



INDONESIA 2018 – 2024 NATIONAL NUTRITION PROGRAMME REVIEW

Full Report

Acknowledgment

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Indonesia 2018 – 2024 National Nutrition Programme Review

Full Report

Executive Summary

BACKGROUND

Indonesia continues to experience a triple burden of malnutrition comprising undernutrition, micronutrient deficiencies, and overweight or obesity. Stunting among children under five declined from 37.2% in 2013 to 30.8% in 2018, and wasting decreased from 12.1% to 10.2%, showing gradual progress but persistent challenges. Anaemia among pregnant women increased from 37.1% in 2010 to 48.9% in 2018, exceeding the World Health Organization's threshold for a severe public health problem. Meanwhile, overweight and obesity rose among adults from 28.9% to 35.4%, affecting 29.3% of men and 46.5% of women, driven by shifts towards unhealthy diets and sedentary lifestyles across both urban and rural populations. To address these issues, the Government of Indonesia has established a strong policy framework through initiatives such as the Scaling Up Nutrition (SUN) Movement, Presidential Regulation No. 42 of 2013 on the National Movement for Nutrition Improvement, the National Strategy to Accelerate Stunting Prevention (STRANAS 2018–2024), and the Health System Transformation Agenda (2022). Building on these foundations, the Ministry of Health, with support from UNICEF, commissioned the National Nutrition Review to document progress, identify remaining bottlenecks, and provide an evidence-based basis for strengthening future nutrition programming from 2018 to 2024.

METHODOLOGY

The review utilized the WHO Six Building Blocks for Health Systems as its analytical framework, covering leadership and governance, service delivery, human resources, supply, financing, and information systems, providing a structured approach to identify system-level gaps and practical solutions. A mixed-methods design was employed, combining desk reviews, key informant interviews and focus group discussions. Data collection spanned six provinces and twelve districts representing western, central, and eastern Indonesia, with fieldwork conducted in twelve Puskesmas and twelve Posyandus. The review engaged over 600 informants from more than seventy stakeholder institutions, including fourteen national ministries and agencies, provincial and district governments, Puskesmas staff, Posyandu cadres, program beneficiaries, and members of the SUN Network. This broad and inclusive approach provided rich, multi-level insights into policy alignment, program implementation, and service delivery realities, forming a robust evidence base for system-strengthening recommendations.

RESULTS AND DISCUSSIONS

Between 2018 and 2024, Indonesia's health system made substantial progress in institutionalizing nutrition programs through stronger policies, digital innovation, and multisectoral coordination. National leadership under Presidential Regulation No. 72 of 2021 formalized convergence through the National Strategy to Accelerate Stunting Prevention (STRANAS), demonstrating high-level political commitment. However, implementation remains primarily focused on stunting, while wasting, anaemia, and overweight prevention receive less attention. This focus differs from global recommendations that call for integrated, life-course and double-duty actions to address all forms of malnutrition. Within the Ministry of Health, nutrition is positioned under the Directorate of Primary Health Care, which limits its strategic influence, and subnational structures are not aligned with national mandates, creating weak accountability and uneven coordination.

Service delivery through Puskesmas, Posyandu, and schools has expanded, yet quality and integration remain inconsistent due to the absence of a costed Essential Nutrition Package (ENP) that defines service standards and roles. The misalignment with global guidance on integrated primary health care limits the continuum of care across the life cycle. Check list-oriented services create missed opportunities in providing quality and person centered service, especially related to nutrition education, counselling, and SBCC-based interventions. Workforce capacity has improved through digital human resource platforms such as SISDMK and DREAMS and competency-based training via Plataran Sehat, but the distribution of staff remains unequal, with unclear task distribution and retention mechanism. Frontline health workers and managers continue to face limited technical and program management capacity.

Supply systems for nutrition commodities have improved but remain fragile. For example, weak coordination and delayed technical guidance contribute to the delayed implementation of supplementary feeding. While capacity for stock management contributed to and stockouts of vitamin A and MCH book. Further policy bottlenecks and local production capacity contributed to the limited availability of ready-to-use therapeutic foods (RUTF). Financing for nutrition shows political will but remains modest and fragmented, with only 6 to 9% of the health budget allocated to nutrition-specific interventions and heavy reliance on central transfers. Nutrition information systems, including SSGI, SKI, e-PPGBM, and Si-Gizi Kesga, have increased data availability, yet they operate in silos.

Overall, progress across the six-health system building blocks remains fragmented and siloed, with limited cohesion among governance, financing, workforce, service delivery, supply, and information systems. The absence of a costed and operational Essential Nutrition Package prevents the establishment of standard inputs, processes, and outputs that could ensure coherence and accountability across programs. Aligning national nutrition strategies with global frameworks, strengthening local institutional capacity, ensuring predictable financing, and integrating monitoring and supply systems will be essential to sustain progress and achieve equitable nutrition outcomes across the life course.

STRATEGIC PRIORITIES GOING FORWARD

1. Revisit and align policies with WHO recommendations, ensuring coherence across platforms and coverage beyond stunting (e.g. national guideline on the management of wasting, contradiction official decrees governing the management of children with concurrent stunting and severely acute malnutrition (SAM) versus those with SAM only)
2. Ensure the development, enforcement, and monitoring of WHO-endorsed 'best buy' policies for obesity and non-communicable disease prevention, including taxation of products high in salt, sugar, and unhealthy fats, interpretative front-of-pack nutritional labelling, and restrictions on the marketing of unhealthy foods.
3. Develop a costed multi-year nutrition strategy under the MoH to guide planning, budgeting, and execution.
4. Define and operationalise an Essential Nutrition Package (ENP) with clear roles, reliable supplies, supportive supervision, sustainable financing, and integrated NiE preparedness.
5. Invest in capacity building for nutrition management to strengthen planning, costing, supervision, and data use across all levels.
6. Integrate nutrition with food systems and climate resilience, to safeguard food security and nutrition from climate shocks, particularly for vulnerable groups like children and women.
7. Elevate nutrition within MoH and the Health Sector Transformation Agenda (HSTA), positioning it centrally across all pillars of reform with leadership, budget lines, and accountability matching its national priority status.



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List of Abbreviations

ANC	Antenatal Care
APBD	Anggaran Pendapatan dan Belanja Daerah/Regional Revenue and Expenditure Budget
APBN	Anggaran Pendaatan dan Belanja Negara/National Revenue and Expenditure Budget
BAPPENAS	Badan Perencanaan Pembangunan Nasional/Ministry of National Development Planning
BAPPEDA	Badan Perencanaan Pembangunan Daerah/Regional Development Planning Agency
BKKBN	Badan Kependudukan dan Keluarga Berencana Nasional/National Population and Family Planning Agency
BMI	Body Mass Index
BMS	Breastmilk Substitute
BOK	Bantuan Operasional Kesehatan/Health Operational Assistance
BPS	Badan Pusat Statistik/Central Bureau of Statistics
CED	Chronic Energy Deficiency
CHW	Community Health Worker
CSR	Corporate Social Responsibility
CSO	Civil Society Organisation
CODE	International Code of Marketing for Breastmilk Substitute
CU5	Children Under Five
DAK	Dana Alokasi Khusus/Special Allocation Fund
DAU	Dana Alokasi Umum/General Allocation Fund
DBHCHT	Dana Bagi Hasil Cukai Hasil Tembakau/Revenue Sharing Fund from Tobacco Excise
DHIS2	District Health Information Software 2
DHO	District Health Offices
DID	Dana Insentif Daerah/Regional Incentive Fund
DPs	Development Partners
DREAMS	Dashboard Tenaga Kesehatan dan Tenaga Medis/Health and Medical Personnel Dashboard
e-PPGBM	Elektronik Pencatatan dan Pelaporan Gizi Berbasis Masyarakat/Electronic Community-Based Nutrition Recording and Reporting
FANTA	Food and Nutrition Technical Assistance
FGD	Focus Group Discussion
FHI	Family Health International
GERMAS	Gerakan Masyarakat Sehat/ Healthy Living Community Movement

GAP	Global Action Plan
GMP	Growth Monitoring and Promotion
GOI	Government of Indonesia
HRH	Human Resource for Health
HSTA	Health System Transformation Agenda
IDHS	Indonesian Demographic and Health Survey
IEC	Information Education and Communication
IFA	Iron and Folic Acid
IHS	Indonesia Health Survey
IKPS	Indeks Khusus Penanganan Stunting/Special Index for Stunting Reduction
ILP	Integrasi Layanan Primer
IMCI	Integrated Management of Childhood Illness
IMAM	Integrated Management of Acute Malnutrition
INEY	Investing in Nutrition and Early Yeras
IYCF	Infant and Young Child Feeding
IYCN	Infant and Young Child Nutrition
KII	Key Informant Interview
KPM	Keluarga Penerima Manfaat/Beneficiary Family
KRISNA	Kolaborasi Perencanaan dan Informasi Kinerja Anggaran/Collaboration on Budget Planning and Performance Information
LAKIP	Laporan Akuntabilitas Kinerja Instansi Pemerintah/Government Agency Performance Accountability Report
LBW	Low Birth Weight
LMIS	Logistics Management Information System
MAD	Minimum Acceptable Diets
MAM	Moderate Acute Malnutrition
MBG	Makanan Bergizi Gratis/Free Nutritious Food
MCH	Maternal and Child Health
MNCH	Maternal, Newborn, and Child Health
MDD	Minimum Dietary Diversity
MEAL	Monitoring Evaluation Accountability and Learning
M&E	Monitoring and Evaluation
MIYCN	Maternal Infant and Young Child Nutrition
MoE	Ministry of Education

MMS	Multiple Micronutrient Supplements
MNPs	Multiple Micronutrient Powders (Taburia)
MP-ASI	Makanan Pendamping ASI/Complementary Feeding
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoU	Memorandum of Understanding
MSG	Mother Support Group
MSP	Multi Stakeholder Platform
MTBS	Manajemen Terpadu Balita Sakit/Integrated Management of Sick Toddlers
MUAC	Mid-Upper Arm Circumference
NiE	Nutrition in Emergencies
NCDs	Non-Communicable Disease
NGO	Non-Governmental Organisation
NNIS	National Nutrition Information System
ODA	Official Development Assistance
PHC	Primary Health Care
PKH	Family Hope Programme
PKPR	Pelayanan Kesehatan Peduli Remaja/Youth Care Health Services
PLATARAN SEHAT	Platform Pembelajaran Digital Kementerian Kesehatan RI/ Indonesian Ministry of Health Digital Learning Platform
PMBA/IMCF	Pemberian Makanan Bayi dan Anak/Infant and Young Child Feeding Counselling Training Module
PMT	Pemberian Makanan Tambahan/Food Supplementation
POSYANDU	Pos Layanan Terpadu/Integrated Health Post
POU	Prevalence of Undernutrition
PPPS	Program Percepatan Pengurangan Stunting/Stunting Reduction Acceleration Program
PUSKESMAS	Pusat Kesehatan Masyarakat/Community Health Center
PW	Pregnant Woman
RAN PASTI	Rencana Aksi Nasional Percepatan Penurunan Angka Stunting Indonesia
RADPG	Rencana Aksi Daerah Pangan dan Gizi/Regional Action Plan for Food and Nutrition
RANPG	Rencana Aksi Nasional Pangan dan Gizi/Food and Nutrition Action Plan
RISKESDAS	Riset Kesehatan Dasar
RPJMN	Rencana Pembangunan Jangka Menengah Nasional/National Mid-term Development Plan
RPJPN	Rencana Pembangunan Jangka Panjang Nasional/National Long-term Development Plan

RUTF	Ready to Use Therapeutic Food
SACA	School Aged Children and Adolescents
SAM	Severe Acute Malnutrition
SBC	Social and Behaviour Change
SPM	Standar Pelayanan Minimal/Minimum Service Standard
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
SDIDTK	Stimulasi, Deteksi, dan Intervensi Dini Tumbuh Kembang/Stimulation, Detection, and Early Intervention of Growth and Development
Si-GIZI KESGA	Maternal and Child Health Nutrition Information System
SIKDA	Sistem Informasi Kesehatan Daerah/Regional Government Information System
SIPD	Sistem Informasi Pemerintahan Daerah/Regional Government Information System
SISDMK	Sistem Informasi Sumber Daya Manusia Kesehatan/Health Human Resources Information System
SSGI	Survei Status Gizi Indonesia/Indonesia Nutrition Status Survey
STRANAS	Strategi Nasional Percepatan Pencegahan dan Penurunan Stunting/National Strategy for Accelerating Stunting Prevention
SUN	Scaling Up Nutrition
SUPAS	Survei Penduduk Antar Sensus/Intercensal Population Survey
SUSENAS	Survei Sosial Ekonomi Nasional/National Socio-Economic Survey
TFC	Therapeutic Feeding Centres
TKPKD	Tim Koordinasi Penanggulangan Kemiskinan Daerah/Regional Poverty Alleviation Coordination Team
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan/National Team for Stunting Prevention Acceleration
TOR	Terms of Reference
TWG	Technical Working Group
UKS	Usaha Kesehatan Sekolah/School health
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAS	Vitamin A Supplementation
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WASH	Water, Sanitation and Hygiene
WIFAS	Weekly Iron and Folic Acid Supplementation

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01. Introduction

1.1 Background

Indonesia has for a long time been experiencing a triple burden of malnutrition, i.e. undernutrition, micronutrient deficiencies, and overweight or obesity. Undernutrition remained widespread despite some improvement over the years, for example, prior to the review, stunting among children under five reduced from 37.2% in 2013 to 30.8% in 2018, affecting nearly one in every three children. Likewise, the prevalence of wasting reduced from 12.1% in 2013 to 10.2% in 2018, showing a slight decline.^{1,2}

Micronutrient deficiencies are also of concern across the life cycle. Anaemia among pregnant women rose sharply, from 37.1% in 2010 to 48.9% in 2018, surpassing the WHO threshold of a severe public health problem.^{3,2} While the prevalence of overweight and obesity among children under five declined from 11.9% in 2013 to 8% in 2018, the prevalence in other age groups was increasing. Among adults, overweight and obesity rose steadily between 2013 and 2018 from 28.9% to 35.4%. The prevalence reached almost 29.3% of men and 46.5% of women.^{1,2} Diets high in sugar, salt, and fat, coupled with increasingly sedentary lifestyles contributed to this shift. While these conditions were once concentrated among urban and wealthier households, they are now increasingly extending to rural and lower-income groups.^{4,5}

Recognizing the seriousness of these trends, the Government of Indonesia had taken important steps before 2018 by strengthening the policy and enabling environment for nutrition. The country joined the Scaling Up Nutrition (SUN) Movement in 2011, signalling alignment with global commitments. The GoI developed the Presidential Regulation No. 42/2013 and launched the National Movement

for the Acceleration of Nutrition Improvement (GERMAS PPG). It also elevated nutrition as part of the national development priority. Similarly, nutrition was also explicitly included in the National Mid-Term Development Plan (RPJMN) 2015–2019, with the National Development Planning Agency (BAPPENAS) and the Vice President's Office coordinating multi-sectoral engagement. In addition, the Food and Nutrition Action Plans (RANPG) were developed and updated to provide central and local governments with a framework for planning, budgeting, and monitoring nutrition action.^{6,7,8}

By 2017, Indonesia had laid solid policy foundations and achieved some progress in reducing malnutrition. However, these did not translate to positive nutrition outcomes; for example, stunting levels remained high, anaemia among women had worsened, and overweight and obesity were on the rise. These persistent and emerging challenges highlighted the need for a more comprehensive and coordinated nutrition response. To address these challenges, in 2018, the GOI developed the National Strategy to Accelerate Stunting Prevention (STRANAS 2018–2024), followed by Presidential Decree No. 72/2021, which reinforced the national coordination mechanisms and targets.^{9,10} The Health System Transformation Agenda (2022) further strengthens nutrition within primary health care reforms. Building on these initiatives and recognizing both the progress made and the challenges that remain, the Ministry of Health, with support from UNICEF, commissioned this National Nutrition Review. The review assesses achievements and bottlenecks from 2018 to 2024 and provides evidence-based recommendations to guide the next phase of Indonesia's nutrition agenda.

1.2 Review Objectives and Scope

The primary objective of the national nutrition programme review is to conduct an evidence-based appraisal of the nutrition situation and nutrition-specific interventions in Indonesia to improve programme performance and outcomes. The review aims to generate actionable insights to support sustainable strategies for reducing all forms of malnutrition across the life course.

This review aims to achieve the following specific objectives:

- Review the progress of the national nutrition programme towards the improvement of the nutrition indicators.
- Identify programme bottlenecks, successes, problems, gaps, enabling factors, emerging issues, opportunities, lessons, and threats.
- Review the capacity of the national and subnational

stakeholders to implement the planned activities outlined in the MoH strategic plan.

- Analyse the nutrition programmes, governance structure, and their contribution towards achieving the national targets.
- Analyse the government's response to nutrition programming in an emergency context and its ability to maintain the quality and coverage of the program.
- Develop recommendations to improve the nutrition programme implementation and results, as well as the contributing roles of the main government entities.

The scope of this review is defined along four dimensions: temporal, geographic, programmatic, and organizational. Together, these dimensions provide a comprehensive framework for assessing progress and identifying system-level gaps.



Temporal Scope

The review assesses Indonesia's 2018–2024 nutrition commitments and progress.



Geographic Scope

The review analyzes national program priorities and implementation across all provinces through nationwide secondary data and selected field visits.



Programmatic Scope

Anchored in WHO's six building blocks, the review examines systemic factors affecting nutrition-specific programs, focusing on maternal nutrition, children under five, and school-age children and adolescents across the continuum of care.



Organizational Scope

The review centres on the Ministry of Health nutrition-specific programs while acknowledging cross-sectoral contributions to provide a comprehensive view of multisectoral engagement.



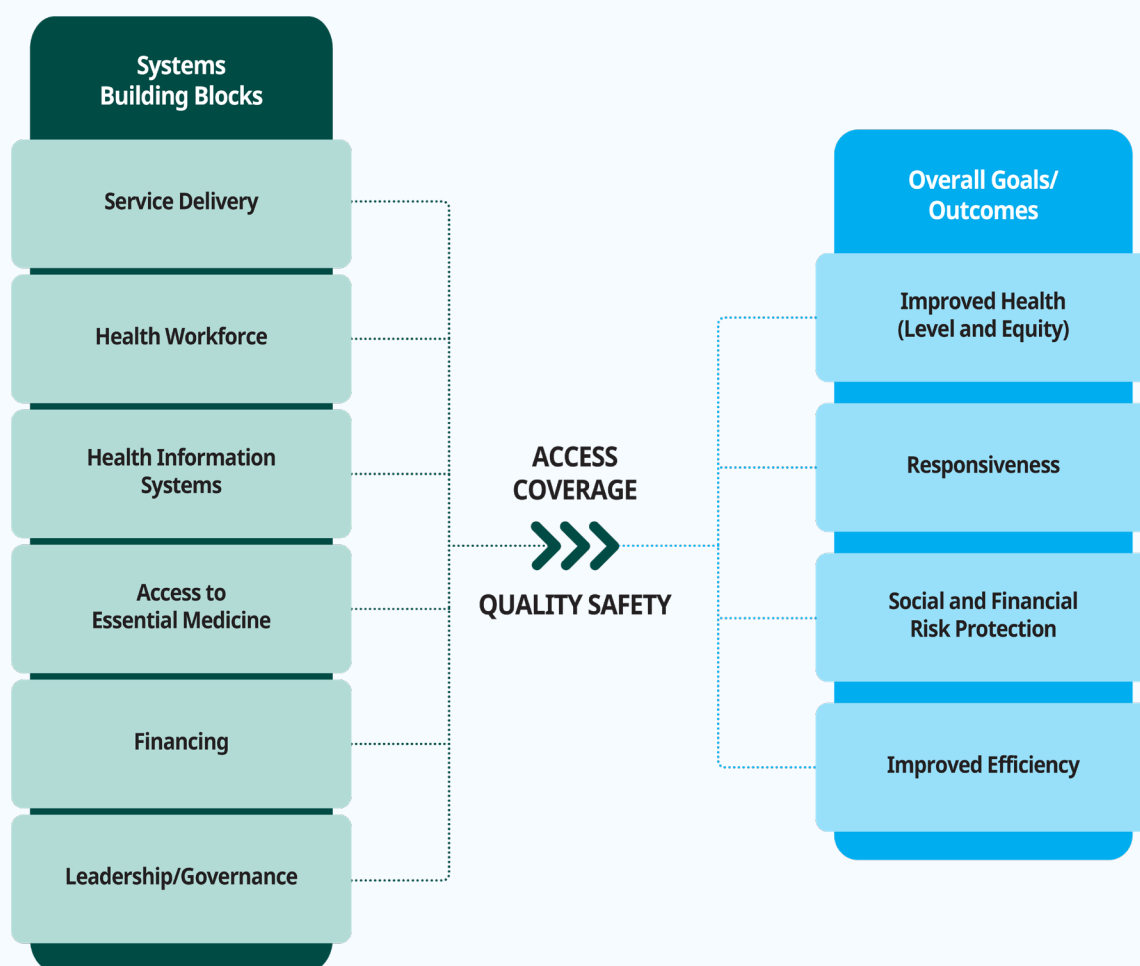
02. Methodology

2.1 Analytical Framework

In alignment with the study's objective, the review applies the WHO's Six Building Blocks for Health System strengthening as a framework for bottleneck analysis. This structured approach

enables a comprehensive assessment of both strengths and challenges in the design, implementation, and sustainability of nutrition-specific interventions in Indonesia.¹¹

Figure 1: WHO Health System Framework: The Six Building Blocks



The six building blocks are explicitly adapted to the nutrition context, offering a system-wide lens to diagnose key constraints, identify enablers, and formulate practical solutions. In this review, the building blocks were also applied to assess nutrition interventions across the life course, with findings synthesized and summarized to highlight key strengths, gaps, and opportunities for improvement. These building blocks include:

- **Leadership and Governance in Nutrition:** This domain reviews the present, alignment and implementation of policies, plans, and guidelines guiding nutrition specific and sensitive interventions, as well as coordination and accountability across sectors.

- **Nutrition Service Delivery:** This block assesses the availability, coverage and quality of nutrition-specific services across the life cycle, including NiE.
- **Human Resources for Nutrition:** This dimension examines the availability, distribution, capacity, and workload of nutrition service providers, along with their competencies, support systems, and ability to deliver quality care.
- **Essential Supply for Nutrition:** This block reviews the availability, quality, distribution, and use of essential nutrition commodities, alongside procurement, storage, and supply systems.
- **Nutrition Information System:** This block reviews the availability and quality of nutrition

data for monitoring and decision-making, assessing routine and survey systems, analysis, and feedback mechanisms.

- **Financing for Nutrition:** This dimension evaluates the adequacy, allocation, and use of nutrition financing across levels, including budget mobilization, alignment, and spending efficiency.

Applying the WHO Six Building Blocks framework offers a structured, systems-based approach to uncover both technical and systemic barriers. In turn, this approach enables the formulation of coherent, root-cause-oriented recommendations, while also identifying scalable good practices and strategic entry points to strengthen national and subnational nutrition systems and accelerate the reduction of all forms of malnutrition.

2.2 Design, Timeline and Sampling

The review adopted a mixed-methods approach to generate a comprehensive understanding of the status, progress, and implementation gaps in addressing malnutrition among pregnant mothers, children under five years old, school-age children and adolescents. The review was conducted from March 2025 to August 2025.

Given Indonesia's vast and diverse context, as well as time and resource constraints, the review used non-probability sampling, combining purposive and convenience approaches. National KIIs targeted key stakeholders in nutrition and cross-cutting areas, while

sub-national data covered provincial, district, and Puskesmas levels. Six provinces were purposively selected based on multiple criteria: triple burden of malnutrition prevalence, overweight/obesity among SACA, stunting investment, disaster risk, food security indicated by prevalence of under-nourishment (PoU), Special Index for Stunting Reduction (IKPS), and geographic variation. In each province, two districts were chosen (the capital and a nearby district that could provide a contrasting, complementary example), with one Puskesmas sampled in each district, selected jointly with local authorities.

Table 1: Criteria for Province Selection for Field Visit

Province Districts	TBM CU5-composite score*	SACA Overweight/ Obesity	Stunting Investment**	Disaster Risk	IKPS (2023)	PoU (2024)	Geographical and other notable conditions
Bali (Denpasar, Tabanan)	5.2 (Low)	26.7%	Doing more with less	Moderate	74.9	Low	Bali Island – Central part of Indonesia – Good TBM indicator
East Java (Surabaya, Jember)	9.8 (Low)	23.5%	Successful investment	Moderate to High	78.5	Medium	Java Island, densely populated - Good TBM indicator
North Sulawesi (Manado, South Minahasa)	12 (Medium)	22.5%	Successful investment	Moderate to High	70.6	Low	Sulawesi Island – Central Part of Indonesia – Medium TBM Indicator
North Maluku (Ternate, West Halmahera)	14.3 (Medium)	16.3%	Under-funded	High	61.2	High	Island – Eastern Part of Indonesia- Remote area – Medium TBM indicator
Aceh (Banda Aceh, Aceh Jaya)	15.5 (High)	17.2%	Inefficient spending	High	71	Medium	Sumatra Island -Varied - Special autonomous region
East Nusa Tenggara (Kota Kupang, Timor Tengah Selatan)	18 (High)	6.1%	Under-funded	Moderate to High	70.2	High	Arid - Eastern Part of Indonesia

* The dataset ranged from 5 to 20, which was divided into three equal intervals of width 5. Each data point was then classified into its corresponding interval (5-10: low; 10-15: medium; 15-20: high.; TBM = Triple Burden of Malnutrition

** National IKPS 7.3

2.3 Data Collection and Analysis

Data were collected through a combination of desk review, key informant interviews (in-depth one-on-one and group formats), and focus group discussions (FGDs). The desk review, conducted in March 2025, examined national policies, guidelines, survey data (BPS, SSGI, Riskesdas), administrative records, and programme documents. Primary data collection through KIIs and FGDs commenced in April 2025, while field visits to the selected provinces were conducted from 14 to 30 of May 2025. The KIIs were undertaken at national, provincial, district, and service delivery levels with policymakers, programme managers, and implementing partners to capture institutional perspectives. FGDs engaged

frontline workers (nutritionists, midwives, Posyandu cadres) and beneficiaries (pregnant women, mothers of under-five children, and school communities) to explore service delivery realities and behavioral drivers. Field validation and primary data collection were conducted between May and June 2025, involving both national and subnational stakeholders. At the subnational level, data were collected across six provinces, twelve districts, and twelve selected Puskesmas and Posyandus, engaging approximately 600 informants in total. Further details of stakeholders consulted and documents utilized are provided in Annex 1, with a summary snapshot presented in the table below.

Table 2: Snapshot of Stakeholders Consulted and Documents Sources for the Review

Stakeholders/Sources	Data Collection Method
National Level	
14 Ministries/National Agency 5 Special teamwork within the family health directorate in the MoH 4 Directorates in the MoH 15 institutions within the SUN Network	Series of In-depth or Group Interviews
Sub-National Level	
- Cross-sectoral stakeholders at the provincial level in 6 provinces - Provincial Health Office in 6 provinces - Cross-sectoral stakeholders at the district/city level in 12 districts/cities - District/City Health office in 12 districts/cities	Group Interviews
Puskesmas and Posyandu health workers, cadres and beneficiaries (pregnant mothers and mothers of children U5) in 12 districts/cities	Focus Group Discussions
Desk Review of key policy and programme documents	
Nationally Representative Health Survey (Riskesdas, SSGI, SKI, Susenas) National Policy and Program documents (President Regulations or Decree, MoH Regulations or Decree, Program Guidelines, Relevant regulations or decrees from other ministries, financing report)	

The review combined secondary analysis of national surveys and MoH routine data (2018–2024), content review of key policy documents, and thematic analysis of KIIs and FGDs. Data were analyzed within the six WHO health system building blocks to capture both quantitative trends and qualitative insights. Triangulation was applied

to integrate findings across data sources, validate interpretations, and ensure robust conclusions, for example, linking policy review with fieldwork observations and stakeholder perspectives. The overall flow of the review process and its steps is illustrated in the figure below.

Figure 2: Process and Steps for the Nutrition Programme Review



2.4 Review Limitations

This review faced several limitations as follows.

- The short time frame for data collection constrained the breadth and depth of data collection and analysis, particularly in relation to subnational variations.
- The non-probability sampling strategy may have introduced selection bias and not fully captured the diversity of Indonesia's health system and nutrition context, making the results not representative to generalize beyond the study locations.
- Low online survey response rate, which may have affected data representation, leading to the exclusion of information from the final analysis.
- Over-reliance on secondary data from government reports and program documents introduced data

bias, as not all sources employed were consistent with operational definitions, which resulted in limited comparability and the scope for extrapolation.

Despite these constraints, several strategies were employed to strengthen the validity of the findings, such as data triangulation across multiple sources, including routine health information systems, survey data, and program reports, to improve reliability. Further, a wide range of key informants at national and subnational levels were engaged to ensure diverse perspectives and contextual insights. Furthermore, validation processes were undertaken through consultation workshops and peer review, thereby enhancing the robustness and credibility of the conclusions.



03. Key Findings of the Review

3.1 Progress in Nutrition Outcome Indicators – How Far Have We Moved Forward?

This section reviews nutrition outcome trends across the life course, highlighting both progress and persistent challenges, and situates them within the broader performance of the health system by examining the influence of service delivery, policy, financing, workforce, supplies, information, and governance. Within the review's timeframe, the findings also reflect the system's resilience in managing the COVID-19 pandemic crisis.

3.1.1 NUTRITION OUTCOMES FOR CHILDREN UNDER FIVE, PREGNANT WOMEN AND SCHOOL AGE CHILDREN AND ADOLESCENTS (SACA)

3.1.1.1 Under five children

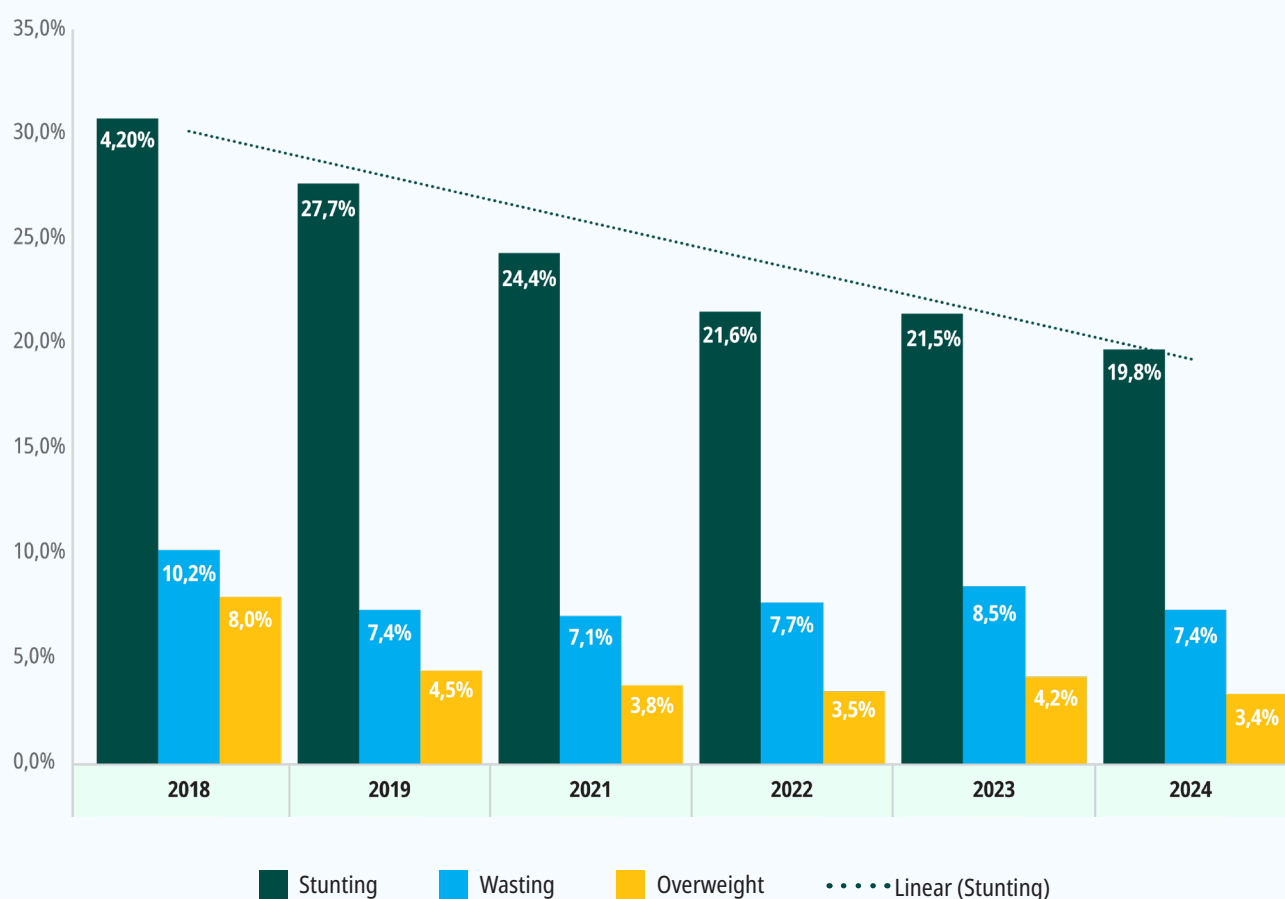
Indonesia has made significant progress in reducing malnutrition among children under five, pregnant women and SACA. Among children under five years old, the prevalence of stunting declined from 30.8% in 2018 to 19.8% in 2024 (SSGI). This represents a 35.7% reduction since 2018 which also surpassing the World Health Assembly (WHA) global target of a 40% reduction by 2025 when compared to the 2013 baseline. These gains reflect results of sustained political commitment and multisectoral action.^{1,2,12,13}

However, despite making these strides, the national target of <14% by 2024 has not been achieved. In addition, there are significant geographic inequities in the prevalence of above 30% among provinces such as East Nusa Tenggara, Papua, and West Sulawesi. Similarly, provinces like Java, though the prevalence is low, contribute a high absolute number to the burden due to their high population size. This demographic disparity creates a dual challenge of addressing high-prevalence by provinces while also prioritizing reducing the burden in highly populated areas. Likewise, wasting among under five children has also declined in the period under review, from 10.2% in 2018 to 7.4% in 2024. These data show improvement, but it is still above the WHA threshold of <5%. Fluctuations in recent years highlight continued gaps in early detection, referral, and treatment of this condition.

Overweight among children under five shows a significant decline from 8.0% in 2018 to 3.4% in 2024; however, the data shows fluctuation across the years (Fig. 3). While levels are relatively low compared to global averages, research suggests that overweight in early childhood is an early warning of potential obesity and non-communicable disease issues in later-life. Dietary risk factors for overweight among this age group in Indonesia, for example, sub-optimal adherence to recommended breastfeeding consumption, and the remarkably high consumption of unhealthy ultra-processed and commercially produced complementary foods, also represent a critical warning. The persistence of overweight in both urban centres and food-insecure regions requires, therefore, close monitoring and preventive action to avoid the escalating health and economic burden associated with this condition.¹⁴

Micronutrient deficiencies, also referred to as “hidden hunger”, continue to threaten child growth and development in Indonesia. However, some strides have been registered to reduce micronutrient deficiencies, for instance, anaemia prevalence among children under five, which declined from 38.5% in 2018 to 23.8% in 2023, meaning approximately one in four children is anaemic.^{2,12} The high prevalence of anaemia among children under five is primarily driven by poor maternal and child nutrition due to inadequate intake of iron by both mothers and children (6 to 59 months), and suboptimal feeding practices. Routine screening and early treatment for anaemia remain limited, particularly at the community level, especially in high-burden areas. Although a national program for multiple micronutrient powder (MNP) supplementation is in place, the scale-up (coverage) of interventions is limited.

Figure 3: Nutrition Outcomes for Children Under-5



3.1.1.2 Pregnant Women and Women of Reproductive Age

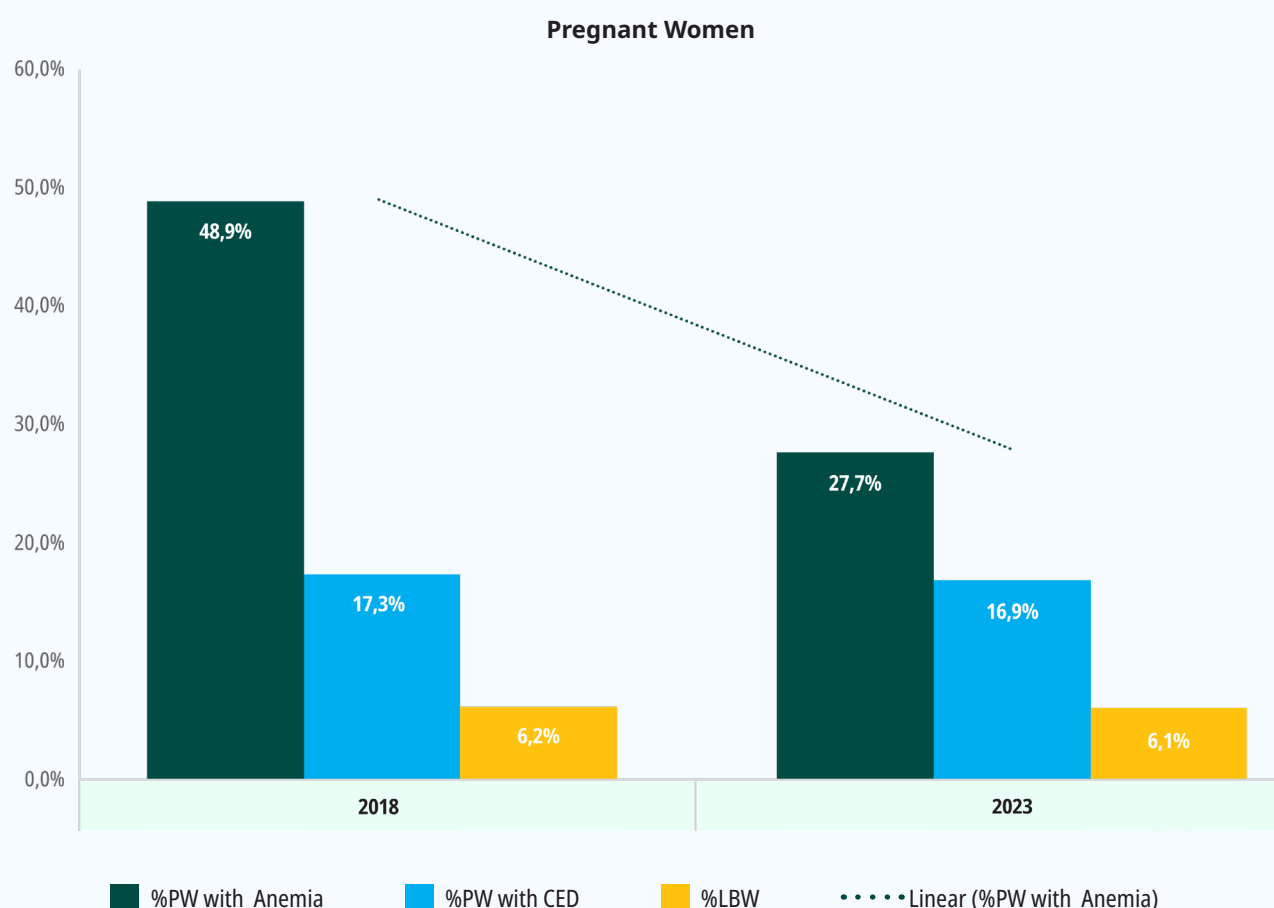
Nutrition indicators among pregnant women have also made some steady progress in some areas, for example, chronic energy deficiency (CED) has slightly declined from 17.3% in 2018 to 16.9% in 2023, while the prevalence of anaemia significantly declined from 48.9% in 2018 to 27.7% in 2023. However, these data remain above WHO's threshold for moderate public health concern.^{2,12} This might be due to poor dietary diversity and low coverage of iron-folic acid (IFA).

The poor nutritional outcome might be contributing to low birth weight (LBW), which also showed slower decline overtime from 6.2% in 2018 to 6.1 % in 2024.^{2,13} However, Indonesia had already

achieved the WHA target of a 30% reduction by 2025 when compared to the 2013 data of 10.2%.¹ These data show sustained efforts in improving maternal nutrition.

During the review, it was observed that between 2018 and 2023, overweight and obesity among the adult population in Indonesia increased from 35.5% to 37.8%, with obesity alone rising from 21.8% to 23.4%.^{2,12} Riskesdas 2018 showed clear gender disparities, with 44.4% of women compared to 26.6% of men being overweight or obese. Although SKI 2023 confirmed a continued rise, it did not publish detailed sex-disaggregated data, and no recent data exist for women of reproductive age or pregnant women, leaving critical surveillance gaps.

Figure 4: Nutrition Outcome for Pregnant Women



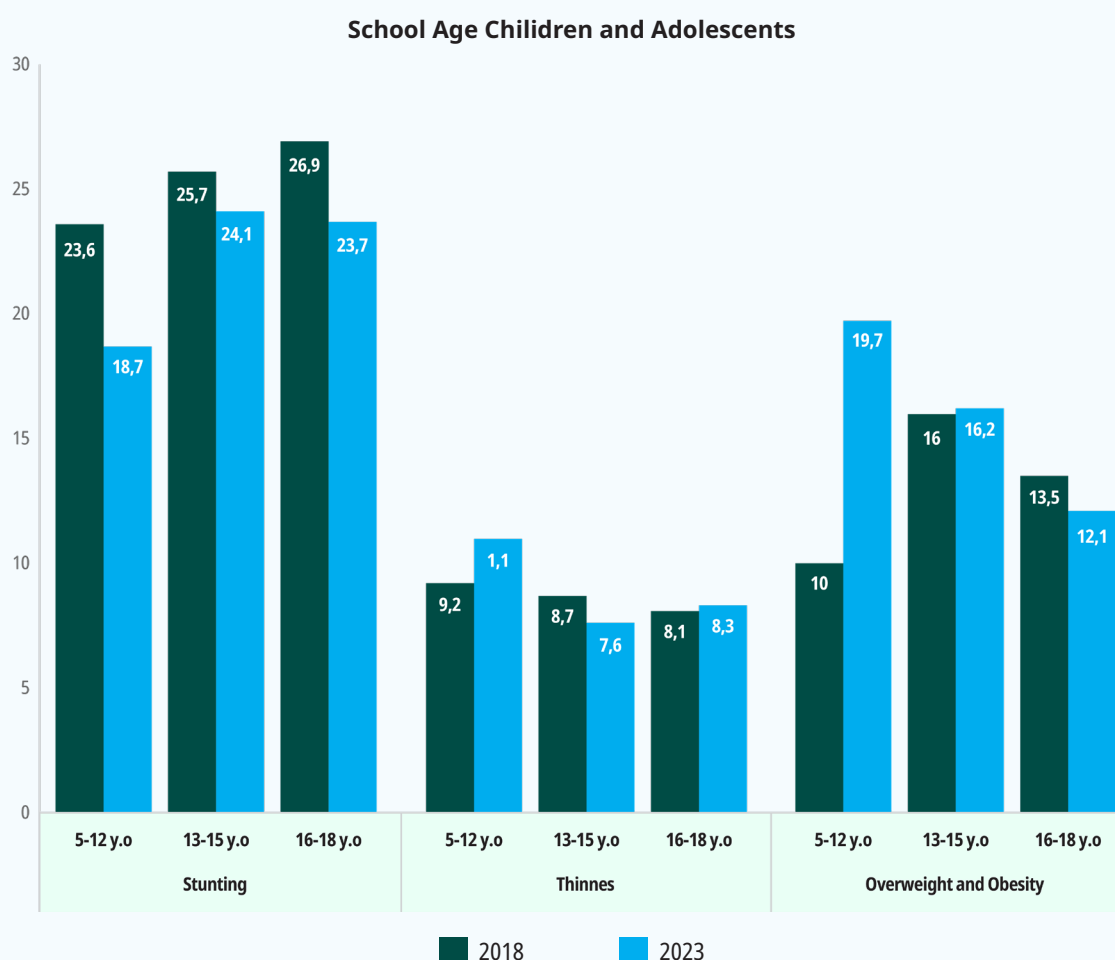
3.1.1.3 School-Age Children and Adolescents

Just like other age groups (under five children and pregnant women), nutrition indicators have also shown some improvement among school-age children and younger adolescents (5–14 years), during the period under review, for instance, anaemia declined from 26.8% in 2018 to 16.3% in 2023, while among older adolescents and young people (15–24 years), it dropped from 32% to 15.5% within the same period.^{2,12}

Stunting has also declined gradually across different groups (5-12, 13 – 15, and 16-18 years) from 2013 to 2023 (Fig. 5). This shows continued trends with early childhood progress; however,

the age segregation needs to be visited as per WHO guidelines to ensure comparability of data. On average, there is a slight improvement in thinness (wasting) among the 13-15 year-olds compared to other age groups, which shows an increase among school-age children (Fig 5). Overweight and obesity have also increased across different school-age children and adolescents, with a sharp rise in younger school-aged groups (Fig. 5). The UNICEF's landscape analysis shows that by 2018, one in five school-age children and one in seven adolescents were overweight or obese, and more recent data from the 2023 Indonesia Health Survey confirm these figures.^{2,12,14}

Figure 5: Nutrition Outcomes in School Age Children and Adolescents



These data show that the triple burden of malnutrition co-exists among school-age children and adolescents. The calls for the need to shift

in prioritisation of interventions that would deal with all forms of malnutrition in a more holistic approach across the life cycle.

3.2 Governance and Leadership in Nutrition

3.2.1 POLICY ENVIRONMENT – PROGRESS AND COHERENCE

The Government of Indonesia (GoI) has put in place an extensive nutrition policy environment during the period under review, back by the Long-Term Development Plan (RPJPN) 2005 to 2025 and the Mid-Term Development Plan (RMJMN) 2019 to 2024 (Fig. 6), with clear targets of reducing stunting to 14% and wasting to below 7% by 2024. Key policy frameworks that guided the attainment of these commitments were the STRANAS 2018–2024, Decree 72/2021, and RAN PASTI.

The MoH developed programme-specific guidelines, such as IFA and MMS supplementation, IMAM, and vitamin A, which provided as national reference material for standardisation of service delivery within

the sector. Despite these advances, the policy environment lacked consistency and alignment with global recommendations across the life cycle.

Several national guidelines are not fully aligned with the WHO and the Lancet recommendations on evidence-based nutrition intervention.^{15,16} overweight and obesity, and micronutrient deficiencies-continues to afflict millions of women and children, particularly in low-income and middle-income countries (LMICs Example for this misalignment including the continuation of postpartum vitamin A supplementation which no longer aligns with the WHO recommendation, the omission of postpartum iron-folic acid (IFA), and calcium supplementation pregnant women lacks clarity where the national regulation provides no guidance on how to identify women in areas with low calcium intake or whether calcium should be

Figure 6: Leadership and Governance in Nutrition – Policy Commitments



given for pregnant women with low risk of pre-eclampsia, lastly despite the Ministry of Health Regulation No 15/2017 on deworming no national strategy nor guideline is available for deworming for pregnant women.^{17,18}

Moreover, despite the persistently high anemia burden among children under five, a nationally scaled program for its prevention and control has yet to be introduced, leaving a significant gap in addressing one of Indonesia's most pressing nutritional deficiencies. The 2022 Ministry of Health Decree on Stunting Management also used terms such as "stunting treatment," which risks medicalising a preventive issue and diverting attention from early interventions within a 1000 days of child growth and development. Policies addressing overweight and obesity remain underdeveloped, with limited adoption of WHO-recommended "best-buy" strategies for NCD prevention, including taxation of sugar-sweetened beverages, front-of-pack nutrition labelling, and restrictions on unhealthy food marketing, particularly in schools.

3.2.2 LEADERSHIP AND COORDINATION ACROSS SECTORS AND GOVERNMENT LEVEL

The Presidential Regulation No. 72/2021 on the National Strategy for Stunting Reduction (STRANAS Stunting) provides a robust framework for convergence across sectors and levels of government. It formalizes stunting reduction as a national development priority, anchored in five coordination pillars that guide cross-ministerial and subnational collaboration.

The operationalization of these five pillars has enhanced coordination between sectors, linking policy, planning, and financing. Budget tagging for stunting enables transparency and

cross-sector accountability, while district-level Rembuk Stunting forums have improved local convergence and community engagement. The focus on stunting made nutrition a national priority, with dashboards, targets, and budgets mobilized across sectors.

However, coordination remains uneven across levels of government. Field assessment suggested that coordination meetings were often irregular, and meaningful follow-up for convergence from cross sectoral actors was limited. At provincial and district levels, nutrition coordination platforms tended to focus mainly on stunting. At the same time, the absence of a multisectoral monitoring framework with shared indicators meant that ministries and districts reported separately against their own mandates rather than being jointly accountable. BAPPENAS, though tasked as convener, had limited authority to ensure alignment across line ministries. This contributed to partial convergence, with some duplication and gaps in coverage. These dynamics were also echoed at the local level, where officials described the challenge of navigating multiple lines of authority and fragmented priorities:

"It's like we have three heads. First, there's Bappenas, which evaluates and oversees planning functions. Then, the Ministry of Home Affairs as the authority over local governments and of course, each ministry has its own reporting system. In addition to local budgets which is often very small, there are also bigger central funds. We've tried to create synergy, but each, 'superior' at central level has its own priorities, so it is difficult for us to align at sub-national level"

Bappeda, North Sulawesi

"Stunting is a major national project that requires strong cross-sectoral coordination, which has been reinforced through Presidential Regulation No. 72 of 2021. Under this regulation, we have several coordination structures, starting from the Stunting Reduction Acceleration Team (TPPS) at the national level down to the district and village levels, as well as the field-level teams (TPK). These mechanisms are a clear improvement over previous arrangements. At the national level, coordination is no longer limited to the health sector; we now work closely with other ministries and agencies to support local governments. A joint action plan has been agreed upon by all stakeholders, and the SUN Network plays an important role in ensuring that everyone contributes to shared planning and documentation. This action plan is coordinated by the Ministry of Home Affairs (Kemendagri) so that we can ensure similar plans are implemented effectively at the provincial, district, and city levels."

National Stakeholder Interview, Bappenas

Thus, at the sub-national level, collaboration often depends on leadership and individual initiative, leading to variations in performance across provinces and districts. Weak data integration between nutrition, health, and social protection systems also limits convergence in evidence-based decision-making.

Partnerships for nutrition under the SUN Movement remain active, involving government, academia, CSOs, donors, and the private sector. Academia has contributed through capacity building and research, while CSOs and donors have supported implementation and advocacy. Yet, collaboration is often fragmented, driven by individual rather than institutional initiatives. Formal MoUs and coordination mechanisms are lacking; CSR activities are not systematically aligned with national priorities. The SUN platforms were more effective at the national level than at provincial or district levels, where nutrition outcomes are most directly influenced.

"The SUN platform is quite active at the national level, but at the local level, where results really happen, it feels less present. The pentahelix idea is often mentioned, but in practice, the synergy is rarely there."

FGD National Stakeholders, SUN Academia

3.2.3 INTRA MINISTRY (MOH) GOVERNANCE AND COORDINATION

Within the Ministry of Health (MoH), nutrition programming shows strong policy alignment but faces ongoing implementation challenges. Frequent updates to technical guidelines, such as those on supplementary feeding with local food, have outpaced the system's capacity for dissemination, supervision, and training. Many districts reported that new protocols were not fully socialized, leaving frontline workers without clear operational guidance.

The Health System Transformation Agenda (HSTA), launched in 2022, aims to reform the post-pandemic health system across six pillars: primary care, referral care, resilience, human resources, financing, and technology. Nutrition is mentioned under the Primary Health Care pillar and in the RPJMN target of accelerating community nutrition. However, nutrition is not prominently featured in HSTA operational plans; there is no costed action plan, and nutrition indicators are missing from the monitoring framework. This limits accountability and the potential for integration.

Institutionally, nutrition is placed under the Directorate of Primary Health Care and linked to health promotion, school health, and NCD units. This structure offers synergy but limits visibility and decision-making authority. The absence of a clearly defined Essential Nutrition Package and standardized competencies for nutrition services has led to fragmented implementation and weak accountability. Field consultations revealed overlapping roles and limited coordination among departments.

In addition, the current MoH organogram is not mirrored at subnational levels, creating overlap and coordination bottlenecks between central, provincial, and district offices. Strengthening local institutional structures is therefore essential to ensure coherent leadership and sustainable integration of nutrition within Indonesia's decentralized health system.

3.2.4 LEADERSHIP AND GOVERNANCE FOR NIE AND CLIMATE RESILIENCE

At the national level, coordination for Nutrition in Emergencies (NiE) has become more structured, with the Ministry of Health leading the Nutrition Sub-Cluster under the Health Cluster, supported by the Health Emergency Operations Centre and the National Disaster Management Agency (BNPB). Recent ministerial regulation (*Permenkes No.75 Tahun 2019 tentang Penanggulangan Krisis Kesehatan*) and health law No 17/2023 have strengthened the mandate for NiE coordination and clarified institutional roles across government.

At the subnational level, implementation remains uneven. Provinces such as Yogyakarta, East Java, and East Nusa Tenggara have issued decrees supporting NiE integration, while in others, such as Central Sulawesi, the Nutrition Sub-Cluster remains unrecognized. Many low-risk districts have not yet included NiE preparedness in contingency plans. Collaboration with NGOs, academia, and other sectors is still limited, and existing plans often do not align with disaster risk maps.

Indonesia is among the world's most disaster-prone countries, facing frequent floods, droughts, landslides, and climate-related shocks that threaten food and nutrition security. UNICEF reports that climate change is expected to reduce the quantity, variety, and quality of food available to children and families, increasing the risk of malnutrition.¹⁹ The World Bank emphasizes that climate change poses serious threats to agricultural production and food system stability.²⁰



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3.3 Nutrition Service Delivery

Strong service delivery is essential for achieving nutrition outcomes. This section provides a systematic assessment of the availability, quality, and coverage of nutrition-specific services across the life course, including Nutrition in Emergencies (NiE). The analysis is organized by target groups i.e. pregnant women and women of reproductive age, children under five, and school-age children and adolescents (SACA) to assess not only how widely the services reach populations but also how they are effectively delivered. Measurement draws on secondary data and qualitative evidence from field visits, with a focus on identifying service gaps and areas where implementation falls short of expected program standards.

CONTEXT FOR NUTRITION SERVICE DELIVERY IN PRIMARY HEALTH CARE

Nutrition services in Indonesia are delivered through a diverse set of platforms that collectively enhance accessibility and coverage across the population. At the core are **Puskesmas**, which function as the main hub for facility-based services, offering antenatal and postnatal care, growth monitoring, micronutrient supplementation, treatment of acute malnutrition, and nutrition education. Services are delivered by medical doctors, midwives, nurses, nutritionists, pharmacists, and other health professionals, supported by technical and administrative staff. **Posyandu**, managed at the community level by community health volunteers (cadres) with support from midwives and nutritionists, provides regular monthly services for mothers, infants, and young children, including growth monitoring, immunization, and counselling. To reach underserved populations, **outreach activities** are conducted by health workers and cadres, extending services to remote and hard to reach areas that face barriers to accessing health facilities.

Service delivery for school-age children and adolescents is primarily implemented through schools, complemented by community-based initiatives offering nutrition education, routine health screening, and IFA supplementation. Anchored in *Usaha Kesehatan Sekolah/Madrasah* (UKS/M) and supported by the *Gerakan Sekolah Sehat* (GSS) and *Aksi Bergizi*, programmes and initiatives integrate activities such as group breakfasts, supervised Weekly Iron and Folic Acid (WIFS) intake, nutrition education and physical exercise, particularly at the junior and senior high school levels. *Petualangan Bergizi*, a pilot programme implemented by the Ministries of Education, Health, and Religious Affairs with

technical support from UNICEF since 2023, is also helping to expand this set of interventions to primary school-age children, with additional components targeting the strengthening of local school and health systems for the prevention of childhood obesity along with other forms of malnutrition. In madrasahs, the inclusion of religious values and peer-support systems enhances engagement and acceptance.

During the COVID-19 pandemic, service delivery across these platforms was heavily affected by mobility restrictions and the closure of Posyandu and schools, creating major gaps in routine interventions. In response, the Ministry of Health (MoH) released a series of guidelines and circulars to sustain essential nutrition services during the pandemic. These included protocols for safe home delivery of vitamin A capsules, guidance on conducting growth monitoring with PPD at home or in small groups, and instructions for continuing WIFS distribution through schools or alternative outreach when in-person classes were suspended.^{21,22} Such adaptations enabled frontline health workers and cadres to maintain critical contact points with communities while observing health protocols.

This multi-platform approach enables Indonesia to deliver nutrition-specific interventions across the life course from pregnancy through adolescence while strengthening equitable access to services. The complementary roles of Puskesmas, Posyandu, and outreach services ensure that, both routine and campaign-based interventions can be implemented at scale, while also allowing flexibility for context-specific adaptations in hard-to-reach and vulnerable communities.

3.3.1 NUTRITION PROGRAMME FOR PREGNANT WOMEN AND WOMEN OF REPRODUCTIVE AGE

3.3.1.1 Iron-Folic Acid Supplementation (IFAS) and Multiple Micronutrient Supplement (MMS) Transition

Iron-folic acid supplementation (IFAS) is one of Indonesia's longest-standing maternal nutrition programmes, supported by clear policies, standardized formulations, and integration into routine antenatal care. Services extend beyond pregnant women to women of reproductive age, postpartum women, and treatment for anaemia in pregnancy. Coverage has steadily improved, with 86.6% of pregnant women receiving IFA tablets and 59.6% consuming at least 90 tablets in 2024 (SSGI 2024). Awareness has also risen, with 61.5% of mothers recognizing IFAS as important for stunting prevention.

Many Puskesmas link IFA distribution with education and counselling, which has helped to improve uptake of the services. Nevertheless, disparities remain, particularly in eastern provinces

such as Papua (less than 50%) and Maluku and North Sulawesi (around 30%). Persistent challenges such as stock-outs, weak counselling, sociocultural barriers, fragmented reporting, and the absence of a robust national tracking system to monitor anaemia prevalence continue to limit program impact and delay timely corrective action.

The WHO recommends postpartum IFA supplementation for six to twelve weeks after delivery in settings with anaemia prevalence of 20 per cent or higher, and weekly IFA for non-pregnant women containing 60 mg iron and 2800 mcg folic acid, or daily IFA with 120 mg iron and 400 mcg folic acid for treatment. Despite WHO recommendations for postpartum IFA and strengthened adolescent supplementation, Indonesia has not implemented postpartum regimens, routine anemia screening for postpartum mothers is absent, and adolescent programs remain limited to schools, with dosages that are insufficient to prevent neural tube defects (The national guidelines prescribe weekly IFA with 60 mg iron and 400 mcg folic acid). These systemic weaknesses highlight the fragility of even long-established programs.

Building on this experience, Indonesia began its transition from IFA to multiple micronutrient supplementation (MMS) in 2024, guided by new Ministry of Health standards and technical instructions. By 2025, implementation had started in fifteen priority provinces with initial supplies supported by development partners and a government commitment to local procurement and national scale-up by 2026, positioning Indonesia as an early adopter of the WHO global recommendation.

However, the MMS rollout risks repeating the weaknesses seen with IFA, with bottlenecks already evident such as: supply chain management is inconsistent, with some facilities distributing only 10–30 tablets in plastic bags, raising safety and compliance concerns; national procurement has yet to begin, leaving the program dependent on donations; training of health workers on MMS protocols is limited; weak counselling further risks low coverage and adherence, as seen previously with IFA; and higher costs relative to IFA require sustained financing and evidence of cost-effectiveness.

The transition to MMS offers an opportunity to address these entrenched challenges rather than replicate them. Ensuring reliable supply, robust quality assurance, strengthened provider capacity, systematic monitoring of anaemia, and sustainable financing will be critical to secure the long-term success of MMS and prevent it from facing the same constraints that have limited the full potential of IFA.

3.3.1.2 Food Supplementation (PMT) For Pregnant Mothers with CED

Coverage of supplementary feeding for pregnant women with CED increased from 25.2% in 2018, when 89.7% was provided as biscuits, to 32.1% in 2023, with 19.2% already shifted to local foods under a transition plan for national expansion by 2026. The program has contributed to improved maternal weight gain and reduced low birth weight, yet inequities persist, with maternal undernutrition ranging from 2–37% across provinces and particularly high among younger mothers (34% at ages 15–19 compared with 6.5% at ages 40–44). While the biscuit-based program was constrained by poor palatability, sharing, low compliance, and weak monitoring, the local food models face new challenges related to quality, safety, and financing. Addressing these gaps requires stronger targeting, supply reliability, compliance monitoring, and the establishment of clear financial coordination mechanisms and guidance to converge resources from multiple stakeholders and ensure sustainable financing of PMT.

3.3.1.3 Other Micronutrient Supplementations (including Deworming)

In Indonesia, other micronutrient supplementation beyond iron–folic acid such as calcium, vitamin A, and zinc, shows mixed progress. Calcium is widely available through the ANC drug package and often provided at Puskesmas, but it remains unregulated, with frequent stock-outs, partial dosing (500 mg/day vs. WHO's 1.5–2 g/day), low awareness, poor adherence, and limited monitoring system. Postpartum vitamin A supplementation, implemented for nearly three decades, remains inadequate: only 57% of women receive any capsules, and 23% complete the two-dose regimen. It is now considered misaligned with updated WHO guidance. Deworming is included in national policy but excludes pregnant women due to lack of

consensus and data on soil-transmitted helminths (STH) among this target group; implementation is weak, marked by stock-outs, low prescription rates, and no coverage data for women of reproductive age or postpartum women, despite the national target of reducing STH prevalence below 10% in all districts (MoH Regulation No. 15/2017).

3.3.1.4 Nutrition Education and Counselling

Ante Natal Care (ANC) coverage in Indonesia has improved but remains uneven, with ANC1 in the first trimester reaching 83.3% in 2024, ANC4 at 75.8%, and ANC6 only 28.1%. Integrated ANC services are designed to include nutrition counselling, laboratory tests, and ultrasound, but the quality of counselling is inconsistent. Although ownership of the Maternal and Child Health (MCH) book rose to 71.7% in 2023, its potential as an educational tool is underutilized, as many women read it only superficially and midwives rarely review its content. Participation in pregnancy classes is also low, with national attendance at 36.6% in 2024 and fewer than 10% in DKI Jakarta and West Papua, reflecting constraints linked to *Bantuan Operasional Kesehatan* (BOK) funding, weekday scheduling, competing responsibilities, and variable facilitation quality.

Nutrition counselling provision is inadequate and often brief, generic, and poorly adapted to women's needs, with limited attention to overweight and obesity in pregnancy. Quality is further undermined by administrative burdens such as inadequate counselling spaces, and shortage of trained nutritionists coupled with the absence of monitoring indicators for accountability. Postpartum counselling is rarely provided, and cultural barriers such as food taboos and reliance on low-trust information sources further reduce impact. These gaps highlight that while ANC coverage has expanded, the potential of nutrition education and counselling to improve maternal and child health outcomes is far from full realization.



3.3.2 NUTRITION PROGRAMME FOR CHILDREN UNDER FIVE

3.3.2.1 Breastfeeding, Complementary Feeding, and Young Child Diets (IYCF)

Breastfeeding remains strong in Indonesia's nutrition landscape, with ever-breastfed rates consistently above 90% nationally and reaching 94.1% in SSGI 2024. Progress is also seen in early initiation, which improved from 58.2% in 2018 (Riskesdas), plunged to 48.6% during the pandemic (SSGI 2021), and rebounded to 62.7% in 2024 (SSGI), and in exclusive breastfeeding, which rose from 52% in 2017 to 74.7% in 2024 (BPS). These gains reflect strong cultural support for breastfeeding and the expansion of service platforms.^{23,13}

At subnational, disparities are evident, with ever-breastfed rates lower in North Sulawesi (80.6%) and West Papua (82.4%), alongside recent declines in Bali and East Nusa Tenggara. Despite nearly universal institutional deliveries (92.5% in BPS 2024), only 69.1% of newborns were breastfed within the first hour, reflecting missed opportunities for facility-based support. Exclusive breastfeeding has also declined sharply in Papua by about 25 percentage points between 2022 and 2024, while mixed milk feeding is rising in Gorontalo and North Sulawesi. Sustaining exclusive breastfeeding is further constrained by aggressive formula marketing, maternal work demands, and persistent perceptions of "insufficient milk," cited by 63% of mothers in both the 2018 and 2023 national surveys.^{1,2}

Complementary feeding shows a similar pattern. There was short-term progress, with Minimum Dietary Diversity (MDD) improving from 46.6% in 2018 to 60.9% in 2023, however, it declined to 48.3% in 2024 (SSGI). Minimum Meal Frequency (MMF) fell from 71.8% in 2017 to 66% in 2024, while the Minimum Acceptable Diet (MAD) remains critically low at 32.7% in 2024. Persistent gaps are most severe in East Nusa Tenggara, North Maluku, and South Papua, where dietary quality is exceptionally constrained.

Egg and flesh food consumption among children aged 6–23 months increased from 69.9% in 2022 to 79.1% in 2024, though still low in South Papua, North Maluku, and West Papua, reflecting affordability and access issues. At the same time, growing exposure to unhealthy foods signals an emerging challenge with one in every four (25.9%) children aged 3–4 years consume unhealthy foods, and more than 50% consume sweet foods and beverages daily. Addressing these shifts will be critical for sustaining gains and preventing the nutrition transition from undermining child health.^{12,13,24}

Nutrition education and counselling remains a vital but underutilized component of service delivery

for under five children. While platforms such as Posyandu, Puskesmas, and maternal and child health services routinely provide counselling, its effectiveness has often been constrained by limited adaptation to local contexts, time pressures that reduce opportunities for meaningful interaction, and insufficient supportive supervision to reinforce quality. As a result, counselling frequently remains information-driven rather than tailored to address mothers' and caregivers' lived realities, such as perceptions of insufficient breast milk, cultural feeding practices, and pressures from formula marketing.

3.3.2.2 Growth Monitoring and Promotion (GMP) and Development Monitoring

Ownership of the MCH book has steadily improved, from 65.9% in 2018 (Riskesdas) to 71.7% in 2023 (SKI) and 78.5% in 2024 (SSGI, owned and shown, with 85% of mothers reporting to have discussed it with health workers. The MCH book not only serves as a key tool for maternal and child health education but also functions as an indicator of access to services, as ownership is closely linked to contact with health providers. However, challenges remain: only 32.7% of children had the latest edition in 2023, digital use was negligible (0.1%), and subnational disparities were wide from 96% in Central Java to just 41% in South Papua. Stock-outs of the latest book also persist, and in remote areas such as West Halmahera, some mothers were asked to purchase copies privately. While mid-upper-arm-circumference (MUAC) screening is integrated into monthly Posyandu growth monitoring, the poor quality of implementation creates a critical bottleneck, leading to missed opportunities for early intervention before children develop wasting.

Growth monitoring has been strengthened since the pandemic, reflecting clear system recovery. Weight monitoring reached 87.4% in 2024, with the proportion of children weighed at least eight times rising steadily from 36.9% in 2021 to 52.6% in 2022 and 65.5% in 2024 (SSGI 2022, SKI 2023, SSGI 2024). Height/length monitoring also showed substantial improvement, increasing from 53.2% in 2018 to 63.7% during the pandemic, and further to 86.1% in 2024, with nearly all children measured at least twice annually (85% in 2023; 96.6% in 2024). Structural barriers have sharply declined, with caregivers reporting absence of facilities dropping from 31.5% in 2018 to 6.9% in 2023, and lack of equipment from 12.9% to 3.1%. However, caregiver-related constraints particularly the perception of being "too busy" have emerged as the main obstacle, underscoring the need for stronger demand-generation strategies. Local innovations, such as providing complementary food incentives at Posyandu and conducting home visits ("sweeping") by cadres and midwives, demonstrate effective practices to sustain and further expand coverage.

By contrast, developmental monitoring and follow-up remain weak. Only 32.8% of SDIDTK forms were completed in 2023 (SKI), reflecting persistent gaps in service delivery and documentation. Field findings highlight that implementation is time-consuming, often carried out in non-child-friendly settings, and constrained by incomplete kits and outdated training. As one provincial staff member noted:

"They often tell us that SDIDTK is one of the most challenging and difficult to do. At the Posyandu, it takes so much time that both children and parents get tired after all the weighing and education: sometimes they just want to go home immediately. The space isn't always child-friendly, too noisy, and a lot of distractions. At the Puskesmas, it is carried out in the same room with MTBS, so it is sometimes together with sick children, which many feels inappropriate for healthy developmental checks. Many staff also say their last training was a long time ago, and I've confirmed myself that the kits are often incomplete, maybe because it was broken or the child did not want to return them. To keep things going, midwives improvise with whatever toys or blocks they can find."

MNCH Staff, Provincial Health Office, North Sulawesi

Finally, while undernutrition is systematically addressed, childhood overweight and obesity remain largely neglected. Few Puskesmas staff were aware of guidelines, and counselling was often reduced to simple dietary advice. As one nutritionist explained:

"I think there is a guideline for management of overweight and obesity, but it's rarely used, since we mostly focus on undernutrition. If a child looks a bit overweight, usually we just tell the parents to cut back on sweet foods and fried fatty snacks."

Nutritionist 1, Puskesmas, South Minahasa

3.3.2.3 Micronutrient Supplementation (Vitamin A, Deworming, MNP)

Micronutrient supplementation in Indonesia demonstrates both important gains and persistent weaknesses. Vitamin A supplementation (VAS) has shown, substantial progress, increasing from 53.5% in 2018 to 80.6% despite the pandemic and continuing to rise to 85.2% in 2024, reflecting the effectiveness of campaign-based delivery platforms and the health system resilience. However, significant disparities persist, with provinces such as Papua and NTT consistently lagging behind the national average. Deworming



coverage continues to lag behind VAS despite being delivered through the same campaigns, pointing to persistent coordination and co-supply challenges. Micronutrient powders (MNP/Taburia), although promising given the high prevalence of childhood anaemia, have not been scaled up nationally. Where it is being distributed, adherence remains low due to poor taste, preparation complexity, and limited caregiver acceptance, while the absence of routine monitoring indicators undermines accountability. As a result, MNP remains underutilized despite its potential contribution to improving child nutrition.

3.3.2.4 Food Supplementation (PMT) for Children with Malnutrition

Coverage of PMT for undernourished children declined sharply, from 41% in 2018 to 32.6% in 2023 and 11.1% in 2024. (Risikesdas 2018, SKI 2023, SSGI 2024) The transition from fortified biscuits to local foods improved acceptance but raised concerns about consistency, safety, and monitoring. SSGI data revealed overlapping modalities (ready-to-eat foods (68.7%), raw ingredients (24.9%), milk (29.4%), and eggs (42.9%)), with totals exceeding 100%, pointing to weaknesses in monitoring systems, beneficiary registries, and reporting frameworks. While PMT Lokal was generally effective and well accepted when menus reflected local tastes, it was often misunderstood by caregivers as a meal replacement. Children typically gained weight during supplementation but relapsed afterward, particularly in poorer households, reflecting rigid intake/discharge criteria and weak integration with social protection and other livelihood programs. Fragmented funding between the MoH- and village-led PMT further undermined efficiency and sustainability, highlighting the need for harmonized approaches and recovery-based discharge criteria to sustain long-term impact.

3.3.2.5 IMAM (Integrated Management of Acute Malnutrition)

When prevention fails or medical complications remain unmanaged, children fall into wasting (moderate or severe wasting). Service delivery through the IMAM approach demonstrates both achievements and persistent gaps.

Integration of IMAM into the broader health and nutrition system has expanded access, strengthened referral pathways, and improved continuity of care, with scale-up across Puskesmas. Early case detection of wasting has been mainstreamed at Posyandu through MUAC screening, also with caregiver-led innovations such as *Family led MUAC* in several areas, including NTT proving effective. The capacity of Puskesmas to manage severe wasting reached 57.5% in 2024, the highest in five years, showing improved readiness,

supported by campaign-based platforms for identification and referral. These developments highlight IMAM as a strong platform for early detection, decentralized treatment, and community follow-up.

Despite the progress, IMAM coverage, quality, and continuity remain limited. Over 40% of under-five children were not captured in e-PPGBM in 2024, leaving more cases of wasting unidentified. Many health facilities lack adequately trained staff, suffer from high turnover, or remain constrained by shortages of standard therapeutic food and the absence of standardized operational guidelines. Although over 50% of Puskesmas now provide care for SAM children, the treatment's effectiveness is undermined by the use of unstandardized therapeutic foods (such as manually mixed or "claimed" F-100) in outpatient settings. This practice critically risks children receiving products that do not meet essential nutritional standards.

Furthermore, Ready-to-Use Therapeutic Food (RUTF), which is globally recommended by WHO and UNICEF as the standard treatment for uncomplicated severe acute malnutrition, is severely limited in quantity. In Indonesia, RUTF has been introduced through small-scale pilots using locally adapted formulations, demonstrating its potential to improve recovery rates and reduce the burden on hospital-based care. However, national adoption remains limited due to regulatory barriers, high production costs, and the absence of a sustainable local manufacturing system. Since 2024, the MoH has taken proactive steps in pursuing RUTF importation while preparing for local production to ensure SAM children receive standard therapeutic foods. Despite UNICEF's support in opening access to the matching fund, the imported quantity remains critically small. This initial RUTF supply is limited to 5,806 cartons (6,403 SAM cases) distributed across 21 districts in nine provinces, representing less than 2% of the total national requirement.

In addition, referral pathways are inconsistent, where children identified in the community often do not reach confirmation and treatment, while post-treatment are not reliably followed up at the community level. Hospital admissions for complicated cases are further constrained by high costs and the need to refer to class A hospitals, often located in other provinces. Furthermore, to improve data-driven decision-making, with support from UNICEF, the MoH has embedded child wasting indicators into the national information system, e-PPGBM (Pelita Kemas module). This effort successfully enabled real-time documentation of screening and treatment at both community and facility levels, supported by the rollout of practical guidance tools (Pelita Kemas pocketbook). Crucially, despite these infrastructure improvements, national data is not yet available

to measure the quality of treatment provided; specifically, core indicators like cure rates, deaths, and dropout rates are missing.

Several opportunities to strengthen IMAM remain underutilized. MUAC screening is often misunderstood and overshadowed by reliance only on weight for height. The family-led MUAC approach also offers a powerful strategic opportunity to complement monthly Posyandu growth monitoring by empowering caregivers to screen their children at home. This decentralized approach uses a simple, low-literacy tool (MUAC tape) to drastically increase the frequency of detection, thereby driving demand for early treatment services and ensuring prompt action

to interrupt the progression of child wasting, without replacing the routine monthly session. Furthermore, the Pelita Kemas application remains underused, severely limiting visibility into crucial treatment outcomes (like cure rates, deaths, and dropouts). To secure quality services, it is crucial to close these gaps by strengthening supply systems, expanding Puskesmas readiness, and reinforcing referral mechanisms. Finally, to prevent counterproductive efforts and frontline health workers' confusion, there is a need to ensure immediate alignment of national policies and guidelines with global recommendations for both stunting and severe wasting management and verify that all marketed therapeutic foods align with the national decree on product standards.



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3.4 Nutrition Programme for School Age Children and Adolescents

3.4.1 WIFAS AMONG ADOLESCENT GIRLS

Data shows gradual progress in the distribution and consumption of IFA tablets among adolescent girls. In 2018, only 10.6% of girls reported receiving at least 52 tablets in a year, while 6.4% reported consuming them. By 2023, coverage had increased, with 18.9% receiving and 11.5% consuming at least 52 tablets annually.^{1,2} This trend reflects modest improvements in program reach, though the gap between receipt and actual consumption highlights persistent challenges in adherence and

follow-up. Riskesdas 2018 survey revealed that the main reasons for not consuming the tablets were; did not think it was necessary (28.7%), did not like the taste and smell of tablets (21.8%), and forgot (11.8%). Qualitative assessment in the Aceh region also revealed issues with the packaging, which creates a negative stigma around consumption. This underlies the importance of nutrition education and reformulating WIFA for adolescent girls.

3.4.2 HEALTH SCREENING INCLUDING FOR ANEMIA AMONG ADOLESCENTS

Health screening coverage in 2024 was high across all school levels, reaching more than 84% in elementary, junior high, and senior high schools. These screenings also included assessment of nutritional status, while routine anaemia screening was limited to adolescents in grades 7 and 10. The 2024 data show that 77.4% of adolescents in these grades were screened for anaemia, with 20.7% of girls identified as anaemic. Among those diagnosed, 88.7% received treatment, suggesting that while service platforms are functioning effectively for case detection and treatment initiation, gaps remain in prevention, adherence, and follow-up. The consistent coverage across school levels demonstrates institutionalization of screening, though strengthening the quality of counselling, continuity of care, and equity in reach remains essential. The restriction of anaemia screening to only grades 7 and 10 highlights the need to expand coverage across all adolescent age groups.

3.4.3 BEHAVIOUR CHANGE PROGRAMME

Dietary behaviours among children and adolescents remain poor despite school-based behaviour change communication being the primary delivery channel. The proportion consuming at least five portions of fruit and vegetables per day declined from 3.3% in 2018 (Risikesdas) to 2.3% in 2023 (SKI), with average vegetable intake stagnating (1.6 to 1.5 portions) and only modest gains in fruit intake (0.5 to 1 portion). These results suggest that nutrition education and promotion have not yet translated into meaningful dietary improvements. Encouraging progress is seen in hygiene and physical activity, with adequate activity among 10–14-year-olds increasing from 35.6% in 2018 to 46% in 2023 and proper handwashing practices rising from 40.1% to 47.2%. However, the food environment strongly shapes choices, with unhealthy dietary patterns widespread: in 2023, nearly half of children and adolescents consumed sweet foods and salty snacks frequently, while over one-third consumed fried, fatty, or high-cholesterol foods more than once per day. These findings highlight modest behaviour change gains in activity and hygiene but persistent challenges in diet quality, underscoring the need to pair school-based communication with stronger interventions to address the obesogenic food environment.

3.4.4 COMMUNITY BASED ADOLESCENT HEALTH SERVICE

Adolescent health services in Indonesia are delivered through schools and three complementary community-based platforms—PKPR, Posyandu Remaja, and Poskestren which together extend coverage and inclusivity. PKPR, the most established, operates in 80.44% of Puskesmas and provides adolescent-friendly services on reproductive health, nutrition, mental health, and substance abuse, supported by peer educators and cross-sectoral collaboration. Posyandu Remaja, introduced in 2018, promotes counselling and health promotion but has low participation, meeting only 20% of targets due to school conflicts, unengaging content, and reduced adolescent-friendly spaces under ILP integration. Poskestren reaches Islamic boarding schools by engaging santri and religious leaders but struggles with limited facilities, trained cadres, and sustainable funding. While these platforms strengthen promotive and preventive care, persistent gaps in participation, quality, and resources highlight the need for clearer roles, stronger supervision, sustainable financing, and tailored strategies to ensure accessibility, equity, and youth-centred service delivery.

3.4.5 NUTRITION PROGRAMME SERVICE DELIVERY DURING EMERGENCY

The guidelines for nutrition response in emergencies was issued in 2021 and trained across 35 provinces.²⁵ Thus, service delivery capacity during emergencies has improved but remains uneven. In Central Sulawesi, emergency kitchens were activated after the 2018 earthquake, and in Yogyakarta, integrated services functioned during the Merapi eruption. In East Java, trained cadres helped resume services quickly after floods.

Many districts lack standard operation procedures (SOPs) for NiE, rapid assessments are not systematically applied, and surge capacity is thin. Infant and Young Child Feeding in Emergencies (IYCF-E) support is inconsistent: breastfeeding counsellors are scarce, lactation corners are limited, and inappropriate foods such as condensed milk are still distributed against code of marketing for breastmilk substitutes. Regulations and adherence to code of marketing for breastmilk substitutes to manage unsolicited donations remain weak.

Community-based platforms, such as Posyandu and PMBA kitchens, are vital during recovery, but long-term displacement often disrupts services. Coordination with other clusters, particularly WASH, logistics, and social protection, is not always systematic, reducing the effectiveness of NiE interventions.

3.5 Nutrition Workforce

Indonesia has made strides in developing service providers' capacity to effectively deliver nutrition services by strengthening the workforce through the implementation and utilisation of digital Human Resources for Health (HRH) mapping platforms, such as SISDMK and DREAMS. This enabled evidence-based planning, which promoted equitable distribution, and targeted training for nutrition personnel. It also ensured the formalisation of nutrition professionals within national health workforce policies, HR regulations, and placement initiatives.

The GOI also ensured continued capacity development by developing various national training platforms, such as e-learning and structured training programs, like Plataran Sehat integrated with Satu Sehat. These initiatives provide opportunities for competency-based capacity building, tracking, and continuing professional education for frontline health workers in nutrition service delivery (some nutrition training is available at Plataran Sehat, e.g., Infant and Young Child Feeding). Further, Community-Based Nutrition Service Delivery is supported at the community level by dedicated trained Posyandu cadres to enhance outreach services, community engagement, and provision of a continuum of care.

Despite making these strides, persistent bottlenecks remain. The sections below review bottlenecks in five

dimensions of workforce development: (1) availability and distribution, (2) competency for technical capacity, (3) programme management competency, (4) workload, role clarity, and supervision, and (5) incentives and retention. Together, they highlight both the progress achieved and the systemic gaps that continue to limit workforce performance.

3.5.1 AVAILABILITY AND DISTRIBUTION

According to MoH data, by 2023, only 56.2 per cent of Puskesmas employed at least one professional in each of the nine essential categories, including nutritionists and midwives. However, there are disparities at Provincial level for example, Jakarta, South Kalimantan, and Yogyakarta achieved over 88 per cent compliance, while Maluku, West Papua, and Papua had less than 25 per cent.

Nutritionist workforce remains low compared with other health care workers. In 2024, there were only 0.09 licensed nutritionists per 1,000 population, compared to 0.99 midwives per 1,000. Between 2019 and 2023, midwives increased by about 70,000, while nutritionists grew by only 5,000, showing uneven placement of the health workforce.

Figure 7: Distribution of Puskesmas with 9 Types of Health Professionals

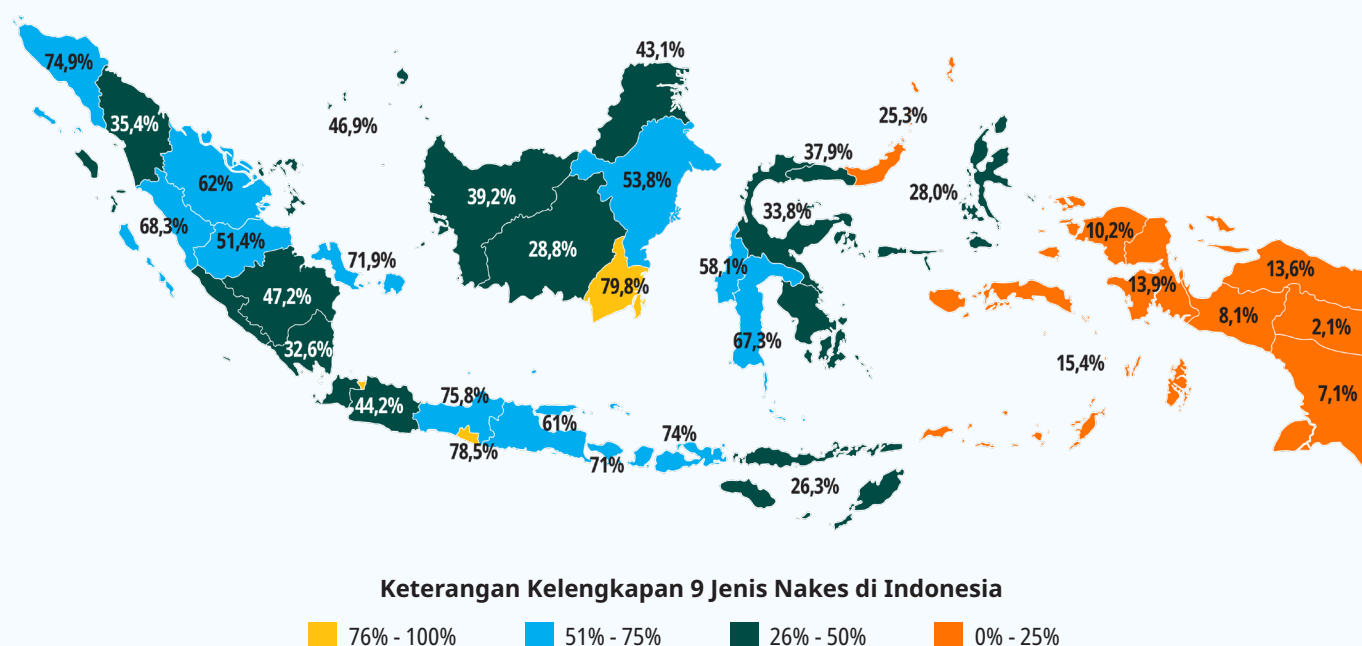
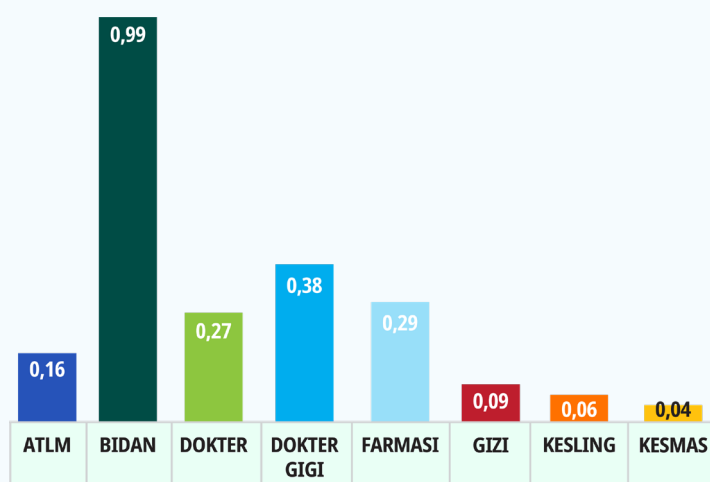
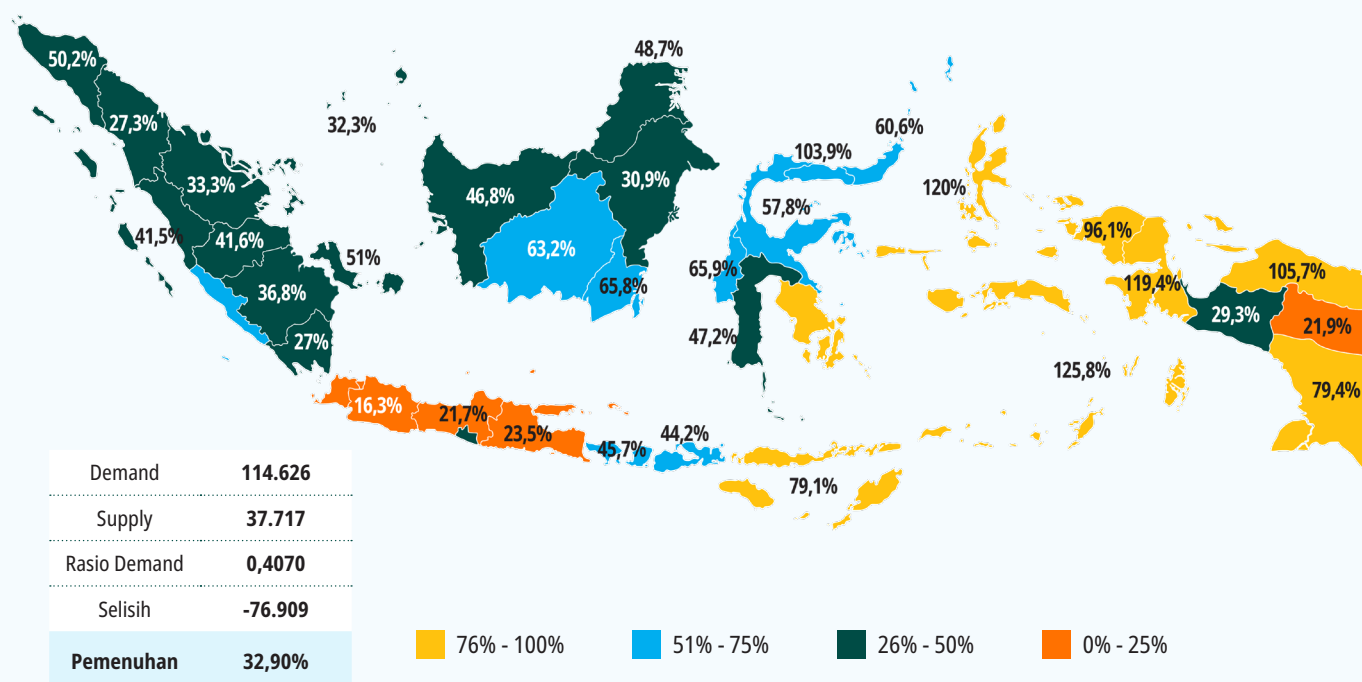


Figure 8: Ratio of Certified Health Workers/1000 Capita



A disaggregated analysis of nutritionist distribution, available through the Ministry of Health's Human Resources for Health (HRH) dashboard (<https://dreams.kemkes.go.id>), shows a mismatch between supply and demand across the country (Fig. 9). While the dashboard provides useful estimates, these figures should be interpreted with caution as demand is calculated primarily based on service utilization and the number of target beneficiaries per capita. In addition, it does not fully take into consideration **geographic and access-related challenges** for example, in the eastern regions of Indonesia where the population is dispersed and difficult terrain demanding for more nutritionists. Similarly, areas with **high population density** face insufficient work force to meet the demand for service provision.

Figure 9: Distribution of Nutritionists Based on Regional Supply and Demand



These findings confirmed the impact of service provision imbalances during the field visits. In some areas, especially in urban settings such as North Sulawesi, some Puskesmas had a substantial number of doctors as opposed to only one nutritionist, leaving them overstretched in nutrition service provision. In North Maluku, cluster-based service models in Halmahera enabled three nutritionists to collaborate across facilities as opposed to the newly established and remote centres, which often had only one nutritionist. These show disparities between urban and better-resourced areas and health workers compared to remote and hard-to-reach regions.

Human resource policy frameworks were found to lag behind programme needs, for example, the 2001 KemenPAN-RB regulation defined nutritionists' roles and introduced a credit-point system for career progression, but had not been updated. Many nutritionists interviewed were unfamiliar with these requirements. The MoH Decree No. 19/204 on Puskesmas introduced a more progressive approach, linking minimum staffing to both population size and geographic accessibility; however, its implementation was not visible during the review period.

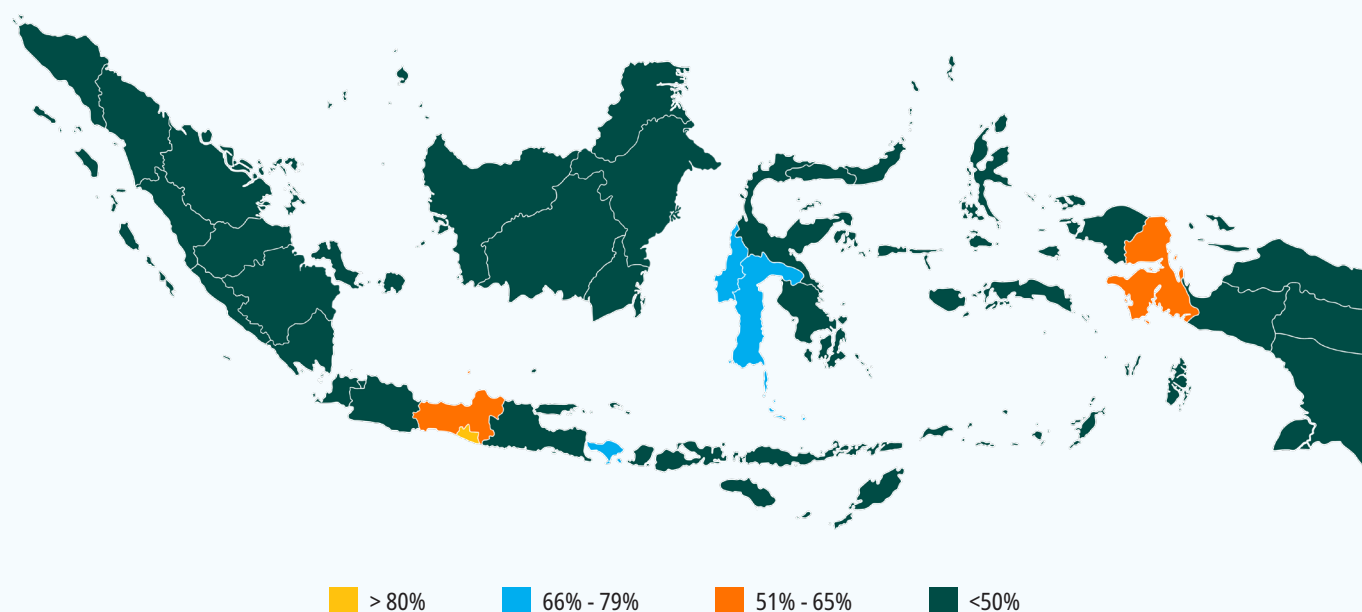
3.5.2 COMPETENCY FOR TECHNICAL CAPACITY

Indonesia expanded pre-service opportunities through universities and polytechnics. Several Centres of Excellence integrated IMAM and IYCF counselling into curricula, for example, Hasanuddin University in South Sulawesi province, Universitas Brawijaya in East Java province, and Poltekkes Kemenkes Kupang in NTT province have successfully included IMAM training into their preservice curricula for dietitians, nurses, midwives, and nutritionists. This crucial step is systemically improving the technical capacity of Indonesia's future frontline health workers in responding to child wasting and other nutrition issues. However, despite such efforts, competencies by graduates in other nutrition programme areas, such as adolescent nutrition, obesity prevention, and behaviour change communication, remained a challenge across

institutions. At the entry point, there was a lack of standardised induction on nutrition, and irregular refresher training, which is mostly donor-dependent; for instance, in Bali, district officials reported that while nutritionists were confident in IFA supplementation, they were less familiar with new MMS protocols.

The National data show that IYCF counselling capacity was limited, with fewer than 50 per cent (Fig 10) of Puskesmas having certified IYCF counsellors by 2024, while in South Minahasa (North Sulawesi), nutritionists reported that while PMBA training had been received, no certified lactation counsellors were available. In Tabanan, Bali, managers noted that the absence of systematic mapping or coordination of counsellors is leading to uneven coverage across facilities. In general, Indonesia is facing an uneven distribution of IYCF counsellors, with most areas having less than 50 per cent (Fig. 10).

Figure 10: Distribution of IYCF Counsellors



These gaps were confirmed during the field visit, for example, a nutritionist in South Minahasa reported that while staff had received training on breastfeeding and complementary feeding counselling (PMBA), no certified lactation counsellors were available.

“Over the past three years, we’ve had training for PMBA counselling for Puskesmas nutrition staff. But we haven’t yet received specific training to become certified lactation counsellors—though that’s planned to start this year.”

Nutritionist 1, Puskesmas, South Minahasa – North Sulawesi

Similarly, a District Health Office official in Tabanan, Bali, observed the lack of systematic deployment, coordination, and mapping of IYCF counsellors, limiting equitable service coverage.

“In our district, not every Puskesmas has an ASI (Breastfeeding) counsellor or PMBA (IYCF) counsellor, so breastfeeding and complementary feeding counselling haven’t been implemented systematically. It really depends on whether the Puskesmas has trained personnel or not. This makes it hard to ensure all mothers receive the same quality of support. At the same time, we don’t yet have a formal network of counsellors in place. There’s no structured coordination or referral system between them, and we also lack a comprehensive mapping of available counsellors. So even if some individuals have been trained, we don’t always know where they are or how to involve them effectively in the program. This is something we recognize as a gap and are hoping to strengthen moving forward.”

District Health Office Staff, Tabanan - Bali

Similar gaps were highlighted in growth monitoring, for example, in Aceh, cadres reported that they could weigh and record data but were unable to interpret charts or advise caregivers. Although a structured national curriculum covering 25 competencies was developed, its implementation was uneven, particularly in high-burden provinces.

Weaknesses were also identified in IMAM implementation including MUAC screening. For instance, in NTT and Maluku, cadres and midwives reported limited skills in case identification, classification, and referral, leading

to poor prevention and management of acute malnutrition cases. Similarly, teachers engaged in adolescent nutrition programmes, reported receiving limited training, affecting the effective delivery of initiatives such as Aksi Bergizi.

The capacity for NiE response has shown some positive progress. NiE training modules and curricula have been developed, including e-learning, but institutionalisation remains partial. Around 3,000 IYCF counsellors have been trained, which was below the national target of 10,000. Training is often one-off, with little follow-up or simulation. Most Puskesmas staff learn NiE practices informally during crises. NGOs help to fill training gaps, but their efforts are ad hoc. Staff turnover further erodes preparedness efforts, as trained personnel are frequently reassigned. Some local innovations, such as retaining trained staff in Jember or establishing Rapid Response Teams in certain districts can offer promising models, but these are not yet scaled. Community volunteers, including cadres and TAGANA youth groups, provide surge support but are not systematically trained or integrated into official SOPs. Formalising their roles through clear tasking, competency standards, and supervision would strengthen workforce resilience.

3.5.3 PROGRAMME MANAGEMENT COMPETENCY

Programme management competencies at district and provincial levels are a critical determinant of effective nutrition service delivery and outcomes. However, programme management capacity was found to be weak with staff holding multiple portfolios giving little attention to nutrition-specific planning, budgeting, monitoring or supervision. Turnover was frequent; in one district in NTT, the head of nutrition changed three times in two years, disrupting oversight and continuity.

Digital tools were introduced to address these challenges. SISDMK supported workforce mapping, DREAMS tracked deployment, and Plataran Sehat monitored competencies. However, in practice, these systems are underutilised. In Maluku, district staff reported entering data “because it was required,” but not using it to inform planning.

Inconsistent and limited supervision systems compromise the identification of key areas that require attention, for example, in North Maluku, cadres reported broken weighing scales for several months, but the problem was not resolved due to unclear responsibilities and weak follow-up. This is a clear indication of limited programme management capacity, which directly affects the quality and timeliness of service delivery.

In addition to program management, collaboration, and capacity improvement of the nutrition workforce for supply chain is also crucial. Most district pharmaceutical installations had pharmacists in place, but only about one-third had received structured training in supply chain management. This limited their ability to forecast needs, manage expiries, and supervise distribution, including for nutrition program supplies. One striking finding from the field visit was the distribution of MMS by a pharmacist using a Ziplock bag rather than in its original bottle.

At the community level, cadres and teachers played an important role in distributing nutrition products (e.g., IFA, MMS, vitamin A) and programme commodities (e.g., MCH books, anthropometric kits). However, they lacked training in inventory management, received no incentives for these additional tasks, and had limited supervision. Field visits confirmed that cadres often felt unprepared to manage stock or maintain records, reducing accountability.

3.5.4 WORKLOAD, ROLE CLARITY, AND SUPERVISION

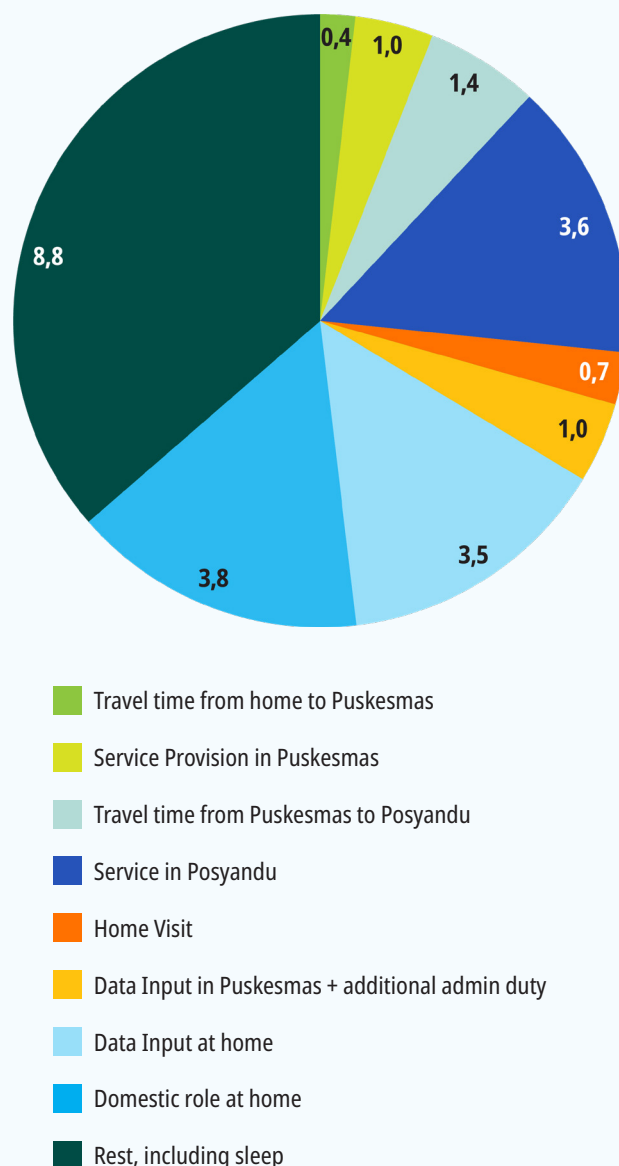
Unclear roles and a lack of supervision lead to heavy workloads. Nutritionists at Puskesmas have to balanced service delivery with administrative reporting, often spending more time on e-PPGBM data entry at the expense of service delivery. To mitigate the challenge, midwives and nurses often stepped in to cover nutrition services, which also brings more workload to these cadres as they have their own roles to fulfil. These face challenges in terms of overall preparation to weigh children, record growth data, mobilise families, distribute supplements, and even provide counselling. In East Java, cadres reported uncertainty about which nutrition messages to prioritise leading to inefficiencies and inconsistencies in quality of service.

The absence of role clarity and a clearly defined Essential Nutrition Package left responsibilities diffuse. Without clarity on who to deliver which intervention, accountability is diluted and frontline staff struggle to prioritize competing demands.

3.5.5 INCENTIVES AND RETENTION

Lack of incentives undermines motivation and staff retention. In Maluku, newly posted nutritionists indicated their intention to transfer after a short time due to isolation

Figure 11: Daily Time Allocations for Nutritionist



and lack of mentoring. The implementation of Law No. 20/2023, which prohibits hiring non-permanent staff, worsened shortages in remote Puskesmas that had previously relied on contract staff.

Cadres continued to serve as volunteers, receiving only small and irregular allowances from village funds, like in South Sulawesi (not part of field visits but supported by secondary sources). Younger cadres often left for paid jobs, leaving older volunteers to provide the services, creating potential gaps for sustainability. Gender norms contributes to these imbalances, as most volunteers were women juggling unpaid community work with domestic duties. This reliance on unpaid, overburdened volunteers remains a structural weakness.

3.6 Essential Supplies for Nutrition

Nutrition commodities in this review are defined in two categories, the first category includes: nutrition products such as iron-folic acid (IFA), multiple micronutrient supplements (MMS), vitamin A, calcium, deworming tablets, micronutrient powders (Taburia), ready-to-use therapeutic foods (RUTF), therapeutic milks (F-75/F-100), and mineral mix. The second category includes: programme commodities and job aids, such as anthropometric equipment, MUAC tapes, haemoglobin (Hb) test kits, SDIDTK developmental monitoring tools, and the Maternal and Child Health (MCH) book. This block reviews the availability, quality, distribution, and utilization of essential nutrition commodities, as well as the systems that support their procurement, storage, and supply.

3.6.1 AVAILABILITY AND STOCK OF ESSENTIAL COMMODITIES

Indonesia has made notable progress in expanding access to essential nutrition commodities, including iron-folic acid (IFA/TTD), multiple micronutrient supplements (MMS), vitamin A, Taburia, ready-to-use therapeutic foods (RUTF), therapeutic milks, and anthropometric equipment. Centralized procurement through the national e-katalog has improved transparency and allowed standardized purchasing across provinces. For instance, biannual vitamin A campaigns continue to reach more than 75 percent of children nationally, and MMS pilot distribution in selected districts has demonstrated stronger availability of supplies, leading to more adherence among pregnant women.

Despite these strides, challenges were noted, for example, large volumes of IFA tablets expired in districts with high anaemia prevalence, while MMS is still limited to only 10 out of 514 districts, leading to unequal access to the service. Additionally, anthropometric equipment and SDIDTK kits are often incomplete or in disrepair, compromising growth and developmental assessments. At the same time, outdated IEC materials limit effectiveness, the MCH Handbook continues to serve as a reliable reference for caregivers and health workers.

"Yes, shortly after it arrived, the baby scale broke. Then the village replaced it with a Salter (an analogue hanging scale), but that also broke after a while, so now we're using this one (manual steelyard balance hanging scale)."

Cadre 2, Posyandu, West Halmahera

"It seems that about half of the baby scales were already broken when they arrived. So, during Posyandu sessions, we borrow from each other. But moving the scales back and forth also causes them to break more quickly. As for replacements, there hasn't been any support from the village yet."

Midwife, Puskesmas, South MInahasa

3.6.2 NUTRITION EQUIPMENT AND SUPPLY CHAIN LOGISTICS

The nutrition supply chain forecasting was found to be weak, and at the national level, it relies on demographic projections, while at the district level, they use retrospective data, creating mismatches that lead to either overstocking, wastage or shortages. In addition, the majority (60%) of storage facilities at the Puskesmas level do not meet the minimum storage standards. Unsafe practices were also observed in some supplies, such as the repackaging of MMS tablets into non-standard containers, compromising quality and shelf life. In terms of supply distribution, delays of three to four months were noted for supplies to arrive, especially in remote provinces such as Papua and NTT. Emergency situation, such as seasonal floods and landslides, exacerbates disruptions.

3.6.3 INFORMATION SYSTEMS AND STOCK MONITORING

Stock monitoring systems were observed to be fragmented and poorly integrated with manual stock cards used as the primary tool in most facilities, despite enormous error rates ranging from 15 to 20 percent. The existing digital systems, such as SIGIZI Terpadu, e-PPGBM, and Komdat Kesmas, are functioning in silos, leading to duplication in reporting. However, the piloting of Pelita Kesmas is promising with 90 percent reporting completeness and has demonstrated the potential for integration with other platforms or systems.

3.6.4 PROGRESS IN LOCAL PRODUCTION

Indonesia made significant progress in advancing local production of both MMS and therapeutic foods (RUTF, F75 and F100) to strengthen long-term availability and sustainability of nutrition supplies. For MMS, the Ministry of Health approved policies consistent with UNIMMAP

standards to ensure alignment with global practice. UNICEF, in collaboration with Vitamin Angels, provided technical support to local manufacturers through coaching clinics and also conducted cost-effectiveness studies. The MoH issued specifications for public procurement and supported local suppliers to meet quality standards. The government procurement of locally produced MMS is expected to begin in 2026; this attracted several domestic producers to invest in readiness for production. Further, the MoH announcement for transitioning from IFA to MMS increased the demand side. MoH also produced a package of communication materials for health workers and communities to enhance awareness of MMS.

Similarly, the local RUTF production feasibility study was conducted in 2021 by the MoH with technical support from UNICEF; the study confirmed the efficacy and acceptability of locally produced formulations. MoH subsequently issued national standards for RUTF, F-75, and F-100, aligning with global recommendations and establishing a regulatory framework for local manufacturers. Following consultations, a couple of domestic producers have committed to start RUTF, F75 and F100 production by 2026 and 2027. UNICEF supported this process through quality assurance and technical assistance to help suppliers meet national standards.

These initiatives promote public-private partnership, and it's a significant opportunity to reduce reliance on imports and donor procurement by building a self-reliant domestic supply chain. The MMS and RUTF local production strengthen Indonesia's ability to scale up interventions to reach more beneficiaries and address undernutrition and its consequences. It will also position the country to contribute to regional and global markets in the future.

3.6.5 ESSENTIAL SUPPLIES AND EQUIPMENT IN EMERGENCIES

Indonesia has established buffer stocks of fortified biscuits and pre-positioned them in 11 logistical zones managed by BNPB. These provide readiness for immediate nutrition assistance during emergencies response. However, this system also faces significant challenges. Beyond fortified biscuits, no other essential nutrition commodities are pre-positioned. Products such as RUTF, therapeutic milks, micronutrient powders, and anthropometric kits are not included in buffer stockpiles and are procured on ad hoc basis or through partners, delaying comprehensive emergency response. Standardised NiE kits tailored for infants, PLW, and elderly populations are not yet available. Enforcement of restrictions on unsolicited donations remains weak, and supply chain capacity varies across provinces.

3.7 Nutrition Financing

Adequate and predictable financing is fundamental to sustaining nutrition interventions across the life course. It provides opportunities for governments to expand services, secure supplies, and strengthen systems for long-term impact. This section examines commitments, accountability and efficiency of nutrition financing.

3.7.1 BUDGET SIZE AND FISCAL COMMITMENT

Indonesia's 2024–2025 national allocation for nutrition reflects strong political will and commitment, but remains modest compared to the total health budget. Nutrition-specific interventions under the Ministry of Health account for only 6% to 9% of the total health spending, while nutrition-sensitive programs across agriculture, education, social protection, and village funds represent more than 80% of total stunting-related expenditure. Budget tagging in 2024 shows that 58% of tagged outputs correspond to sensitive interventions, 11% to coordination activities, and 31% to specific interventions.²⁶

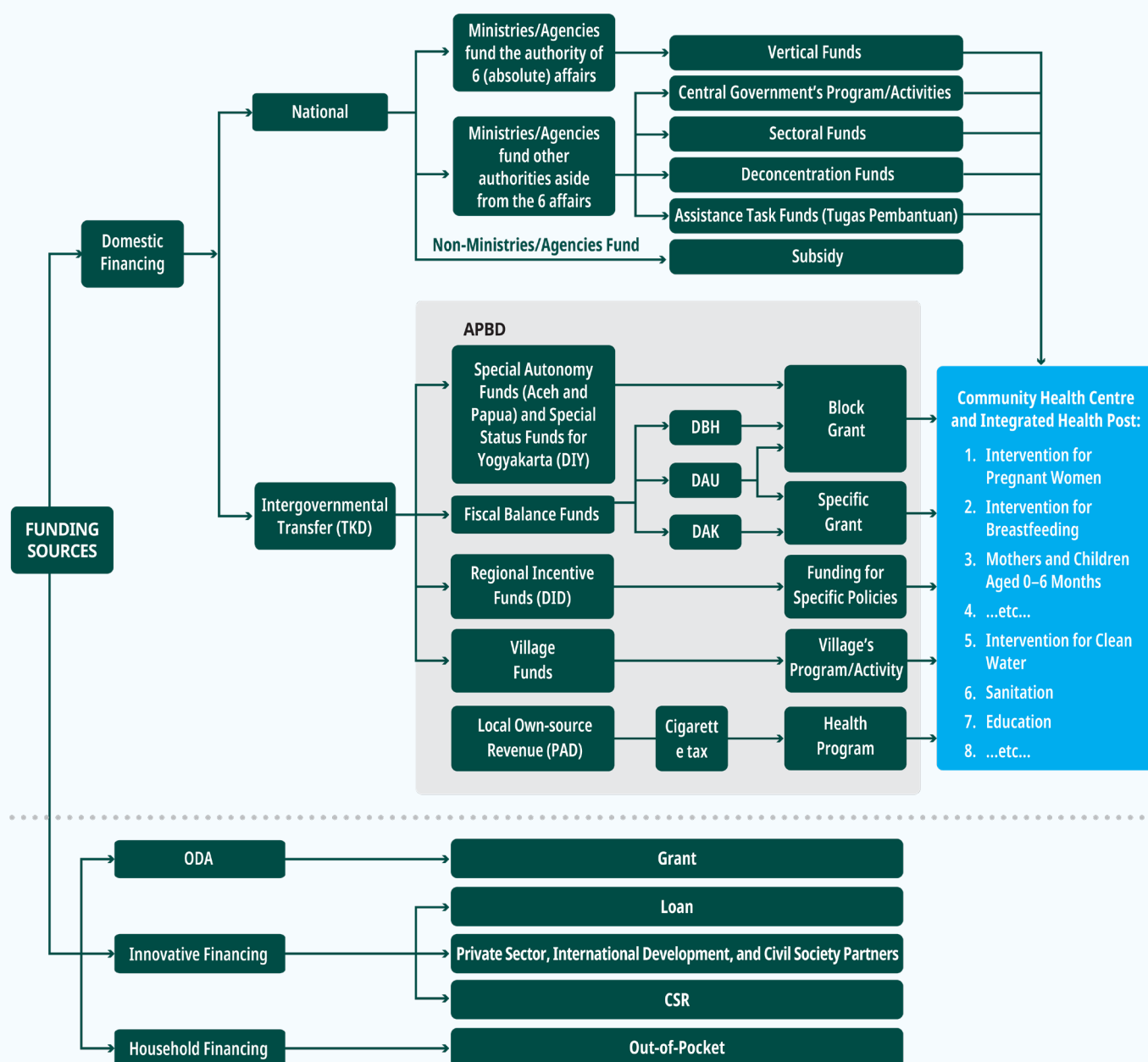
Subnational governments depend heavily on central transfers through DAK, TKDD, and village fund, which together contribute 80% to 85% of total local nutrition financing.²⁷ Between FY 2022 and 2024, the national nutrition budget increased by about 15%, mainly driven by DAK Gizi and Dana Desa, although growth was uneven across provinces. Fiscal inequities persist, as larger provinces in Java and Sumatra absorb most allocations, while poorer or remote provinces in eastern Indonesia receive less despite higher stunting prevalence. The current DAK formula does not fully reflect nutrition burden indicators, leading to resource misalignment.

3.7.2 BUDGET SOURCES AND ACCOUNTABILITY

Nutrition financing comes from multiple sources, including the national (APBN) and regional (APBD) budgets, village funds, and contributions from development partners and corporate social responsibility (CSR) initiatives. These resources support key interventions such as breastfeeding promotion, complementary feeding, and micronutrient supplementation. Dana Desa has become an important mechanism for revitalizing Posyandu and strengthening community-based nutrition and early childhood development.

However, fragmentation across more than ten ministries with separate budget codes

Figure 12: Source of Funding



and reporting systems reduces efficiency and coordination. Efforts to improve accountability through the STRANAS Stunting budget tagging have increased transparency but remain inconsistent; only about 62% of tagged outputs in 2024 had complete performance information. The absence of a unified nutrition accounting framework continues to hinder expenditure tracking and cost-effectiveness assessment.

Private sector and CSR initiatives have brought additional diversity to the financing landscape. Companies such as Danone and Mayora, and foundations such as the Tanoto Foundation, have supported stunting prevention, nutrition education, and cadre training. However, most activities remain short-term and project-based, while the external financing has been catalytic. The

World Bank's Investing in Nutrition and Early Years (INEY) program, implemented from 2018 to 2024, mobilized a USD 24 million grant and a USD 400 million loan tied to performance based indicators, encouraging cross-sector and district-level convergence in stunting reduction. Development partners, including UNICEF, WFP, and WHO, have provided technical assistance and targeted project financing on a smaller scale.

Households also bear a significant share of nutrition-related costs, including food and transportation for follow-ups at Puskesmas, especially for children with severe acute malnutrition. However, data on household out-of-pocket spending remain limited, making it difficult to assess the scale and equity of these contributions.

3.7.3 EFFICIENCY AND EFFECTIVENESS

Budget efficiency for nutrition-specific interventions under the Ministry of Health remains high, with 93% realization in 2024, compared with 59% to 63% for multi-ministerial programs. Coordination weaknesses, fragmented data, and different reporting systems continue to limit effectiveness. Misalignment between national targets and local implementation data often results in performance gaps and low budget absorption, particularly for BOK funds.

Although fund disbursement is generally timely, delays in the release of technical and financial reporting guidelines can slow implementation. Preventive and promotive nutrition services continue to rely on limited central funds, as most local health spending remains focused on curative care. Posyandu cadres receive inconsistent and modest incentives, which affects motivation and service quality. Nevertheless, promising local innovations, such as Dana Desa-funded local feeding programs and the CSR award mechanism in North Sulawesi, show the potential of decentralized and multisectoral collaboration.

To enhance sustainability, Indonesia would benefit from a costed multi-year essential nutrition plan linked to a unified accountability system. Strengthening subnational fiscal autonomy and integrating private, external, and domestic financing within a coherent framework would improve efficiency, equity, and long-term impact across all levels of the nutrition system.

3.7.4 FINANCING FOR NIE

NiE financing remains reactive and fragmented. Local governments depend on the Unexpected Expenditure Fund (BTT), which is released after a disaster declaration. At the national level, BNPB's Standby Fund (DSP) provides emergency resources, but access can be slow and centralised.

Preparedness funding is especially limited. With the phase-out of deconcentration funds, few District Health Offices have dedicated NiE budget lines. Simulations and training are rarely budgeted. To address this, the government is piloting a Disaster Pooling Fund that could finance preparedness and recovery activities and is developing Anticipatory Action mechanisms that would release funds based on forecasts such as El Niño. Both innovations offer pathways to shift from reactive to proactive financing.

3.8 Nutrition Information System

This section examines Indonesia's evolving nutrition information system, focusing on how data are generated, managed, and used to inform policies and programs. It reviews the scope and frequency of national surveys, the functionality and integration of routine reporting platforms, and the quality, completeness, and usability of data at different levels of the health system. It also explores challenges of interoperability, reporting burden, and limited data use for local decision-making.

3.8.1 SYSTEM LANDSCAPE

Indonesia's nutrition information landscape has expanded significantly. Population-based surveys, including Riskesdas (2018), SSGI (2021, 2022, 2024), and SKI (2023), now provide national and provincial estimates of stunting, wasting, and overweight more frequently than in the past. Complementary surveys, such as SUSENAS and SUPAS, provide socio-economic and demographic information that strengthen nutrition analysis.

Routine reporting platforms such as e-PPGBM and Si-Gizi Kesga provide continuous data on growth monitoring and maternal-child health services. The Ministry of Health introduced quarterly "desk data" reviews, while new indicators, including dietary diversity, minimum acceptable diet, animal protein intake, and child overweight, were added to better capture the double burden of malnutrition.

However, the expansion of surveys has also created concerns around efficiency. Conducting an annual national nutrition survey to track stunting is not aligned with global recommendations. Stunting changes slowly, and most countries measure it through large-scale surveys every 3–5 years. Annual surveys consume substantial resources but offer limited additional value for programme planning, suggesting a need to reconsider survey frequency.

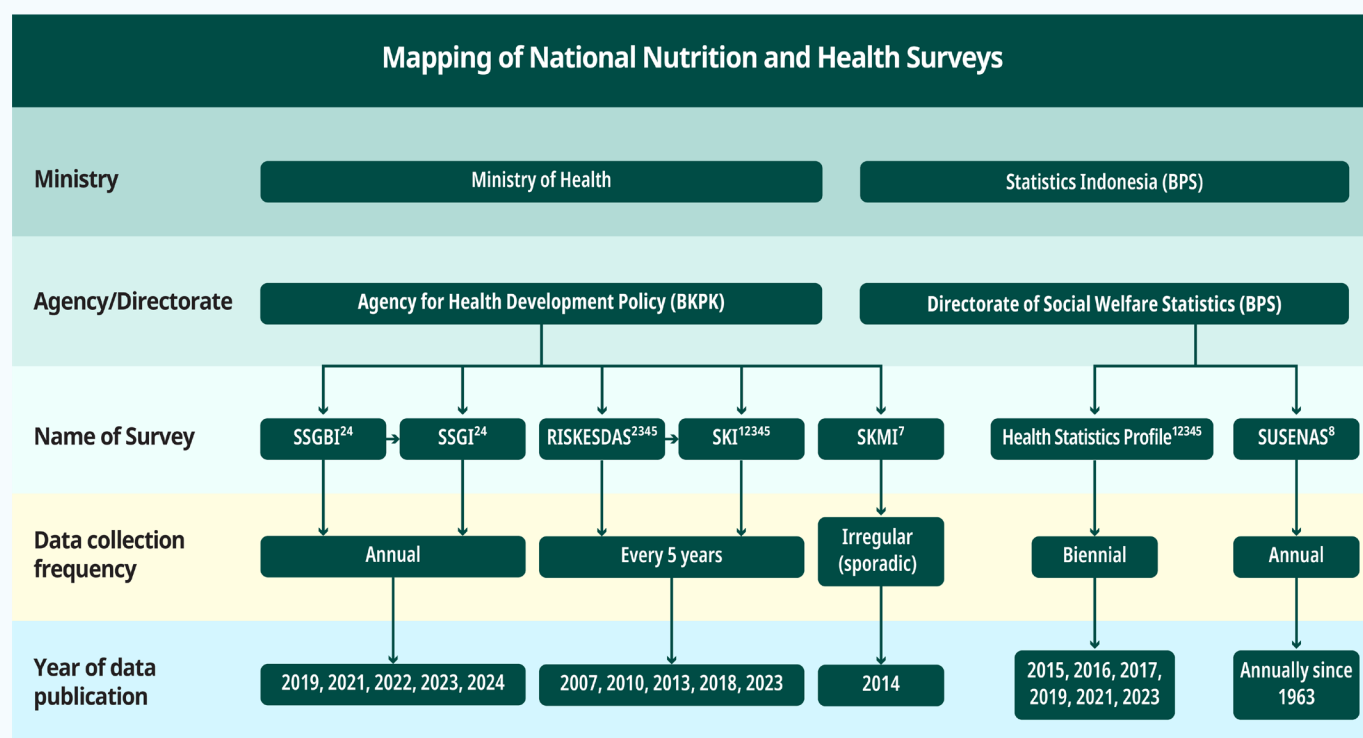
3.8.2 DATA QUALITY, COVERAGE, AND COMPLETENESS

The volume of data has increased, but quality and coverage remain uneven. Surveys provide reliable prevalence estimates for stunting and wasting, but they do not consistently capture micronutrient biomarkers, dietary intake, or outcomes for adolescents and adults. This leaves critical gaps in monitoring anaemia, overweight, and hidden forms of malnutrition.

Routine reporting systems face challenges with accuracy and completeness. Field visits noted variation in anthropometric measurements due to cadres not always being trained or adequately

Figure 13: Mapping of National Health and Nutrition Survey

National surveys include nutrition indicators, but some are overlaps while some other key indicators (micronutrient) remain inconsistently tracked or lack adequate sample sizes.



Indicators documented:

1. Newborn (vital health, nutrition status, program coverage)
2. Toddler and Preschool Children (vital health, nutrition status, program coverage)
3. School-Age Children and Adolescent (nutrition status, program coverage)
4. Maternal (vital health, nutrition status, program coverage)
5. Adult & Reproductive Health (nutrition status, program coverage)
6. Integrated Management of Acute Malnutrition (IMAM)
7. Individual Food Consumption
8. Household Food Consumption

Glosarium:

1. **SSGI:** Survei Status Gizi Indonesia (Indonesian Nutritional Status Survey)
2. **Riskesdas:** Riset Kesehatan Dasar (Basic Health Research Survey)
3. **SKI:** Survei Kesehatan Indonesia (Indonesian Health Survey)
4. **SSGBI:** Survei Status Gizi Balita Indonesia (Indonesian Child Nutritional Status Survey)
5. **SKMI:** Survei Konsumsi Makanan Individu (Individual Food Consumption Survey)
6. **Susenans:** Survei Sosial Ekonomi Nasional (National Socio-Economic Survey)

equipped. Some dietary indicators are reported based on estimates rather than standardised recall, limiting comparability. In addition, outcome indicators for the treatment of wasting such as cure, mortality, and default rates are not systematically captured, making it difficult to assess programme performance.

Discrepancies between survey and routine estimates further undermine confidence in the data. These inconsistencies make it harder for policymakers to use data for resource allocation and programme adjustments based on evidence.

3.8.3 INTEGRATION, INTEROPERABILITY, AND REPORTING BURDEN

The number of reporting platforms has multiplied, but integration has lagged. Systems such as DHIS2, SIKDA, Komdat Kesmas, e-PPGBM, and Si-Gizi Kesga continue to operate in silos. This leads to duplication, with the same information often entered in multiple formats.

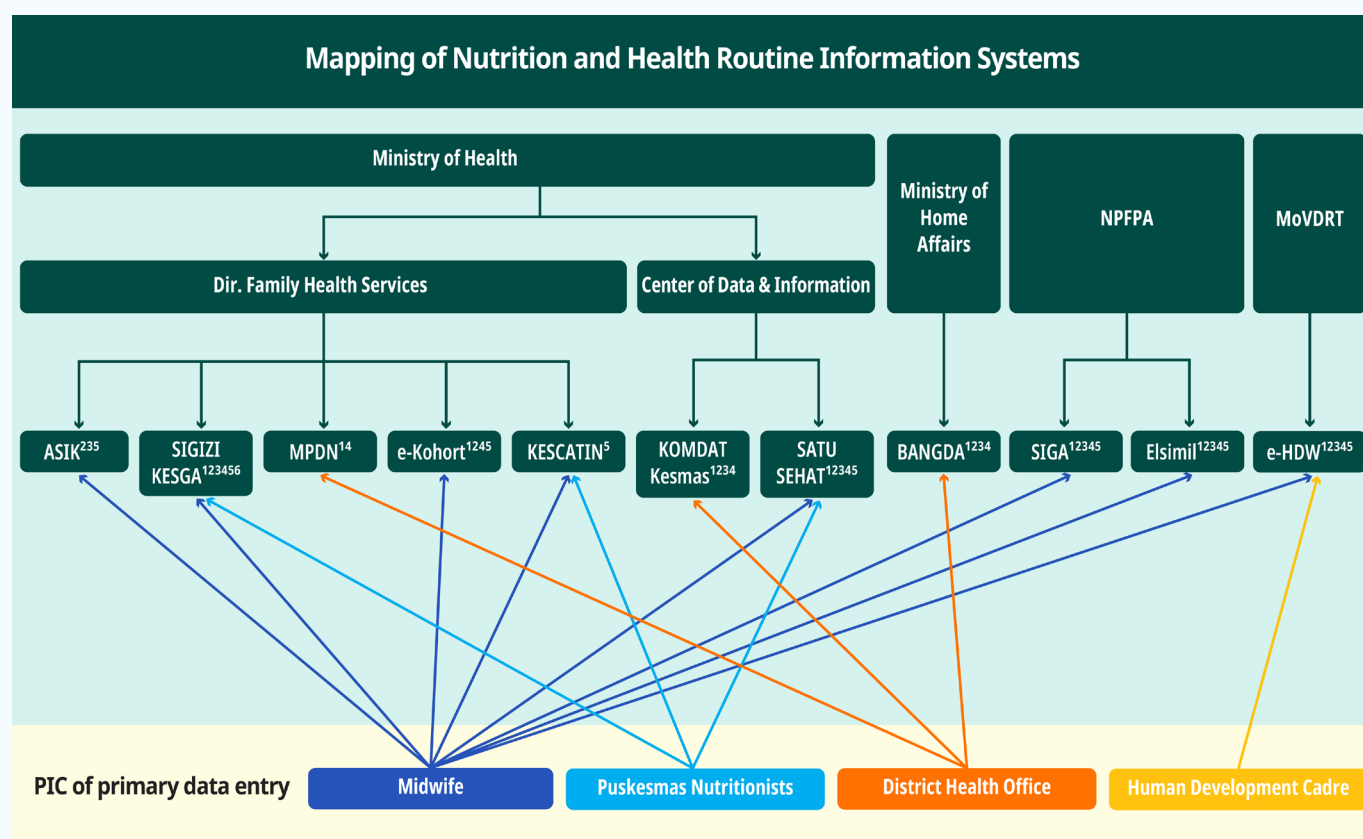
The burden falls heavily on frontline staff. Nutritionists, who are often the only nutrition professionals in a Puskesmas, reported spending

long hours completing data entry, often after working hours. Poor internet connectivity in some areas further delays reporting. This reduces the time available for counselling, outreach, and supervision, ultimately contributes to staff fatigue.

The introduction of Pelita Kesmas successfully demonstrated that an integrated digital system

can capture the entire SAM patient pathway from screening and referral to treatment at both Puskesmas and hospitals. However, the sub-optimal implementation of this system means that no reliable national data on treatment quality is yet available, specifically lacking vital indicators such as cure rates, default rates, and mortality rate.

Figure 14: Mapping of Health and Nutrition Information Platforms



Indicators documented:

1. Newborn (vital health, nutrition status, program coverage)
2. Toddler and Preschool Children (vital health, nutrition status, program coverage)
3. School-Age Children and Adolescent (nutrition status, program coverage)
4. Maternal (vital health, nutrition status, program coverage)
5. Adult & Reproductive Health (nutrition status, program coverage)
6. Integrated Management of Acute Malnutrition (IMAM)

Glosarium:

1. **MoVDRT:** Ministry of Villages, Development of Disadvantaged Regions, and Transmigration
2. **NPFPA:** National Population and Family Planning Agency
3. **ASIK:** Aplikasi Sehat IndonesiaKu
4. **SIGIZI KESGA:** Sistem Informasi Gizi dan Kesehatan Keluarga (including Pelita Kesmas)
5. **MPDN:** Maternal & Perinatal Death Notification
6. **e-Kohort:** Elektronik Kohort
7. **Kescatin:** Kesehatan Calon Pengantin
8. **Komdat Kesmas:** Komunikasi Data Kesehatan Masyarakat
9. **Bangda:** Pembangunan Daerah
10. **SIGA:** Sistem Informasi Keluarga
11. **Elsimil:** Elektronik Siap Nikah dan Hamil
12. **eHDW:** e-Human Development Worker

3.8.4 DATA USE AND ACCOUNTABILITY

Access to nutrition data has improved. Subnational governments now have greater access to disaggregated data, and several provinces have introduced dashboards to track progress in reducing stunting. However, the use of data for planning and accountability remains limited. District staff are expected to report data upwards, but often lack training in analysis and interpretation. As one nutritionist in East Java explained, *“We enter the numbers every month, but we don’t always discuss what they mean or how to act on them.”* This reflects a wider pattern where data is collected but rarely applied to guide local decision-making.

Feedback loops are weak. Cadres and Puskesmas rarely receive tailored analysis, and districts often lack mechanisms to provide constructive feedback. Cross-sectoral use of nutrition information also remains underdeveloped in education, agriculture, and social protection programmes occasionally integrate nutrition indicators into their planning. Opportunities

to link nutrition data with climate, food systems and disaster preparedness are not yet realised. Similarly, there is no Joint Monitoring and Evaluation framework that defines indicators to be reported by each of the sectors.

3.8.5 INFORMATION SYSTEMS FOR NIE

Information systems for emergencies remain fragmented. While SIGIZI is the national platform for nutrition data, NiE indicators are not fully integrated. Systems used by the MoH Health Crisis Center and BNPB are not intercomparable. In practice, reporting is slow and hierarchical, for example, Puskesmas staff often use ad hoc forms and report through multiple administrative layers. Rapid assessments are inconsistently applied, and frontline staff have limited training in emergency data management. Most reporting tracks outputs (e.g., the number of children screened) rather than outcomes (e.g., recovery rates). Strengthening interoperability, developing shared dashboards, and building capacity for emergency data management and mapping are priorities.



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04. General Discussion

Indonesia's health system demonstrates significant progress toward institutionalizing nutrition programme, supported by policy reform, digital transformation, and multisectoral coordination. However, systemic bottlenecks persist across all six WHO building blocks, constraining equitable and sustained progress toward reducing all forms of malnutrition.

→ **LEADERSHIP AND GOVERNANCE.** Political commitment has been a defining strength. The Presidential Regulation No. 72/2021 institutionalized multisectoral convergence under the STRANAS Stunting, driving coordination and budget tagging across ministries and districts. Despite these advances, the policy environment showed gaps in consistency and alignment with global recommendations across the life cycle. Furthermore, “stunting-centric” bias leads to less emphasis put on wasting, anaemia, and obesity. Likewise coordination at all levels needs to be strengthened by expanding the agenda beyond stunting, this can be facilitated by having a joint monitoring and evaluation framework with shared indicators to be reported by each sector.

Within the Ministry of Health, nutrition remains positioned under the Directorate of Primary Health Care, limiting decision-making authority and visibility. Frequent updates to technical guidelines have outpaced system capacity for dissemination and supervision, creating uneven adoption at the frontline. Moreover, the current organogram is not mirrored at the subnational level, leading to overlap and weak vertical coordination. Strengthening local structures and formalising multisectoral engagement at the district level remain key priorities. The Nutrition in Emergencies (NiE) framework under the Health Cluster and BNPB represents progress in preparedness, yet its operationalization remains uneven across provinces. With Indonesia facing increasing climate-related disasters, NiE must evolve into a climate-resilient system that anticipates shocks and safeguards nutrition services rather than reacting post-crisis.

→ **NUTRITION SERVICE DELIVERY.** Indonesia's extensive network of Puskesmas, Posyandu, and school-based nutrition programs provides a strong foundation for service delivery. Coverage for breastfeeding, growth monitoring, vitamin A supplementation, and antenatal care has recovered following the COVID-19 pandemic. However, service

quality remains uneven. Nutrition counselling is often generic, while IMAM and supplementary feeding (PMT) programs face weak monitoring and inconsistent implementation.

The absence of a standardized Essential Nutrition Package (ENP) continues to fragment service delivery, as clear protocols and defined roles are lacking. Integration across the life course from maternal to adolescent nutrition remains incomplete. In addition, continuity of care across community-based services, primary health care, and referral facilities—and back referral to the community—is particularly weak in the management of wasting. Overall, service delivery tends to be checklist-driven rather than needs-based, with limited coordination between facility- and community-level platforms. Inconsistent supervision and insufficient follow-up further reduce the effectiveness of service delivery and the sustainability of nutrition outcomes.

→ **HUMAN RESOURCES FOR NUTRITION.** Workforce capacity has improved through digital HRH platforms such as SISDMK and DREAMS, and training systems like Plataran Sehat. These initiatives enable evidence-based deployment and continuous professional development. However, the number and distribution of nutritionists remain insufficient. Heavy workloads, especially for female staff, and limited incentives for Posyandu cadres reduce motivation and quality of service delivery. Strengthening managerial, analytical, and leadership competencies for nutrition staff is critical to improve planning, supervision, and accountability.

→ **ESSENTIAL SUPPLY FOR NUTRITION.** Supply systems show partial improvement but remain fragile. Procurement and distribution of key commodities such as RUTF, MNPs, and calcium for pregnant women are inconsistent, and postpartum vitamin A coverage remains low. Weak coordination between logistics units and delayed technical guidelines often leads to stockouts. Integrating nutrition commodities into a unified procurement and monitoring system under e-logistics platforms would enhance efficiency and ensure continuity of essential services.

→ **NUTRITION INFORMATION SYSTEM.** Indonesia's nutrition information landscape has expanded through frequent surveys (SSGI, SKI) and strengthened routine platforms (e-PPGBM, Si-Gizi Kesga). While this expansion has improved data availability, the quality, interoperability, and use of

data for decision-making remain limited. Multiple platforms operate in silos, creating duplication and reporting burdens. Routine data quality is inconsistent due to variations in anthropometric measurement and limited feedback loops. Strengthening interoperability through a unified digital platform and building subnational capacity for data interpretation would improve accountability and policy responsiveness.



FINANCING FOR NUTRITION. Fiscal commitment to nutrition is evident, but spending remains modest and fragmented. Nutrition-specific programs represent only 6%–9% of total health expenditure, with most funds directed toward stunting-sensitive interventions. Subnational nutrition financing depends heavily (80%–85%) on central transfers, with unequal distribution between provinces. The STRANAS budget-tagging mechanism has improved transparency but remains inconsistently applied. Private sector engagement through CSR (e.g., Danone, Mayora, Tanoto Foundation) and external programs such as the World Bank's INEY have diversified funding sources. Still, initiatives remain short-term and poorly integrated into government systems. A costed multi-year nutrition plan linked to performance-based budgeting is needed to ensure sustainability and efficiency.



CROSS-CUTTING ANALYSIS. Indonesia's nutrition system is transitioning from fragmented program delivery toward a more institutionalized and system-wide approach. Reforms such as the digitalization of human resources, the expansion of nutrition information systems, and fiscal decentralization reflect meaningful progress toward greater resilience and adaptability. However, progress remains largely siloed within individual pillars or vertical programs, with limited cohesion across the six-health system building blocks, across programs, as well as platforms (continuum of care).

This lack of coherence stems from the absence of an operationalized and costed Essential Nutrition Package (ENP) that could guide all components of the system throughout the life cycle. A well-defined ENP would establish standard inputs, processes, and outputs across the nutrition system, covering workforce competencies, budget allocation, supply chain management, and data use, ensuring consistency and accountability across all platforms. Without such a framework, alignment between programs and life-course nutrition priorities remains weak, and efforts to institutionalize nutrition within the broader health system risk continuing in isolation. Addressing these gaps requires a coherent ENP, strengthened local institutional capacity, predictable financing, and integrated systems for monitoring, supply, and accountability to ensure sustained and equitable nutrition outcomes nationwide.

Indonesia's response to the triple burden of malnutrition among children under five demonstrates how the six-health system building blocks are interdependent. Strong leadership through national policies and laws has established a solid foundation for early-life nutrition, yet the absence of a costed and unified Essential Nutrition Package (ENP) limits coherence across programs and weakens coordination among financing, workforce, and service delivery. Despite increased funding, resource allocation remains fragmented, leaving critical areas such as anaemia and obesity prevention underfunded. Workforce shortages and limited technical capacity, such as IYCF, including EBF counselling, reduce service quality and hinder the use of available data for tailored interventions. Similarly, weak logistics and supply chain management lead to stockouts of key commodities and job aids such as anthropometric kits and MCH books, while fragmented information systems overburden health workers and limit data use for decision-making. These gaps illustrate that progress in one building block cannot compensate for weaknesses in others; without an operational ENP to integrate governance, financing, workforce, supply, information, and service delivery, Indonesia's nutrition response will continue to operate in silos, constraining its impact on child nutrition outcomes.



05. Recommendations

To move from recovery toward transformation, Indonesia requires a coherent policy and programmatic roadmap that consolidates gains, closes persistent gaps, and positions nutrition as a core element of health and development.

The following recommendations are structured to address systemic bottlenecks across the six building blocks of the health system.



REVISIT AND ALIGN POLICIES (GOVERNANCE & LEADERSHIP)

Update national nutrition policies to reflect global recommendations, while tailoring them to Indonesia's burden and implementation capacity. This ensures coherence across platforms and alignment with WHO standards.



DEVELOP A COSTED MULTI-YEAR STRATEGY (FINANCING)

Establish a multi-year, costed nutrition strategy under the MoH to guide planning, budgeting, and execution. This provides predictability, enables resource tracking, and aligns government, donor, and CSR financing.



DEFINE AN ESSENTIAL NUTRITION PACKAGE (ENP) (SERVICE DELIVERY; WORKFORCE; SUPPLIES; GOVERNANCE)

The ENP should clarify roles and responsibilities across platforms, ensure predictable financing, guarantee reliable supplies, and embed supportive supervision. Including NiE preparedness will strengthen resilience in the face of frequent disasters.



BUILD CAPACITY FOR NUTRITION MANAGEMENT (WORKFORCE; GOVERNANCE & LEADERSHIP; INFORMATION SYSTEMS)

Invest in developing managerial, analytical, and leadership skills for nutrition staff at all levels of the system. Stronger capacity in planning, costing, supervision, and data use is essential to translate resources and policies into effective programmes and sustained results.



INTEGRATE FOOD SYSTEMS AND CLIMATE RESILIENCE (GOVERNANCE & LEADERSHIP; INFORMATION SYSTEMS)

Connect nutrition programming with food systems reform and climate adaptation strategies to safeguard healthier diets. This helps protect progress on stunting and wasting while addressing rising obesity and the risks posed by climate shocks.



ELEVATE NUTRITION WITHIN MOH AND THE HSTA (GOVERNANCE & LEADERSHIP; FINANCING; WORKFORCE)

Raise the profile of nutrition management within MoH, strengthen intra-ministerial coordination, and position nutrition centrally in the Health System Transformation Agenda. This will ensure nutrition is a core part of system reform, with leadership, budget lines, and accountability that reflect its national priority.

06. References

1	Badan Penelitian dan Pengembangan Kesehatan. <i>Riset Kesehatan Dasar (RISKESDAS) 2013</i> . Ministry of Health Republic of Indonesia; 2013. doi:1 Desember 2013
2	Kementerian Kesehatan RI. Laporan Riskesdas 2018. Published online 2018. doi:10.1017/CBO9781107415324.004
3	Badan Litbang Kesehatan. Laporan Riskesdas 2010. <i>Jakarta Badan Litbang Kesehat</i> . Published online 2010:78.
4	Thamrin SA, Arsyad DS, Kuswanto H, Lawi A, Arundhana AI. Obesity Risk-Factor Variation Based on Island Clusters: A Secondary Analysis of Indonesian Basic Health Research 2018. <i>Nutrients</i> . 2022;14(5):1-11. doi:10.3390/nu14050971
5	Ayuningtyas D, Kusuma D, Amir V, Tjandrarini DH, Andarwati P. Disparities in Obesity Rates among Adults: Analysis of 514 Districts in Indonesia. <i>Nutrients</i> . 2022;14(16):1-18. doi:10.3390/nu14163332
6	Kementerian PPN. Rencana Pembangunan Jangka Menengah Nasional 2015-2019. <i>Rencana Pembang Jangka Menengah Nas 2020-2024</i> . Published online 2019:313.
7	PRESIDEN REPUBLIK INDONESIA. <i>PERATURAN PRESIDEN REPUBLIK INDONESIA NOMOR 42 TAHUN 2013 TENTANG GERAKAN NASIONAL PERCEPATAN PERBAIKAN GIZI</i> .; 2013:1-16.
8	Presiden Republik Indonesia. Peraturan Presiden Republik Indonesia No. 83 Tahun 2017 tentang Kebijakan Strategis Pangan dan Gizi. <i>Rencana Umum Energi Nas</i> . 2017;(73):1-6.
9	Sekretariat Wakil Presiden RI. <i>Strategi Nasional Percepatan Pencegahan Anak Kerdil (Stunting)</i> . Vol 11. Sekretariat Wakil Presiden RI; 2019. http://scioteca.caf.com/bitstream/handle/123456789/1091/RED2017-Eng-8ene.pdf?sequence=12&isAllowed=y%0Ahttp://dx.doi.org/10.1016/j.regsciurbeco.2008.06.005%0Ahttps://www.researchgate.net/publication/305320484_SISTEM_PEMBETUNGAN_TERPUSAT_STRATEGI_MELESTARI
10	PRESIDEN REPUBLIK INDONESIA. <i>PERATURAN PRESIDEN REPUBLIK INDONESIA NOMOR 72 TAHUN 2021 TENTANG PERCEPATAN PENURUNAN STUNTING</i> .; 2021.
11	World Health Organization. Monitoring the Building Blocks of Health Systems. <i>A Handb Indic their Meas Strateg</i> . Published online 2010:1-92.
12	BADAN KEBIJAKAN PEMBANGUNAN KESEHATAN. <i>Suvei Kesehatan Indonesia Dalam Angka 2023</i> .; 2023. https://www.badankebijakan.kemkes.go.id/hasil-ski-2023/

13	Kementrian Kesehatan Republik Indonesia. <i>SSGI 2024 Dalam Angka</i> .; 2024. https://docu.bkkbndiy.id/wp-content/uploads/2025/05/SSGI_DALAM_ANGKA_LAUNCHING_250526_signed.pdf
14	UNICEF. <i>Landscape Analysis of Overweight and Obesity in Indonesia</i> .; 2022. https://www.unicef.org/indonesia/media/15481/file/Landscape analysis of overweight and obesity in Indonesia.pdf
15	Keats EC, Das JK, Salam RA, Lassi ZS, Imdad A, Black RE BZ. Effective interventions to address maternal and child malnutrition: an update of the evidence. <i>Lancet Child Adolesc Heal</i> . 2021;May(5(5)):367-384. doi:10.1016/S2352-4642(20)30274-1
16	World Health Organization. Essential Nutrition Action: mainstreaming nutrition through the life-course. Published online 2019:210. https://iris.who.int/bitstream/handle/10665/326261/9789241515856-eng.pdf
17	Kemenkes RI. <i>Panduan Pelayanan Pasca Persalinan Bagi Ibu Dan Bayi Baru Lahir</i> .; 2022.
18	Kementrian Kesehatan RI. <i>Pedoman Pelayanan Antenatal Terpadu 2020 Ed.3. Vol III</i> .; 2020. https://repository.kemkes.go.id/book/147
19	UNICEF. <i>Climate Change and Nutrition in Indonesia</i> .; 2024.
20	The World Bank Group and Asian Development Bank. Climate Risk Profile: Indonesia (2021). Published online 2021:36. https://climateknowledgeportal.worldbank.org/sites/default/files/2021-05/15504-Indonesia Country Profile-WEB_0.pdf
21	Kementerian Kesehatan RI. Panduan Kesehatan Balita pada Masa Tanggap Darurat Covid-19 bagi Tenaga Kesehatan. <i>Kementeri Kesehat Republik Indones</i> . Published online 2020:1-60. https://infeksiemerging.kemkes.go.id/download/Panduan_Yankes_Balita_Pada_Masa_GapDar_Covid19_Bagi_Nakes.pdf
22	Kementerian Kesehatan RI. Pedoman Pemberian Tablet Tambah Darah (TTD) Bagi Remaja Putri Pada Masa Pandemi COVID-19. Published online 2020:22.
23	Kementrian Kesehatan RI. <i>Buku Saku Hasil Studi Status Gizi Indonesia (SSGI) 2021</i> .; 2024. doi:10.36805/bi.v2i1.301
24	Kementrian Kesehatan RI. BUKU SAKU Hasil Survei Status Gizi Indonesia (SSGI) 2022. Published online 2022.
25	Dipo DDP. Respon Gizi pada Masa Tanggap Darurat Bencana. <i>Kementeri Kesehat RI</i> . Published online 2020:3-143. https://yankes.kemkes.go.id/view_artikel/2600/respons-gizi-pada-masa-tanggap-darurat-bencana
26	Kementerian Perencanaan Pembangunan Nasional/BAPPENAS. Laporan Kinerja Anggaran dan Pembangunan: Program Pencegahan dan Percepatan Penurunan Stunting Melalui Belanja Kementerian/ Lembaga-SEmester 1 tahun 2024. Published online 2025:167-186.
27	Kementrian Kesehatan Republik Indonesia. <i>PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA NOMOR 12 TAHUN 2025 TENTANG RENCANA STRATEGIS KEMENTERIAN KESEHATAN TAHUN 2025-2029 DENGAN</i> . Vol 8.; 2024:1-356.

07. Annexes

Annex 1 List of stakeholders for National Level Consultation

NO.	ORGANIZATION
1	PMO Directorate of Primary Health Promotion and Community
2	Nutrition Working Team
3	Deputy for Food and Nutrition Vulnerability, National Food Agency (Bapanas)
4	Expert Staff to Deputy for Coordination of Disaster and Social Conflict Management
5	Director of Family Health Services
6	Director of Family Resilience for Toddlers and Children, Ministry of Population and Family Development/ BKKBN
7	Assistant Deputy for Fulfillment of Children's Rights to Health and Education, Ministry of Women Empowerment and Child Protection
8	Head of Human Resources Development Agency, Ministry of Home Affairs
9	Director of Village Fund Utilization Facilitation, Ministry of Villages, Disadvantaged Regions Development and Transmigration
10	Director of Community Health and Nutrition
11	Director of Early Childhood Education, Ministry of Primary and Secondary Education
12	Director of Elementary Schools, Ministry of Primary and Secondary Education
13	Director of Junior High Schools, Ministry of Primary and Secondary Education
14	Director of Senior High Schools, Ministry of Primary and Secondary Education
15	Director of Processed Food Standardization, National Agency of Drug and Food Control (BPOM)
16	Director of Processed Food Distribution Supervision, National Agency of Drug and Food Control (BPOM)
17	Director of Madrasah Curriculum, Facilities, Institutions, and Student Affairs, Ministry of Religious Affairs

18	Director of Regional Government Affairs III, Ministry of Home Affairs
19	Director of Regional Government Affairs IV, Ministry of Home Affairs
20	Director of General Transfer Funds, Ministry of Finance
21	Director of Special Transfer Funds, Ministry of Finance
22	Director of Village Funds, Incentives, Special Autonomy, and Privileges, Ministry of Finance
23	Director of Budget Execution, Ministry of Finance
24	Director of Budget for Human Development and Culture, Ministry of Finance
25	Director of Nutrition Fulfillment System, National Nutrition Agency
26	Director of Victim and Refugee Handling Facilitation, National Disaster Management Agency (BNPB)
27	PMO Directorate of Family Health Services
28	Head of Maternal and Neonatal Health Working Team
29	Head of Toddler and Preschool Children Health Working Team
30	Head of School Age and Adolescent Health Working Team
31	Head of Family Health Surveillance Working Team
32	Director of Health Human Resources Planning
33	Director of Health Human Resources Quality
34	Director of Non-Communicable Diseases
35	Director of Primary Health Governance
36	Director General of Fiscal Balance
37	Director General of Regional Development
38	SUN Academia and Development Partners
39	SUN Donor and UN Civil Society Network
40	SUN Civil Society Organization

Annex 2 List of stakeholders for Sub National Consultation

NO.	ORGANIZATION/GROUP	PROVINCE
1	Provincial Health Office of Aceh	Aceh
2	City Health Office of Banda Aceh	Aceh
3	District Health Office of Aceh Jaya	Aceh
4	Provincial Health Office of East Java	East Java
5	City Health Office of Surabaya	East Java
6	District Health Office of Jember	East Java
7	Provincial Health Office of Bali	Bali
8	City Health Office of Denpasar	Bali
9	District Health Office of Tabanan	Bali
10	Provincial Health Office of East Nusa Tenggara	East Nusa Tenggara
11	City Health Office of Kupang	East Nusa Tenggara
12	District Health Office of South Central Timor	East Nusa Tenggara
13	Provincial Health Office of North Sulawesi	North Sulawesi
14	City Health Office of Manado	North Sulawesi
15	District Health Office of South Minahasa	North Sulawesi
16	Provincial Health Office of North Maluku	North Maluku
17	City Health Office of Ternate	North Maluku
18	District Health Office of West Halmahera	North Maluku
19	Regional Disaster Management Agency	East Java
20	Family Planning Office	East Java

21	Education Office	East Java
22	Social Affairs Office	East Java
23	Food Security Agency	East Java
24	Regional Development Planning Agency (Bappeda)	East Java
25	Community Health Center (Puskesmas)	East Java
26	Hospital	East Java
27	Health Cadre	East Java
28	Beneficiary	East Java
29	Regional Disaster Management Agency	East Nusa Tenggara
30	Family Planning Office	East Nusa Tenggara
31	Education Office	East Nusa Tenggara
32	Social Affairs Office	East Nusa Tenggara
33	Food Security Agency	East Nusa Tenggara
34	Regional Development Planning Agency (Bappeda)	East Nusa Tenggara
35	Community Health Center + Therapeutic Feeding Center	East Nusa Tenggara
36	Hospital	East Nusa Tenggara
37	Health Cadre	East Nusa Tenggara
38	Beneficiary	East Nusa Tenggara
39	Local Development Partner	East Nusa Tenggara
40	Provincial Education Office of Aceh	Aceh
41	Regional Office of Ministry of Religious Affairs	Aceh
42	Regional Development Planning Agency (Bappeda)	Aceh
43	Social Welfare Division (Regional Secretariat)	Aceh

44	Community Health Center 1	Aceh
45	Posyandu Cadre (Integrated Health Post)	Aceh
46	Beneficiary	Aceh
47	Student	Aceh
48	Teacher	Aceh
49	Village Government	Aceh
50	National Nutrition Agency (BGN)	Aceh
51	Women Empowerment and Child Protection Office	Aceh
52	Education Office	Bali
53	Ministry of Religious Affairs	Bali
54	Regional Development Planning Agency (Bappeda)	Bali
55	Community Health Center (Puskesmas)	Bali
56	Posyandu Cadre (Integrated Health Post)	Bali
57	Beneficiary	Bali
58	Student	Bali
59	Teacher	Bali
60	Village Government	Bali
61	Community Health Center (Manado City and South Minahasa)	North Sulawesi
62	Posyandu Cadre (Manado City and South Minahasa)	North Sulawesi
63	Beneficiary (Manado City and South Minahasa)	North Sulawesi
64	Provincial Regional Development Planning Agency of North Sulawesi	North Sulawesi
65	Provincial Education Office of North Sulawesi	North Sulawesi
66	Provincial Community and Village Empowerment Office of North Sulawesi	North Sulawesi

67	Provincial National Population and Family Planning Board of North Sulawesi	North Sulawesi
68	Regional Development Planning Agency of Manado City	North Sulawesi
69	Education Office of Manado City	North Sulawesi
70	National Population and Family Planning Board of Manado City	North Sulawesi
71	Regional Development Planning Agency of South Minahasa	North Sulawesi
72	Education Office of South Minahasa	North Sulawesi
73	Community and Village Empowerment Office of South Minahasa	North Sulawesi
74	National Population and Family Planning Board of South Minahasa	North Sulawesi
75	Regional Secretary of South Minahasa	North Sulawesi
76	Community Health Center (Ternate City and West Halmahera)	North Maluku
77	Posyandu Cadre (Ternate City and West Halmahera)	North Maluku
78	Beneficiary (Ternate City and West Halmahera)	North Maluku
79	Provincial Regional Development Planning Agency of North Maluku	North Maluku
80	Provincial Education Office of North Maluku	North Maluku
81	Provincial Community and Village Empowerment Office of North Maluku	North Maluku
82	Provincial National Population and Family Planning Board of North Maluku	North Maluku
83	Regional Development Planning Agency of Ternate City	North Maluku
84	Education Office of Ternate City	North Maluku
85	National Population and Family Planning Board of Ternate City	North Maluku
86	Regional Development Planning Agency of West Halmahera	North Maluku
87	Education Office of West Halmahera	North Maluku
88	Community and Village Empowerment Office of West Halmahera	North Maluku
89	National Population and Family Planning Board of West Halmahera	North Maluku



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CEGAH STUNTING DENGAN 3 PERILAKU KUNCI

1. IBU HAMIL
Bantu ibu hamil dengan memastikan:
- Ibu hamil mendapat makanan bergizi yang cukup
- Ibu hamil mendapat layanan kesehatan yang tepat
- Ibu hamil mendapat dukungan emosional

2. ANAK USIA 6-24 BULAN
Bantu anak usia 6-24 bulan dengan memastikan:
- Anak mendapat makanan bergizi yang cukup
- Anak mendapat layanan kesehatan yang tepat
- Anak mendapat dukungan emosional

3. SEMUA ANAK BALITA
Bantu semua anak balita dengan memastikan:
- Anak mendapat makanan bergizi yang cukup
- Anak mendapat layanan kesehatan yang tepat
- Anak mendapat dukungan emosional

PERLU DIINGAT!
Stunting adalah kondisi kronis yang disebabkan oleh kekurangan gizi yang berlangsung dalam waktu yang lama. Stunting dapat menyebabkan anak mengalami gangguan pertumbuhan, perkembangan, dan kesehatan. Stunting juga dapat meningkatkan risiko anak mengalami masalah kesehatan lainnya.



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