational levels, and Indonesia represents a clear case in which these multi-tier interactions profoundly shape health service effectiveness (Rodden, 2018). To explicitly map and compare these regional policy asymmetries, Table 2 outlines the subnational health policy progress across diverse provincial profiles.

**Table 2. Comparative Matrix of Subnational Health Policy Progress and Governance Maturity**

| **Regional Profile & Capacity** | **Fiscal & Administrative Autonomy** | **Digital Health Integration** | **Primary Care & JKN Capitation Management** | **Intergovernmental Coordination Maturity** |
|---|---|---|---|---|
| High-Capacity / Progressive Regions *(e.g., Jakarta, West Java, Yogyakarta, Bali)* | High Autonomy; exhibits low path-dependence on central fiscal transfers; possesses substantial local revenue to fund targeted health programs. | Advanced; successfully deploys real-time health dashboards, integrated EMR systems, and big data for epidemiological surveillance. | Optimized; primary care facilities strategically leverage capitation funds to strengthen promotive and preventive interventions. | High Maturity; strong structural alignment between central mandates and regional development plans; proactive localized oversight. |
| Low-Capacity / Underserved Regions *(e.g., Eastern Indonesia, parts of Sulawesi, Nusa Tenggara, Papua)* | Low Autonomy; trapped in extreme dependence on central fiscal transfers; negligible local revenue to support independent health policies. | Nascent; severely hindered by weak digital infrastructure, unreliable networks, and weak data recording systems among health workers. | Sub-optimal; capitation funds are inefficiently trapped in basic curative and operational expenditures due to restricted primary care capacity. | Weak Maturity; coordination remains superficial and compliance-driven; high vulnerability to local political cycles and policy discontinuity. |

Source: Compiled by the researcher (2026)

International comparative studies show that highly decentralized developing countries, such as the Philippines, India, and Brazil, face

remarkably similar structural challenges, particularly regional disparities and inconsistent service quality across territories. Yet, experiences from Brazil and India demonstrate that national standardization can be highly effective when accompanied by strong central oversight, rigid compliance tracking, and performance-based fiscal incentives. Literature notes that Indonesia is beginning to adopt similar international approaches through national accreditation standards, integrated health data architectures, and performance-based financing mechanisms (World Health Organization, 2020). Nevertheless, actual implementation on the ground still requires consistent cross-level policies and sufficient technical capacity across peripheral regions.

These multi-level findings suggest that Indonesia's health sector transformation is complex rather than linear. While significant progress has been achieved in macro-level areas such as UHC financing frameworks, digital health blueprints, and primary care strengthening, systemic constraints persist, including uneven subnational capacity, weak data governance, and fragmented policy implementation. These patterns align precisely with international literature indicating that health reforms in developing countries commonly face deep administrative capacity gaps and severe difficulties in building robust, sustainable coordination mechanisms across tiers of government (Kieny et al., 2017; OECD, 2018).

**2. Health System Reform**

Indonesia's health reform since 2010 has increasingly centered on comprehensive health system strengthening, with the National Health Insurance serving as the overarching framework and multi-level governance as its core political-administrative architecture. The launch of JKN in 2014 not only expanded coverage but fundamentally altered the relationships between service providers, government, and the public, with current enrollment exceeding 246 million individuals, making it one of the largest universal health coverage programs globally (BPJS Kesehatan, 2023). However, a critical analysis of JKN implementation reveals a structural disconnect between this centralized universal financing mechanism and the acceleration of upstream stunting reduction efforts, mirroring broader global challenges where a misalignment between financing and service provision weakens overall system performance (Reich et al., 2016; Sparkes et al., 2019). Theoretically, JKN

and stunting are intimately linked through the primary healthcare (PHC) ecosystem governed by community health centers (*Puskesmas*). *Puskesmas* serve as the foundational frontline for stunting-specific interventions, spanning antenatal care (ANC), continuous child growth monitoring, and household nutrition counseling for vulnerable families (World Health Organization, 2019). Consequently, the performance of these specific interventions is inherently contingent upon how JKN fiscal resources are allocated and utilized at the primary care level.

Although JKN financing is highly centralized under the national health insurance agency (BPJS Kesehatan), the operational authority and physical management of primary healthcare infrastructure, including *Puskesmas* and frontline health workers, fall entirely under the jurisdiction of district and municipal governments. This dual-authority architecture serves as the root cause of systemic inefficiencies in public nutrition financing. One of the most acute manifestations of this inefficiency is the emergence of a "curative bias" in the utilization of JKN capitation funds. Districts with limited fiscal capacity and weak planning frameworks tend to disproportionately allocate capitation funds to curative medical services and basic *Puskesmas* operational expenditures rather than directing resources toward promotive nutrition campaigns and preventive outreach programs (Trisnantoro, 2020). This misallocation is further exacerbated by systemic failures in enforcing the Commitment-Based Capitation Payment System (KBK), whose ground-level implementation remains highly inconsistent, thereby failing to generate robust financial incentives for meeting primary nutrition service standards. The cumulative impact of these upstream budgeting inefficiencies is an escalated burden on secondary (hospital-based) curative care due to the delayed detection and management of chronic malnutrition at the community level.

This structural implementation inequality clearly explains why certain districts achieve accelerated declines in stunting while others experience stagnation or policy failure. From a historical institutionalism perspective, low-performing districts are typically trapped in bureaucratic path dependency, wherein past structural fragmentation and unintegrated approaches continue to shape current policy paths (Sparkes et al., 2019). In underserved regions, particularly within parts of Sulawesi,

Nusa Tenggara, and Papua, stunting governance is paralyzed by acute shortages of trained nutrition personnel, low local policy literacy, and a proliferation of unintegrated nutrition reporting applications (e.g., the fragmentation between SIGIZI and e-PPGBM platforms), which imposes severe administrative burdens on community cadres without enhancing interventional accuracy (Overseas Development Institute, 2018). Intersectoral coordination in these low-capacity regions remains superficial and compliance-driven on paper, failing to translate into substantive integration within local development and budgeting documents.

High-performing districts successfully bypass these institutional constraints by adopting collaborative governance models (Bebbington et al., 2020) and leveraging the flexibility of hybrid governance structures. Progressive regions, such as Central Java and Yogyakarta, exhibit mature technocratic leadership capable of boldly integrating health, nutrition, and social protection datasets into a single, unified digital platform, such as the SIPS. Successful districts prevent agencies from operating in isolation; they strategically align JKN capitation funding with Village Funds to establish precise intervention convergence at the household level. Their success demonstrates that the macro-availability of central fiscal transfers remains ineffective unless backed by mature local governance, sustained political commitment from regional leaders, and aligned incentive structures capable of coherently mobilizing multi-actor networks (Prakasa & Riyanto, 2022).

These reform dynamics underscore that Indonesia's stunting strategy structurally aligns with the World Health Organization's (WHO) double-duty actions framework by integrating maternal and child health, nutrition, and sanitation interventions. The long-term sustainability of this strategy is no longer determined by the mere addition of technical regulations from central ministries. Instead, it hinges entirely on the success of broader governance reforms aimed at resolving structural fragmentation, enhancing multi-level accountability mechanisms, and narrowing the administrative capacity gaps across subnational territories in this decentralized era (Kieny et al., 2017; OECD, 2018).

### 3. Intergovernmental Coordination, Financing Politics, and Multi-Actor Dynamics in Indonesia's Stunting Policy Regime

Dismantling stunting in Indonesia demands an analytical lens that cuts far deeper than mere public health inputs; the crisis is fundamentally bound to subnational political economies and multi-tiered administrative friction. Since the 2001 overhaul toward radical decentralization, transformed power dynamics between central authorities and local municipalities have come to dictate the trajectory of nutritional programs. This institutional devolution has split implementation capacities unevenly across the archipelago, yielding volatile service delivery from one territory to another (Hadna & Dwimawanti, 2020; Mietzner, 2019). Shifting focus to fiscal politics, subnational budget outlays remain acutely sensitive to local rent-seeking and shifting electoral horizons. Local executives face distorted political incentives. They routinely downplay invisible, long-term investments in human capital, such as early childhood nutrition, preferring instead high-visibility public works that offer instant political leverage and immediate voter appeal. Thus, despite central mandates requiring Regional Stunting Action Plans (RAD) alongside targeted fiscal transfers, local administrations often treat these frameworks as exercises in bureaucratic box-checking. They lack the concrete local budgetary backing needed to mobilize frontline operations or hit meaningful key performance metrics (Kharisma & Rinaldi, 2021).

Compounding this horizontal fragmentation are vertical policy overlaps among central line ministries, a friction that breeds deep institutional ambiguity for subnational actors (Antlov et al., 2016; Bebbington et al., 2020). For instance, while the Ministry of Home Affairs oversees regional administrative performance, it possesses no real enforcement teeth to penalize missed nutritional targets. Meanwhile, the Ministry of Health issues clinical benchmarks but has zero say over regional checkbooks. To complete the gridlock, the Ministry of Finance pulls the levers on fiscal flows like General Allocation Funds (DAU) and Village Funds without mapping out the granular programmatic reality of the programs. This multi-authority vacuum leaves local resource allocation, particularly the deployment of Village Funds, highly exposed to low policy literacy and localized elite capture.

Budget tracking data from marginalized districts confirms that when transfer funds lack strict technocratic guardrails or performance-contingent conditions, village elites regularly channel them into visible, rent-generating brick-and-mortar endeavors, such as village hall facelifts or asphalt roads. This structural diversion starves essential primary care infrastructure, local-food-based supplementary feeding (PMT), and stipend pools for community health cadres. Breaking this pattern requires strict fiscal earmarking paired with performance incentives, a combination that empirically forces local leaders to align health resources where they matter most.

These intergovernmental and intersectoral breakdowns are more than just administrative bottlenecks; they translate directly into biological deficits within the domestic sphere. Eradicating childhood stunting conceptually requires that clinical (nutrition-specific) and structural (nutrition-sensitive) programs reach vulnerable families concurrently. Yet, when entrenched institutional silos isolate local departments, this convergence model collapses before hitting the household level. Consider a scenario where the Department of Public Works builds functional latrines and water systems in a target hamlet. If its actions are decoupled from the Department of Health, the community misses out entirely on intensive counseling regarding Infant and Young Child Feeding (IYCF) and household sanitation hygiene. The family ends up with clean infrastructure but unchanged behavioral habits.

The resulting exposure to environmental pathogens triggers environmental enteric dysfunction (EED) and chronic sub-clinical diarrhea in toddlers, systematically short-circuiting the child's intestinal nutrient absorption. Growth failure occurs as a direct biological consequence, even where food security is secure (UNICEF, 2022; Victora et al., 2021). Poor data interoperability similarly isolates social safety nets like the Conditional Cash Transfer program (PKH) from localized nutrition surveillance. Lacking structural bridges to primary counseling, cash transfers to destitute households often leak into non-nutritional consumption, leaving infant animal protein gaps completely unaddressed.

Placed in a broader international context, these multi-tier friction points relegate Indonesia to a mid-tier position compared to countries that engineered rapid, historic stunting reductions, such

as Vietnam, Ethiopia, and Rwanda. Those high-performing regimes operate on centralized political leverage, stringent top-down evaluation via mandatory performance compacts, and single-source data infrastructures that align funding flows from the ministerial level down to individual homes. Vietnam, for instance, clusters its agricultural, educational, and primary health streams under a singular command line, making certain that structural macro-reforms translate to actual dietary improvements on the family dinner plate (World Bank, 2023). Indonesia's macro reduction from 37% in 2013 to 21.6% in 2022 is a major administrative feat, but anchoring these gains permanently requires radical adjustments. The state must break regional financial capture, dissolve institutional fiefdoms, force total database interoperability across isolated tracking platforms like SIGIZI and e-PPGBM, and restructure multi-level incentives to reflect the ground-level social realities of vulnerable households.

**4. Governance Coherence, Policy Alignment, and Institutional Sustainability**

The long-term success of stunting reduction efforts in Indonesia hinges critically on the degree of governance coherence, defined as the extent to which governmental and non-governmental institutions operate harmoniously, reinforce each other's roles, and coordinate mandates without overlap or conflict. Robust cross-sectoral governance serves as a primary prerequisite for various interventions to operate simultaneously, thereby generating a comprehensive impact on the root determinants of child nutrition. At the national level, cross-sector coordination has demonstrated structural progress through the implementation of the National Strategy for *Stranas Stunting*, which successfully mandated 23 ministries and agencies to collaborate within a unified framework. However, this integrative architecture frequently undergoes deconstruction when devolved to the subnational level (provinces and districts/municipalities), where the decentralized system grants extensive discretion to local leaders who possess highly variable administrative capacities, sociopolitical commitments, and political affiliations (Bebbington et al., 2020).

At the subnational level, the Regional Development Planning Agency (Bappeda) theoretically holds a constitutional mandate to act as a coordination hub for cross-sectoral development planning. In operational reality, however, Bappeda frequently fails

to execute this steering function due to limited dynamic capabilities and the absence of binding executive authority to enforce alignment among technical line departments. Bappeda's failure as an integrator is rooted in bureaucratic power asymmetries and vertical-horizontal steering conflicts. Subnational department heads (such as those in Health, Public Works, or Social Affairs) structurally exhibit far stronger compliance toward vertical directives from their respective line ministries at the center than toward the horizontal coordination attempted by Bappeda at the regional level (Antlov et al., 2016). This occurs because bureaucratic career advancements, technical implementation guidelines, and sectoral budget allocations are tightly controlled by central ministries. Consequently, each regional government apparatus (*Organisasi Perangkat Daerah* - OPD) continues to operate within the silos of its own fragmented institutional logics. This sectoral ego manifests in misaligned programming, such as sanitation infrastructure development proceeding without synchronization with community behavioral modification initiatives (Lieberman et al., 2022; World Bank, 2018). Without regulatory instruments capable of reconciling these conflicting logics into a shared incentive structure, coordination under Bappeda stagnates as a mere paper-driven procedural formality devoid of genuine intervention convergence on the ground.

This systemic weakness in enforcing horizontal accountability in Indonesia stands in sharp contrast to the successful governance models of countries that have achieved accelerated stunting reductions, such as Rwanda and Vietnam. As an international benchmark, Rwanda bypassed localized bureaucratic fragmentation by institutionalizing the *Imihigo* system, a mandatory performance contract signed by district mayors directly before the President of the Republic. Under the *Imihigo* model, reductions in stunting prevalence and household nutrition convergence targets are rigidly incorporated as core political evaluation instruments that dictate the career longevity of local officials and the volume of subsequent regional budget allocations (Fanzo et al., 2021). Meanwhile, Vietnam utilizes a structural integration approach that embeds agriculture, education, and primary healthcare sectors within a unified vertical command chain overseen directly by the Prime Minister, thereby ensuring that sensitive macro-level policies are immediately translated into improved

nutritional consumption at the dining tables of vulnerable families (World Bank, 2023). This disciplined international approach demonstrates that multisectoral coordination requires tangible legal enforcement mechanisms and political incentives to prevent it from dissolving into overlapping bureaucratic routines.

Beyond the challenge of coherence, the institutional sustainability of Indonesia's stunting policies remains highly vulnerable to the shocks of local political cycles (Pilkada). In the run-up to regional elections, stunting is frequently utilized as a political commodity or campaign slogan; however, post-election shifts in regional leadership are routinely accompanied by altered development priorities, bureaucratic reshuffling, and the discontinuity of ongoing nutritional policies. An over-reliance on individual regional leadership figures (*individual leadership dependency*) in the absence of systemic institutionalization leaves stunting interventions highly susceptible to collapse during political successions (Reich & Balarajan, 2020; Sparkes et al., 2019). This tension is further exacerbated by the disconnect between top-down technocratic approaches imposed by the center and the diverse socio-cultural norms at the grassroots level. Without cultural adaptation that embeds intervention programs within traditional structures, local leadership systems, and customary caregiving patterns, the technical and logistical aid provided by the government risks being rejected or underutilized by local communities (World Health Organization, 2021). Therefore, sustaining the stunting reform agenda in Indonesia demands structural alignment that not only unifies policy instruments, such as strictly linking the Conditional Cash Transfer program with intensive nutritional counseling, but also constructs resilient accountability anchors capable of withstanding regional political cycles.

## CONCLUSION

This study concludes that the primary barrier to accelerating stunting reduction in Indonesia stems not from a scarcity of clinical interventions or technical regulations, but from structural asymmetries and multi-level governance friction within the decentralized framework. Devolution has transformed subnational budgetary politics into a dominant determinant of child health outcomes; specifically, a pervasive curative bias within community health centers and the diversion of Village Funds by local elites frequently fracture

intervention convergence pathways, thereby causally transmitting systemic shocks that compromise household-level nutrient absorption. As a sharp concluding policy implication, Indonesia must radically pivot from prescriptive coordination models toward binding fiscal and political accountability reforms. This paradigm shift should be operationalized by institutionalizing mandatory performance contracts for regional leaders, tying their political career longevity directly to stunting reduction benchmarks, akin to Rwanda's *Imihigo* system or Vietnam's vertical command chain, and enforcing strict fiscal earmarking on central transfer funds (DAU and Village Funds) conditioned rigorously upon real ground-level nutritional convergence metrics.

The primary novelty of this study lies in its analytical paradigm shift, explicitly deconstructing stunting not through the conventional biomedical, epidemiological, or individual nutritional deficit lenses that dominate existing literature, but through a multi-level institutional and political economy framework. This research successfully bridges a critical gap by providing a comprehensive mapping of how macro-level political-economic decisions interact non-linearly with subnational bureaucratic discretion, and how these governance frictions ultimately manifest as clinical-biological growth failure at the micro-household level. By integrating historical institutionalism (path dependency) and collaborative governance theories within the context of Indonesia’s decentralization dynamics, this study offers an essential evaluative framework for policymakers tasked with architecting sustainable governance reforms to eradicate chronic malnutrition crises.

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