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# Policies Lost in the Field: A Critical Study of Communication, Resources, and Bureaucratic Structure in the Stunting Program

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**ABSTRACT**

Stunting remains a serious global health problem. Of the 162 million children recorded as stunted worldwide, 56% are in Asia and 36% in Africa. The WHO recommends reducing stunting rates by 3.9% annually to achieve the target of a 40% reduction by 2025. In Indonesia, stunting reduction programs have been a national priority for the past two decades. However, in reality, real efforts to address stunting remain challenging. This article analyzes the case of stunting management at the Puskesmas (Community Health Center) Karang Rejo in Balikpapan City. The George Edward III theoretical framework of policy implementation is used to highlight how bureaucratic constraints and social interactions shape the complexity of policy implementation. Data were collected from interviews with 25 informants, observations, and secondary data. The results show that the implementation of the stunting program here is hampered by communication problems, limited competent human resources, and the absence of standard operating procedures (SOPs). The public perception of stunting as a "hereditary problem" demonstrates an epistemic gap between policy logic and local understanding. The failure of health policy implementation is not only caused by technical factors, but also by social relations and bureaucratic structures that interpret policies differently at the grassroots level.

**KEYWORDS**: Bureaucracy, communication, disposition, policy_implementation, stunting

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## INTRODUCTION

Stunting is the result of a complex relationship between policy governance, socio-economic structures, parenting practices, environmental conditions, and the reproduction of intergenerational inequality. Domestic practices cannot be separated from broader structural conditions. Short birth intervals eliminate the health benefits of the first child and increase the risk of stunting in subsequent children, especially in poor households (Dhingra and Pingali 2021). Nutritional interventions are most effective during the preconception phase and the first 1,000 days of life, but these phases are often overlooked in policies that are overly oriented towards curative interventions. Micro studies in Indonesia (Wardita, Suprayitno, and Kurniyati 2021) and a national analysis in Bangladesh (Haque et al. 2022) highlight the crucial role of maternal health, exclusive breastfeeding practices, and the impact of adolescent pregnancy and maternal stunting as multiple risk factors that reinforce each other.

Stunting has implications for children's oral health, revealing multidimensional impacts that are often overlooked in policy(Sadida, Indriyanti, and Setiawan 2022). Technology-based approach through a mobile application for stunting diagnosis and education, which has been proven to help mothers with low literacy (Ponum et al. 2020). However, from a critical perspective, these technological solutions still require a supportive social context so that they do not become individualistic interventions that ignore structural inequalities.

However, stunting cannot be addressed solely through improved nutritional intake. A combination of unsafe drinking water and poor sanitation significantly increases the risk of stunting in Indonesia(Torlesse et al. 2016). This finding is reinforced that while the COVID-19 pandemic has worsened the economic conditions of rural households, the root cause of stunting remains inadequate sanitation (Murlianti and Nanang 2021) ,(Yunitasari et al. 2022). In fact, community environmental hygiene has a stronger influence

on child growth than an exclusive focus on individual nutrition, challenging the narrow and technocratic intervention paradigm (Banerjee and Dwivedi 2020).

Socio-economic studies show that stunting is more of a manifestation of structural inequality. Analysis of IFLS shows that maternal education, household wealth, and access to sanitation are key determinants and major contributors to child health inequality in Indonesia (Rizal and van Doorslaer 2019; Widyaningsih et al. 2022). These findings resonate with cross-country studies in Rwanda and Bangladesh, which confirm that the decline in stunting is closely related to the improved welfare of the lowest economic groups (Binagwaho et al. 2020) and the social position of families as reflected in parental education and wealth indices (Chowdhury et al. 2022). Within a critical sociological framework, stunting thus represents a mechanism for the reproduction of biological and social poverty, where children's bodies become the arena for the accumulation of structural disadvantages passed down across generations.

Various studies on stunting policy governance confirm that the stunting convergence approach has become the dominant framework, but its implementation remains uneven. The integration of cross-sectoral services at the district/city level is a key prerequisite for success, but achievements between regions in Kalimantan are still uneven (Prasetyo et al. 2023). The evaluation of the GEMPITA policy confirms that strong regulatory support does not automatically result in policy effectiveness without the readiness of infrastructure and human resources (Ahri et al. 2022).

The city of Balikpapan, considered a developed city in East Kalimantan, is an interesting example of this contradiction. The city government has a flagship program called “Cerita Stunting” (Prevent, Detect, Treat) with various forms of cross-sectoral interventions. However, stunting rates in several sub-districts, including Karang Rejo, remain above the city average. At the community health center level, program implementation faces limitations in human resources, the absence of specific standard operating procedures (SOPs), and low community participation, with stunting still viewed as a “genetic inheritance” rather than a nutritional problem. This situation highlights the gap between policies formulated on paper and the social reality on the ground.

This article stems from a critical question: why have well-designed stunting prevention policies at the central government level still failed to be implemented effectively at the local level? This study seeks to describe how the dimensions of policy implementation operate in practice in the field, by conducting an in-depth case study in Karangrejo sub-district. This study does not merely assess the effectiveness of the program, but also examines the politics of implementation at the grassroots level. It focuses on how public policies are implemented, negotiated, and lived by local actors in their respective social contexts. Here, policy implementation is understood as a social process full of negotiation and meaning. This article contributes to efforts to understand policy failure not merely as a technical problem, but as a structural symptom of the gap between the logic of state policy and the social logic of society.

## METHOD

This study was designed as a case study to gain an in-depth understanding of how stunting prevention policies are implemented at the local level by stakeholders at the Puskesmas Karang Rejo. The qualitative approach allows researchers to explore the meanings, experiences, and social dynamics behind the success or failure of policy implementation (Snelson 2016). This study focuses on tracking social processes and policy interpretations that occur in the field. Case studies allow researchers to understand complex phenomena in real-life contexts, where the boundaries between phenomena and their contexts are not always clear (Zhang et al. 2020).

Research data was collected through in-depth interviews with 20 informants and participatory observation. The main informants consisted of the head of the community health center, nutrition officers, Posyandu (Integrated service post) cadres, and parents of toddlers who were the target group of the program. The interviews were conducted in a semi-structured manner to explore the informants' more reflective experiences and views. Observations were used to record practices and social interactions between facilitators and the community in Posyandu activities and program socialization. The analysis process was carried out simultaneously with data collection, allowing researchers to interpret emerging patterns in depth. Data validity was strengthened through source and technique triangulation by comparing interview results, observation notes, and official health center documents.

## RESULT AND DISCUSSION

The study of public policy implementation has traditionally been influenced by George C. Edward III's (1980) model, which places the success of implementation as the result of the interaction between four factors: communication, resources, disposition, and bureaucratic structure (Ricca Handayani and Sri Rahayu 2023)(Ricca Handayani and Sri Rahayu 2023). Public policy is considered effective if the policy message is clearly conveyed, the implementers have sufficient capacity, the implementers' attitudes and commitment are strong, and the bureaucratic structure supports coordination. This approach views implementation not only as a technical stage following policy formulation, but as a political and administrative process that determines the final outcome of the policy. In the context of health policies such as stunting prevention, these four dimensions are key to understanding how nationally designed policies, often ideal in conception, frequently encounter obstacles when implemented at the local level.

The street-level bureaucracy theory of Michael Lipsky (1980) and Maynard-Moody & Musheno (2022) captures the complexity of social relations in policy implementation practices at the grassroots level . This perspective assumes that field implementers, such

as Posyandu cadres and health center officers, are not merely policy implementing agents, but also social actors who have discretion and interpret policies according to the actual conditions in their work environment. Lipsky views public policy as ultimately being "shaped" at the meeting point between formal rules and the daily practices of grassroots bureaucrats.

Field data findings show that the implementation of the stunting prevention program at the Karang Rejo Community Health Center reflects a structural failure to bridge the logic of state policy with the social logic of the community. The four dimensions in Edward III's model: communication, resources, disposition, and bureaucratic structure, do not stand alone but are intertwined in creating a policy-practice gap. Inconsistent policy communication results in misconceptions at the implementation level; limited resources reinforce the tendency to improvise. Weak disposition and social perception cause implementers and the community to interpret policies based on their own interests and beliefs. And a fragmented bureaucratic structure slows down coordination and turns programs into mere administrative activities. Under these conditions, policies that appear rational on paper lose their substantive meaning when translated into social practice.

### 1. The Gap Between Planning And Reality In The Field

The national policy to combat stunting is designed as an integrated intervention between the health, education, and social protection sectors, with a target of reducing prevalence to below 14 percent by 2024. The city of Balikpapan has translated this policy into a flagship program called "Cerita Stunting" (Prevent, Detect, Treat), which is implemented by the Health Office through community health centers. In the planning document, the Karang Rejo Community Health Center is tasked with carrying out growth monitoring, nutrition education, and providing supplementary food to pregnant women and toddlers.

The results of the study show that there is a significant gap between normative policy planning and the reality of implementation in the field. Based on interviews with health center heads and nutrition officers, routine Posyandu (Integrated Health Service Post) activities are indeed carried out, but they are not sustainable and not all targets are consistently present. Cadres often carry out activities "just to fulfill monthly reports" without following up on cases of children indicated as stunted. One cadre said, "We do weigh the children every month, but sometimes the weighing scales are broken, sometimes the mothers don't come. In the end, the data is incomplete" (Interview, Posyandu A Cadre, June 2024). The child growth monitoring mechanism, which should be at the heart of the program, is hampered by technical issues and community participation.

Nutrition counseling is only conducted occasionally, with general material that is rarely tailored to local needs. Nutrition officers explain that, "Actually, we want to go out into the field regularly, but we have limited personnel. One person is responsible for several subdistricts, so there is no time for evaluation" (Interview, Nutrition Officer, June 2024). Limited human resources and inconsistent policy communication are the main obstacles to achieving policy objectives.

**Table 1. Disparities in the Stunting Program at the Karang Rejo Community Health Center**

| Policy Planning Aspects | Field Reality | Impact on Implementation |
|---|---|---|
| Policy dissemination is carried out periodically to all officers and cadres. | Only carried out once at the beginning of the year, Many new cadres do not receive training. | Cadres' understanding is not uniform, Misinterpretation of stunting indicators. |
| Community health centers are required to report the results of their activities through the e-PPGBM application. | Nutrition officers often fill in data manually due to network constraints. | The data is inaccurate and not synchronized with the center's reports. |
| Key policy message: "Stunting can be prevented." | The majority of the community considers stunting to be "inherited." | There is a gap between policy logic and local knowledge. |
| Cross-sector coordination takes place in nutrition integration forums. | Coordination is merely a formality, with no follow-up. | Program integration is weak, with overlapping activities. |

***Source:*** *Interviews, observations, and field documentation (2024)*

Lower-level implementers do not simply carry out instructions, but also interpret and adapt them to local conditions. Policy messages designed at the central level, such as "stunting can be prevented," lose their power because they are not supported by a complete understanding of public health logic. As a result, activities are symbolic and administrative, but fail to change behavior or parenting patterns in households.

This phenomenon shows that the implementation of central policies at the local level is not a linear process, but rather an arena for social negotiation between bureaucratic actors and the community. Cadres and nutrition officers act as street-level bureaucrats

(Lipsky (1980)), who must balance policy demands and social realities. In the context of the Karang Rejo Community Health Center, they act as "policy interpreters" who work amid limited resources and minimal structural support.

### 2. Limited Resources And Implementation Capacity

The availability and capacity of human and material resources are among the most decisive factors in the successful implementation of public policy. This study found that limitations in personnel, facilities, and budgetary support resulted in the suboptimal implementation of stunting prevention programs. Programs that were originally designed as cross-sectoral efforts with multi-layered interventions turned into administrative activities that depended on the initiative of individual implementers.

The number of nutritionists at community health centers is not proportional to the size of the working area and the number of target toddlers. One nutritionist is responsible for several sub-districts at once. As a result, activities such as home visits and child growth monitoring are often delayed. A nutrition officer stated, "I handle three areas, and it is impossible to visit all of them every month. So we focus only on active integrated health service posts." This has an impact on the imbalance in service distribution: integrated health service posts in densely populated areas are visited more often, while those in suburban areas are often neglected.

Limited resources are also evident in the lack of training for cadres. Only one technical training session is held per year, and not all cadres are able to attend. Some new cadres admit to learning informally from their more experienced colleagues. One cadre said, "We were taught how to measure height, but there was only one tool. Sometimes, when it broke, we just used estimates." This situation highlights the weakness of the ongoing training system and the absence of adequate supervision from the relevant agencies.

Limited operational budgets exacerbate the situation. Funds for Posyandu activities are often only sufficient to cover meeting expenses or transportation costs for cadres, rather than technical capacity building. Some cadres even purchase their own measuring instruments or activity logbooks. Policy implementation at the local level is driven by a logic of survival (Brodkin, 2012), whereby implementers strive to maintain the continuity of activities with minimal resources . Resource constraints not only affect the intensity of activities, but also shape the behavior patterns of field bureaucrats, who tend to be selective in determining work priorities (Merten et al. 2021).

**Table 2. Resource and Implementer Capacity Constraints**

| Policy Aspect | Field Findings (Empirical) | Impact on Implementation |
|---|---|---|
| Each community health center has at least two nutrition workers | There is only one nutrition worker handling three subdistricts. | High workload, monitoring activities are uneven across regions. |
| Training for cadres is conducted twice a year by the Health Office | Training is only conducted once and not all cadres participate. | New cadres lack understanding of stunting indicators and reporting procedures. |
| Each Posyandu is equipped with anthropometric tools (digital scales and height measuring devices). | Many tools are damaged and not replaced; some health posts use borrowed tools. | Measurement data is inaccurate; risk of misclassification of stunted children. |
| Health center operational funds are used for field activities and nutrition education. | Most of the funds are used for administrative activities and meeting expenses. | Educational activities and home visits have decreased due to minimal logistical support. |

***Source:*** *Interviews, observations, and field documentation (2024)*

These resource limitations are not merely technical barriers but also structural issues that influence the behavior of implementers at the grassroots level. When resources are limited, implementers use discretion to decide which activities are most feasible. In the context of street-level bureaucracy, this is referred to as "pragmatic adaptation," a strategy implemented by implementers to maintain the continuity of public services amid structural pressures (Abebe et al. 2019), (Hupe, 2019).

There is a clear discrepancy between national policy logic and the reality of local bureaucracy. On paper, stunting policies are designed on the assumption that all community health centers have adequate capacity and resources. However, in practice, implementers operate in conditions that are far from ideal. Program achievements are more often administrative in nature, measured by the number of activities and reports, rather than by substantial changes in children's nutritional status. Implementation at the field level is not a passive process of policy execution, but rather a social process full of negotiation and improvisation, in which field actors adapt policy demands to their local resources and context.

### 3. Disposition And Social Perception Of The Program

The disposition or attitude of the implementer and the community's perception of the program also determine its success. Disposition encompasses the commitment, motivation, and willingness of implementing actors to implement the policy. Research at the Karang Rejo Community Health Center indicates that these two aspects are closely interconnected and contribute to a form of "symbolic

implementation," where the policy is implemented administratively but fails to translate into substantive behavioral changes in the community.

Interviews with several cadres revealed significant variation in disposition. Some cadres exhibited high enthusiasm and a moral awareness that the stunting program is a shared social responsibility. However, others displayed apathy due to a lack of incentives and structural support. One cadre commented, "We've been out in the field many times, but sometimes the community doesn't listen. We're tired too, because there's nothing extra. So we just do what we can." This quote demonstrates that the motivation of field implementers depends not only on moral commitment but also on the institutional recognition and rewards they receive (Hanifa Muslimah and Subhandi Bakhtiar 2021) , (De Vries et al., 2021).

On the other hand, public perceptions of stunting are still influenced by local knowledge and cultural norms. Many parents view short stature as "normal" or a "family inheritance." In one interview, a mother of a toddler stated, "My child has always been small, just like his father. But he's active, so I don't think it's an illness." (Interview, Karang Rejo resident, July 2024). This view reflects an epistemic gap between the language of state policy, which is based on medical indicators, and public understanding, which is based on social experiences and local traditions.

These findings demonstrate that policy implementation cannot be separated from the social and moral context of the recipient community. As explained by Hupe (2019) and Tummers (2019), public policy will only be effective if implementers believe in the policy's values and objectives (policy belief), and the community has a social meaning that aligns with the policy's message . At the Karang Rejo Community Health Center, these two sides have not yet ideally converged. Cadres operate with a pragmatic spirit, while the community interprets the policy through a different cultural lens. As a result, health messages often lose moral authority, and community participation becomes a formality.

**Table 3. Disposition of Implementers and Community Social Perceptions of the Stunting Program**

| aspect | Empirical Field Findings | Impact on Implementation |
|---|---|---|
| Cadre Motivation and Commitment: | Senior cadres are highly dedicated, but newer cadres lack motivation due to the lack of additional incentives. | Variation in the quality of implementation among integrated health posts (Posyandu); some activities are discontinued.. |
| Community Perception of Stunting | Many residents consider short stature to be "hereditary" and not a nutritional issue. | Many residents consider short stature to be "hereditary" and not a nutritional issue. |
| Social Relationships Between Cadres and the Community. | Personal relationships are used to encourage residents to attend Posyandu, informal approaches are more effective | Implementation relies on social relationships, not formal policy mechanisms. |
| Social Values and Trust in Programs | Some residents consider government programs "seasonal" because they frequently change names. | Public trust in program consistency is low; participation fluctuates.. |

***Source:*** *Interviews, observations, and field documentation (2024)*

The disposition of policy implementers and community perceptions mutually influence the direction of policy implementation. When cadres lose motivation due to minimal structural support, they tend to decrease the intensity of activities. Conversely, community skepticism about the significance of stunting will reinforce the tendency for formal and administrative implementation. As explained by Tummers and Bekkers (2014), the interaction between the beliefs of policy implementers and recipients results in what is known as policy alienation, a condition where actors in the field feel separated from the meaning and objectives of the policies they implement .

Policy implementers at the Karang Rejo Community Health Center act as social bridges, negotiating state and community values. However, without adequate training, incentives, and two-way communication, they lack the space to strengthen the social meaning of policies in the eyes of the community. Implementation issues cannot be resolved solely by increasing technical resources, but also by strengthening the social and moral dimensions of policy implementers and recipients. As stated by Van Hulst et al. (2020), the success of policies at the grassroots level depends heavily on the ability of local actors to develop sense-making practices, a process of social interpretation that makes policies relevant to the context of residents' daily lives.

### 4. Bureaucratic Structure And Policy Fragmentation

Overly complex and hierarchical structures can slow decision-making and weaken coordination between implementing agencies. At the Karang Rejo Community Health Center (Puskesmas), program implementation at the village level relies on cross-sectoral coordination between the Health Office, the Social Service Office, the village office, and community cadres. Although the policy is designed to be integrated on paper, practice in the field shows that each agency operates within a different logic and reporting system.

Interviews with the head of the community health center revealed that cross-sectoral coordination is often administrative in nature. This situation leads to overlapping activities, such as the distribution of supplementary food by the community health center and the Family Welfare Movement (PKK) simultaneously without coordination. Although the community health center has primary responsibility, some activities rely on the initiatives of community cadres or village officials, which do not always align with technical health standards.

The absence of specific standard operating procedures (SOPs) for implementing stunting programs at the community health center (Puskesmas) level exacerbates this fragmentation. Field officers admitted to lacking standard guidelines for monitoring and evaluation mechanisms. One cadre stated, "We don't know the required report format; it sometimes changes from the office. So we just write what we can." Inconsistent SOPs lead implementers to interpret policies in a personal and situational manner. From a street-level bureaucracy perspective, this phenomenon illustrates the emergence of policy improvisation, a situation where implementers adapt policies to the social context and available resources (Tummers & Bekkers, 2014; Maynard-Moody & Musheno, 2022) .

**Tabel 4. Struktur Birokrasi dan Fragmentasi Kebijakan Penanggulangan Stunting**

| Structural Aspects of Policy | Empirical Field Findings | Structural Aspects of Policy |
|---|---|---|
| A cross-sector coordination forum exists between community health centers (Puskesmas), sub-districts, the Family Welfare Movement (PKK), and the Social Service. | The forum is only active at the beginning of the year; there is no follow-up mechanism. | Coordination is symbolic; programs operate partially across agencies. |
| Each community health center has its own SOP for implementing nutrition and stunting programs. | There is no specific SOP for stunting; implementers use outdated guidelines. | Implementation is inconsistent; it relies on individual implementer initiative. |
| Activity reports use the integrated e-PPGBM format. | Report formats change frequently; internet connections are weak; some data is entered manually. | Data is not synchronized with central reports; policy evaluation is difficult. |
| Supervision is conducted quarterly. | Supervision is infrequent; it focuses on administrative audits, not implementation quality. administratif, bukan kualitas pelaksanaan. | Accountability is formal; improvements in implementation quality are not occurring. |

***Source:*** *Results of interviews, observations, and field documentation (2024)*

These findings indicate that bureaucratic fragmentation is a major obstacle to policy implementation. As explained by Peters (2018) and Christensen et al. (2020), fragmentation often arises when public institutions operate in siloed organizations, each with a distinct agenda, structure, and accountability system (Abebe et al. 2019). In the Karang Rejo context, this situation led to a loss of horizontal integration between agencies and vertical inefficiencies between agencies and field implementers.

Bureaucratic fragmentation also impacts implementer motivation. Without clear coordination and guidelines, community health center cadres and staff feel the policies they implement lack strategic direction. As a result, activities are carried out merely to fulfill administrative obligations. This aligns with the findings of Van der Voet and Steijn (2021) that fragmented bureaucracies tend to result in compliance-oriented implementation, where policy implementation focuses on reporting rather than on desired social outcomes .

An overly hierarchical bureaucratic structure limits the room for improvisation for implementers at the lower levels. Officers with innovative ideas are often unable to follow through due to complicated procedures. "We once proposed additional training for cadres, but it had to go through numerous letters. In the end, it didn't happen," said a Nutrition Officer. This situation emphasizes that policy implementation in the field faces not only limited resources but also structural obstacles stemming from a rigid and fragmented bureaucratic culture. The implementation of the stunting program at the Karang Rejo Community Health Center cannot be understood solely as a technical problem, but as a socio-political consequence of a decentralized but not yet functionally integrated government structure. In line with O'Toole's (2017) analysis, effective implementation in a modern government system requires network governance that can unite various actors through collaborative coordination mechanisms, rather than solely through hierarchical control.

## 5. CONCLUSION

This study shows that the implementation of stunting reduction policies at the Karang Rejo Community Health Center is not simply a linear administrative process from the central government to the regions, but rather a complex and negotiated social arena. George Edward III's four key implementation dimensions, communication, resources, disposition, and bureaucratic structure—were all found to operate under less-than-ideal conditions and mutually reinforce inequalities between levels of government.

In the communication dimension, policies experience distortion because top-down messages and technical instructions are not fully understood by implementers or the public. Policy information loses substantive meaning when passed through long and fragmented bureaucratic chains. Implementers' resources and capacity are severely limited. Nutrition officers and integrated health post (Posyandu) cadres operate within a logic of survival, not policy development. They implement programs with minimal tools, limited time, and minimal support. The disposition of implementers and the public's social perceptions demonstrate a misalignment of meaning: implementers lose motivation due to a lack of recognition, while the public interprets stunting through the lens of local culture, not public health. The hierarchical and fragmented bureaucratic structure weakens cross-sector coordination and encourages administrative practices that are solely oriented toward compliance, rather than social change.

Conceptually, these findings confirm the street-level bureaucracy's view that policy implementation is fundamentally a negotiated social practice. Implementers in the field are not merely passive agents of policy, but rather actors who interpret, adapt, and even modify policies according to the social context and resources at their disposal. In other words, implementation failure is not the result of "non-compliance," but rather a reflection of the structural tension between technocratic policy design and grassroots social realities.

The case of the Karang Rejo Community Health Center demonstrates that public health policy in Indonesia still operates within a linear, administrative, bureaucratic paradigm, while the problem of stunting is multidimensional and requires a socio-communitarian approach. Without changing the implementation paradigm to be more adaptive, contextual, and based on the social meanings of citizens, every policy will continue to repeat the same pattern: well-planned on paper, but failed in practice.

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