Scientific Foundation SPIROSKI, Skopje, Republic of Macedonia
Open Access Macedonian Journal of Medical Sciences. 2022 Jan 03; 10(T8):200-206.
https://doi.org/10.3889/oamjms.2022.9464
eISSN: 1857-9655
Category: *T8 –"APHNI: Health Improvement Strategies Post Pandemic Covid-19"*
Section: *Pediatrics*

The Intervention Service Coverage on Convergence Action to Reduce Stunting in Riau Province Priority Districts, Indonesia

Tuti Rahmawati*, Heryudarini Harahap

Regional Development Planning Board, Research and Development, Riau Province, Indonesia

Edited by: Ksenija Bogoeva-Kostovska
Citation: Rahmawati T, Harahap H. The Intervention Service Coverage on Convergence Action to Reduce Stunting in Riau Province Priority Districts, Indonesia. Open Access Maced J Med Sci. 2022 Jan 03; 10(T8):200-206. https://doi.org/10.3889/oamjms.2022.9464
Keywords: Convergence action; Specific and sensitive intervention; Stunting
***Correspondence:** Tuti Rahmawati, Regional Development Planning Board, Research and Development, Riau Province, Indonesia. E-mail: trahma.tr@gmail.com
Received: 13-Oct-2021
Revised: 21-Nov-2021
Accepted: 02-Dec -2021

Funding: This research did not receive any financial support
Competing Interests: The authors have declared that no competing interests exist

Abstract

BACKGROUND: The prevalence of stunting in Riau, Indonesia based on the Indonesian Toddler Nutrition Status Survey in 2019 was 23.95%. Efforts to reduce the prevalence of stunting remain challenging to achieve the target of 18% by 2024. One of the pillars in efforts to reduce stunting is convergence action involving multi-stakeholders to ensure the service delivery interventions received by targeted 1000 days of the early life households.

AIM: This study objective was to describe the intervention service coverage on stunting convergence action to reduce stunting in Riau Province, Indonesia.

METHODS: The intervention service coverage was obtained from web monitoring convergence Action and Reporting System in 2020 and nutritional status was from the Electronic Community-Based Nutrition Recording. Data were taken from ten priority districts. There were 11 specific interventions and nine sensitive interventions were analyzed. The data were analyzed descriptively by districts and type of intervention.

RESULTS: The specific and sensitive interventions implemented in 161 priority villages in 2021.The results of the study were 6.0% of 392,444 under-five aged children indicated stunting. The average coverage of specific interventions was 78.3% and sensitive intervention was 50.3%. In specific intervention, supplementary feeding for wasted child (92.4%) and chronic energy deficiency pregnant women (91.1%) were the only indicator that reached the set target. All sensitive intervention were not reached the target. Rokan Hulu (89.5%), Pekanbaru (88.0%), Kampar (84.4%), and Pelawan (82.6%) districts had a high specific intervention. The highest sensitive intervention was in Rokan Hulu (74.6%). The budget from regional development for specific intervention was 28.2% and sensitive intervention was 71.8%.

CONCLUSION: The coverage service of sensitive intervention was lower than specific intervention. Only two out of 11 specific interventions coverage had reach the target and all of sensitive intervention coverage had not reach the target. The specific and sensitive intervention coverage was varied among priority district. The strengthening of interventions is required to increase coverage service delivery to the targeted household. The local government convergence action and increasing the role of the village authorities were the main keys in accelerating stunting reduction.

Introduction

Stunting remains a major nutrition and health issue in Indonesia, including in Riau Province. The integration result of the Indonesian Toddler Nutritional Status Survey (SSGBI) and the National Socioeconomic Survey (SUSENAS) in 2019 indicates that the prevalence of stunting in Indonesia was 27.7% [1]. To put things into perspective, the prevalence of stunting in 2013 and 2018 declines on average by 1.6% per year for the past 6 years. In the National Medium Term Development Plan 2020–2024, the stunting reduction program becomes a major project prioritized to achieve the prevalence of stunting reduction goals in Indonesia in 2024 by 14% [2]. Based on the results of SSGBI in 2019, the prevalence of stunting in Riau Province was 23.9% [1]. In the Middle Term Development Plan of Riau Province in 2020–2024, the target for the prevalence of stunting in 2024 is set to be 18% [3].

The national strategy for stunting reduction in Indonesia stipulated in presidential decree number 72 year of 2021 concerning stunting reduction acceleration as the guideline for all parties in accelerating the achievement of stunting reduction goals. There are five pillars of stunting reduction. The first pillar is strengthening the commitment and vision of leadership at the level of ministries/institutions, local government and village government. The second pillar is promoting the behavioral changes and community empowerment. The third pillar is improving the convergence of specific interventions and sensitive interventions. The fourth pillar is increasing food and nutritional security at the individual, family, and community levels. The fifth pillar is strengthening and development of data systems, information, research, and innovation [4].

One of the strategies in strengthening the third pillar is to implement convergence actions at the districts/cities level as the intervention focus. The convergence action is defined as an intervention approach conducted in a coordinated, integrated, and collective manner on targeted geographic areas and priority households to prevent stunting. The implementation of convergent interventions is implemented by combining

or integrating various resources to achieve common goals. There are 11 specific interventions, which is iron supplementation for pregnant women, supplementary feeding for chronic energy deficiency (CED) pregnant women, supplementary feeding for wasted children, integrated post-service (Posyandu) attendance, pregnancy monitoring, vitamin A supplementation for under-five children, complete basic immunization, Zink supplementation for diarrhea, iron supplementation for teenager, post-partum care, and maternity class. The sensitive intervention is 9 that are toddler-family support group, safe drinking water, proper sanitation, proper sanitation, early childhood education, health insurance, nutrition and health program participation for family hope program (PKH) beneficiaries, access of poor family to non-cash-food-assistance (BNPT) program, and access of 1000 HPK of poor family [5].

Several countries have also implemented programs to reduce the prevalence of under-nutrition including stunting. Vietnam is one of the countries that on the track to achieve at least four of the six WHA targets: stunting, wasting, anemia, and exclusive breastfeeding. The key to success in overcoming the problem of under-nutrition is prioritizing nutrition in the national agenda. The program was the National Plan of Action for Nutrition (NPAN) for 1995–2003, followed by National Nutrition Strategies for 2001–2010 and 2011–2020. Other keys success were generating evidence for nutrition, the nutrition cluster partnership group, Vietnam's commitment to global initiatives on nutrition, research, development and innovation, as well as the role of media [6]. In Thailand, the program "Scaling up a community-based program for maternal and child nutrition" was implemented. The program was carried out in the primary health care and community-based nutrition. This program was successfully implemented through community participation through labor mobilization and capacity building, financing, and organization. Monitoring of growth and development, promotion of infant and child feeding, and sharing budget between government and community were implemented [7]. Uganda performed the Uganda Nutrition Action Plan for 2011–2016. Key success factors in Uganda in achieving nutrition targets were commitments to scaling up nutrition, strong policy environment, increased financing for nutrition, improved resources to nutrition programming, greater coordination for stronger advocacy, commitment to the sun movement, and emerging commitment to accountability [6].

UNICEF state that ten proven nutrition interventions for providing children the best chance to grow and develop to their full potential. The interventions are early initiation of breastfeeding, exclusive breastfeeding in the first 6 months of life, solid foods, and continue breastfeeding, the right food in quantity and quality, good hygiene and clean hands, iron and Vitamin A supplementation and deworming, nutritious foods given frequently during and after illness, caring malnourished children, improving the nutrition of adolescent girl, and better nutrition during pregnancy and lactation [8]. The results of a systematic review found that interventions that were effective in reducing stunting were a combination of political commitment, multi-sector collaboration, community engagement, community-based service delivery platforms, and wider program coverage and compliance [9].

Since 2019, the Government of Riau Province has encouraged the districts/cities decreed as the focus of interventions to implement the convergence actions. The determination of the intervention focus village is based on the situation analysis of the service coverage specific intervention. The villages or sub-districts with low service coverage are defined as priority of intervention focus and the type of intervention is ideally focused on indicators with low coverage. Based on the outputs of the scope of service analysis, 161 villages or sub-districts will be designated as the focus areas of the intervention in ten districts/cities in 2021.

There are few studies on intervention of convergence action in Indonesia. The published studies used different analysis and on a smaller area or service coverage intervention [10], [11]. This study objective was to describe the intervention service coverage on stunting Convergence Action to Reduce Stunting in Riau Province, Indonesia. The results of the study were expected to provide information how service coverage intervention in term of convergence implementation to decreased stunting, policy, and recommendation in improving health and nutritional of pregnant women and under-five aged children.

Methods

The design of this study was cross-sectional. The data collected were secondary data that obtained from the Web Monitoring of Convergence Action in 2020. There were 11 specific interventions and nine sensitive interventions were analyzed. The operational definition and target of each intervention are shown in Table 1. Data were collected from ten districts/cities which were Rokan Hulu, Kampar, Pelalawan, Rokan Hilir, Kepulaun. Meranti, Bengkalis, Siak, Indragiri Hulu, Indragiri Hilir, and Pekanbaru City.

Children length or height aged 0–60 months was categorized −3 SD to < −2 SD as (stunted) and < −3 SD (severely stunted) based on the Regulation of the Minister of Health Number 2 of 2020 concerning the Anthropometry Standards of Children [12]. Data were obtained from Electronic Community-Based Nutrition Recording.

The data were analyzed descriptively. Comparisons of service coverage were performed

Table 1: The operational definitions and target of intervention service coverage

Intervention Service Coverage	Operational Definition	Target (%)
Iron supplementation for teenager	The percentage of 13–18-year-old young women who get TTD to the total 13–18-year-old young women	58
Maternity class	The percentage of pregnant women attended the pregnant mother class to the total of pregnant women	n/a
Post-partum care	The percentage of postnatal mothers who get postnatal services at least 3 times to all postpartum mothers in the same period	75
Pregnancy monitoring (K4)	The percentage of pregnant women who get antenatal services at least 4 times during pregnancy period scheduled once in the first trimester, once in the second trimester and twice in the third trimester of all pregnant women in the same period	90
Iron supplementation for pregnant women	The percentage of pregnant women with CED who get PMT recovery for all Pregnant women with CED in the same period	90
Supplementary feeding for CED pregnant women	The percentage of pregnant women receiving the TTD of at least 90 tablets during pregnancy period to all pregnant women in the same period	80
Complete basic immunization	The percentage of infants aged 0–11 months who get basic immunizations and complete immunizations to all infants aged 0–11 months	90
Integrated health post (Posyandu) attendance	The average percentage of children aged 0–5 years who visit posyandu per month to all children aged 0–5 years in the work area of posyandu	75
Vitamin A supplementation for 6–59 months children	The percentage of infants aged 6–59 months obtained vitamin A to all infants aged 6–59 months	88
Zink supplementation for diarrhea	The percentage of diarrheal toddlers who received zinc supplementation to total toddlers within a year	n/a
Supplementary feeding for wasted children	The percentage of skinny toddlers who get PMT to total skinny toddlers in the same period	90
Food sustainable program	The percentage of the village with the sustainable food house program	Na
Toddler-family support	The percentage of families who follow BKB to all families with toddlers	n/a
Early childhood education	The percentage of children aged 2–6 years registered (learners) in early childhood education to the total children aged 2–6 years	70
Parenting classes attendance	The percentage of pregnant women and parents with children under 2 years attended parenting classes to the total number of pregnant women and children under 2 years	70
Health insurance	The percentage of residents registered as National/Regional Health Insurance participants of all residents	95
Safe drinking water	The percentage of households that have access to potable drinking water sources to the total household	100
Access of 1000 HPK poor family to non-cash-food-assistance (BPNT) program	The percentage of families of 1000 HPK poor groups as recipients of BPNT to the total number of families of 1000 HPK poor groups	90
FDS of "PKH" beneficiaries	The percentage of PKH beneficiary attended the FDS on nutrition and health to the total of PKH beneficiary	90
Proper sanitation	The percentage of households with improved sanitation to the total household	90

CED: Chronic energy deficiency, FDS: Family development session. HPK=1000 days of early life, PKH=hope family program.

against the target, comparisons by district/city, and comparisons of applied specific and sensitive intervention programs.

Results

In 2020, the recorded data in ten city districts the focus of the intervention of 23,682 (6.0%) toddlers were categorized as short and very short out of 392,444 measured toddlers. In Table 2, Bengkalis District reported as the district with the highest stunted and severely stunted under-five children which is 4231 (9.1%) yet compared to the total number of toddlers measured, then Meranti Islands District reported as the district with the highest percentage of stunted and severely stunted toddlers (12.3%). In 2021, the number of targeted toddlers as the focus of the intervention is 6589 under-five children distributed in 161 villages of the intervention focus locations in ten priority districts (Table 2).

Table 3 described service coverage of specific and sensitive intervention by district. The average coverage of specific interventions was 78.3%. Rokan Hulu (89.5%), Pekanbaru (88.0%), Kampar (84.4%), and Pelawan (82.6%) districts had a high specific intervention. Iron supplementation for teenager coverage remains low and has not reached the target. The supplementary feeding indicator for wasted child and CED pregnant women were the only indicator that reached the set target. On the indicator of coverage of specific intervention services with the target group of mothers and young women, Kampar District showed the best performance (95.1%), contrarily with Meranti Island (58.6%) and Pelalawan (59.1%) that had a low performance. The average of specific intervention services coverage at the target group of toddlers in Indragiri Hilir district remains low, primarily on zinc supplementation as one of the treatments for under-five children with diarrhea. The highlight occurs in Rokan Hulu District with a perform the average service coverage, yet Posyandu presence was quite low compared to the target.

In the course of sensitive interventions, no indicators have reached the target and the average service coverage remains low compared to the target, as in the Toddler-Family Support Group and Food

Table 2: The stunted and severely stunted among reported under-five children during 2020 in priority districts

District	Under-five Measured (n)	Stunted (n)	Severely Stunted (n)	Priority Village	Targeted children in Priority Villages (n)	Prevalence of Stunting (%)
Rokan Hulu	46,097	1428	354	10	301	3.9
Kampar	68,230	2774	1094	19	973	5.7
Kep. Meranti	15,218	1323	546	30	952	12,3
Pelalawan	37,317	804	169	11	292	2.6
Rokan Hilir	32,113	1366	356	21	468	5.4
Bengkalis	46,300	3025	1206	15	103	9.1
Indragiri Hilir	34,526	1603	671	15	540	6.6
Indragiri Hulu	29,479	2175	690	10	356	9.7
Siak	33,155	2284	945	15	1168	9.7
Pekanbaru	50,009	668	201	15	436	1.7
Total	392,444	17450	6232	161	5589	6.0

Table 3: Service coverage of specific and sensitive intervention during 2020 by Priority Districts

Intervention	Target (%)	Rokan Hulu (%)	Kampar (%)	Kep. Meranti (%)	Pela-lawan (%)	Rokan Hilir (%)	Beng-kalis (%)	Indragiri Hilir (%)	Indragiri Hulu (%)	Siak (%)	Pekan-baru (%)	Priority districts (%)	Priority Village (%)
Specific interventions		89.5	84.4	79.0	82.6	77.4	70.6	65.6	72.8	73.1	88.0	78.3	72.2
Intervention for mother and girl	n/a	81.8	95.1	58.6	59.1	66.0	73.0	61.1	58.4	61.9	77.3	69.2	67.7
Iron supplementation for teenager	58	59.1	100.0	39.6	29.0	15.5	89.6	45.0	46.4	50.5	27.6	50.2	48.6
Maternity class	n/a	52.4	100.0	90.6	22.3	96.1	47.8	37.2	49.1	54.0	69.9	61.8*	65.6*
Post-partum care	75	92.5	87.0	45.8	76.5	61.6	52.9	64.5	59.2	66.8	83.8	69.1	64.4
Pregnancy monitoring (K4)	84	92.8	83.4	41.8	78.6	62.4	63.5	70.0	56.5	63.5	91.4	70.4	66.1
Iron supplementation for pregnant women	90	93.8	100.0	39.3	77.7	61.6	85.5	75.5	61.3	63.1	90.0	74.9	70.7
Supplementary feeding for CED pregnant women	80	100	100.0	94.3	70.5	99.5	98.5	74.1	77.8	73.3	100	88.8^	91.1^
Intervention for Children	n/a	89.5	84.4	79.0	82.6	77.4	70.6	65.6	72.8	73.1	88.0	78.3	77.4
Complete basic immunisation	90	95.8	54.1	64.2	80.0	55.2	74.9	58.1	46.9	30.7	87.8	64.8	63.4
Integrated health post (Posyandu) attendance	80	55.9	77.0	73.0	74.5	52.8	54.7	63.5	74.7	71.8	66.8	66.5	62.3
Vitamin A supplementation for 6–59 months children	88	95.7	90.6	94.5	83.1	80.1	87.7	79.0	91.0	92.8	85.3	88.0^	87.0
Zink supplementation for diarrhea	n/a	99.9	100.0	74.6	88.0	99.5	42.4	40.2	55.0	89.3	100.0	78.9*	82.2*
Supplementary feeding for wasted children	90	100.0	100.0	88.7	87.4	99.5	93.4	87.3	96.3	80.9	100.0	93.3^	92.4^
Sensitive Interventions	n/a	74.6	51.1	55.7	49.0	34.7	60.1	51.8	45.3	26.2	54.3	50.3	48.1
Food sustainable program	n/a	36.6	4.0	8.9	14.4	6.5	61.3	6.4	12.9	24.4	45.8	22.1*	26.1*
Toddler-family support Group	90	50.1	34.0	67.8	58.5	8.1	23.9	9.4	17.0	0.1	25.4	29.4	33.9
Early childhood education	70	99.6	8.7	35.5	10.2	6.5	27.8	29.6	23.5	34.1	29.3	30.5	23.2
Parenting class	70	50.9	99.9	35.1	100.0	-	28.8	96.6	0.1	46.1	29.3	48.7	45.4
Health insurance	95	42.7	78.4	89.3	12.0	33.5	58.7	79.9	87.2	12.0	61.0	55.5	56.5
Safe drinking water	100	100.0	54.4	54.4	68.5	72.0	63.0	74.3	19.4	13.3	38.0	55.7	46.5
Access of 1000 HPK poor family to BPNT program	90	100.0	88.6	74.5	45.3	26.6	94.8	8.3	75.8	2.1	97.6	61.4	58.9
FDS of "PKH" beneficiaries	90	99.4	29.1	44.0	50.8	89.9	100.0	96.0	85.2	12.6	97.6	70.5	69.6
Proper sanitation	90	92.6	62.5	91.5	81.2	69.4	82.6	65.4	86.5	90.7	65.0	78.7	72.9

n/a: Not available, ^Reach the target, *Not be evaluated.

Sustainable Program. The coverage of services on sensitive intervention indicators in Siak District with the lowest average (26.2%) and Rokan Hulu District has performed (74.5%). In the parenting class indicator, service coverage remains very low in Rokan Hilir and Indragiri Hulu districts.

The representation of service coverage average in the villages of intervention focus locations is generally almost the same compared to the picture of the ten priority districts. In the sensitive interventions, the indicators of early childhood education in priority villages still need to be the focus of the intervention as the coverage remains low. In that way, it was applied to the Food Sustainable Program and the Toddler Family Support Group as well.

The priority districts that have set priority villages have drafted budgets to implement interventions in the focus interventions village. Nevertheless, the detailed information was not obtained on the budget allocation for each intervention to increase the services coverage as priority in each village. The sources funding at village perform the significant contribution to finance the interventions at the village level. The proportion of specific intervention was 28.2% and sensitive intervention was 71.8% from regional development budget (Table 4).

Table 4: The summary of reported budget allocation in priority district 2021 for stunting reduction program

Budget Source	Amount (IDR)
Regional Government Budget (APBD)	
Specific intervention	34,122,142,098
Sensitive intervention	86,680,478,692
Village Allocation Budget (APBDesa)	122.398.544,533
Corporate Social Responsibility Program and Other Sources	2,247,071,428
Total	245,448,236,751

Source: Web Monitoring and Evaluation Report on Convergence Action, 2021.

Figure 1 showed the percentage of specific intervention, sensitive intervention, and prevalence of stunting. It was interesting the district that reached specific intervention above 80% had lower proportion

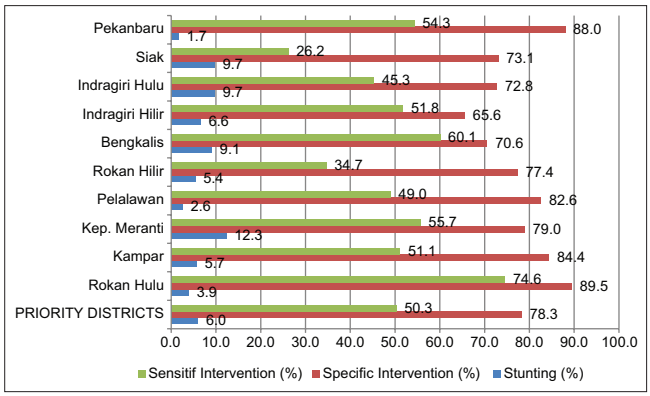

Figure 1: The specific intervention, sensitive intervention, and stunting (%)

of stunting (Rokan Hulu, Kampar, Pelalawan, and Pekanbaru) and three of them (Rokan Hulu, Kampar, and Pekanbaru) had sensitive intervention coverage above average priority districts (50.3%). Two of four districts (Indragiri Hulu and Siak) had specific and sensitive intervention coverage below average priority districts.

Discussion

The stunting prevalence of stunting from the present study (6.0%) was quite lower than the Indonesian Toddler Nutritional Status Survey (SSGBI) 2019 (23.9%). This difference was due to differences in data collection (most of the children vs. sampling) [1]. Although most of the children were measured of their height based on Electronic Community-Based Nutrition Recording, most of them were children who attended to the Posyandu. Children who do not attend to the Posyandu usually experienced nutritional

problems because their growth and development was not monitored. The prevalence of stunting in coastal districts (Meranti slands, Siak, and Bengkalis) was higher than mainland districts, which showed problems in limited access to infrastructure, inadequate health services, and higher poverty.

The coverage of specific intervention services in priority districts, as well as intervention focus villages, remains to be increased as they have not yet reached the targets set out in the National Strategy for the Reduction of Stunting (StraNas). In this study, the sensitive intervention coverage was lower (50.3%) than specific intervention coverage (78.3%). This type of intervention was focused on the low coverage of identifying the root causes of stunting are multi-sector as directed in the StraNas. The main focuses converge activities on health, early childhood education and development, water, sanitation, and hygiene (WASH), food security, as well as social protection incentives for parents to get nutritional and health support through conditional cash transfers and non-cash food assistance (Bantuan Pangan Non-Tunai/BPNT). The improved aligning incentives across key ministries, local governments, service providers, communities, and households would help to improve service coverage, quality, and utilization. In addition, annual tracking of key early childhood outcomes such as stunting would help to sustain public awareness and enable ongoing progress monitoring and program adjustment [13]. In Vietnam, there was the NPAN for 1995–2003, National Nutrition Strategies for 2001–2010 and 2011–2020 as national agenda to overcoming under-nutrition. Provide nutrition evidence nutrition cluster partnership group, commitment to global initiatives on nutrition, and role of media were some drivers of keys success [6].

The quantitative research showed that changes in health and nutrition services, household assets, and hygiene and sanitation explain two-thirds of the change in stunting among children <5 years in Chhattisgarh [14]. The policy analysis highlighted that expansion of health and nutrition program at the national level contributed to the changes seen in program coverage. Similarly, state-level innovations to grow the economy and to reduce poverty through work and food security program supported poverty decline [14]. In this study, the geographical factor and poverty associated with low coverage of specific and sensitive intervention. It can be seen that Indragiri Hilir and Meranti Islands districts which is located in the coastal area have lower coverage and high stunting prevalence.

The gap in service coverage between districts of priority locations based on the observation of the Provincial Stunting Reduction Coordination team may be affected by several factors including quality and data management at the village level, staff capacity in management and delivery service, and program coordination and synchronization among agencies in determining planning and budgeting priorities. The data management factors meet the challenges in perceptual difference of indicators definition and data collection mechanisms. Data on specific indicators are generally coordinated by each Primary Health Center which includes several villages. Primary Health Center with the quantity and quality of qualified officers may collect the detail and precise data in each village yet some data are not available at the village level. Several ministries develop the applications or data systems as the mandatory assigned duty of officers in Primary Health Center, Local Government Agency, and at the village level and city/district levels. The presence of Human Development Workers assigned in each village to ensure the convergence of stunting reduction at the village level becomes fundamental to be prioritized, the reporting of convergence action at the village level is monitored through Electronic Human Development Worker data system. At the district level, the reporting system is monitored through the Web Monitoring and Evaluation of the Regional Development Directorate of the Ministry of Home Affairs.

The targeted intervention for the target group of 1000 HPK families was especially monitored by the Health Officer/Cadre. The presence of health officers and health cadres at the village level is a major key in the delivery service. The role of the Family Development Welfare Driver Team in coordinating cadres in villages and sub-districts is fundamental in the implementation of services to target groups. To ensure targeted interventions, the commitment of staffs and coordination with all stakeholders are required, especially at the village level. From the institutional point of view, coordination at the district level remains well managed by the regional development planning agency. As far as the observation of the provincial coordination team and the director-general of Regional Development Ministry of Internal Affair, the role of Planning Development Agency, Research and Development as a coordinating body is particularly effective in improving the integration and convergence program.

Study Nepal showed improvements in both nutrition-specific and nutrition-sensitive sectors have been critical to stunting decline, particularly in the areas of poverty reduction, health, education, and sanitation [15]. Key initiatives focused on decentralizing the health system and mobilizing community health workers to increase accessibility; long-standing nationwide provision of basic health interventions; targeted efforts to improve maternal and child health; and the prioritization of nutrition-sensitive initiatives by both government and donors. National and community stakeholders and mothers at village level highlighted a mixture of poverty reduction, access to health services, improved education, and increased access to WASH as drivers of stunting reduction [10].

Despite recent efforts to push spending to districts and improve national and district coordination, the current arrangements for delivery of nutrition

interventions suffer from fragmentation, delayed implementation, significant resource misallocations, poor data quality, and use and ineffective multi-sector coordination. Expenditures on nutrition interventions are significant in Indonesia [16]. However, there are large significant efficiency and effectiveness issues related to what the resources are spent on and where. For example, the lack of service delivery is largely a management problem rather than a resource problem. The government of Riau Province have been already spent budget allocation for stunting reduction program approximately was IDR 120.8 billion (USD 1.8 million). For specific intervention was 28.2% and sensitive intervention was 71.8%. However, not all is spent on the most cost-effective interventions. At the local level, the government spent a budget on Local Government Agency to prioritize interventions on target groups. However, in the planning and budgeting documents, not all Local Government Agencies at the targeted district level focus on the group in the intervention focus villages. The funding support from the Non-Physical Special Allocation Fund for the operation of convergence activities up to the village level is consistently provided to local governments.

The role of non-state actors in the form of community development and CSR has been demonstrated in the collaboration of program implementation. The contributions in the form of sharing activities through each funding provide opportunities in increasing the coverage of services to target groups. As example in Thailand, some of key success was community participation through labor mobilization and sharing budget between government and community [7].

The provincial government is mandated to implement the coaching and monitoring of convergence actions in the ten intervention focus districts/cities. The monitoring and reporting of convergence actions may be monitored through an application system developed by the Ministry of Home Affairs. The assessment of the performance of convergence actions is conducted annually to determine the achievement of convergence actions of stunting reduction in the intervention focus district/city. An appreciation for performed district may motivate them to increase service coverage, reduce the prevalence of stunting as an outcome, and improve the quality of human resources as an expected impact.

The data that were analyzed were taken from Reporting System and Web Monitoring Convergence Action system in 2020. Some districts (Rokan Hulu, Kampar, Meranti Island, Pelalawan and Rokan Hilir) have been presented the data on stunting convergence action assessment, but other districts have not been assigned as priority districts. The coverage service was analyzed from 2020 data, whereas the planning of program (budgeting and activity) was conducted in 2019. In 2020, the pandemic COVID-19 started happening until now. Some study showed that the coverage of maternal and childcare estimated declined during COVID-19 pandemic due to movement restriction and shocking on health system in low and middle incomes countries [17]. One study in Riau showed that the pandemic impact on low coverage on complete basic immunization for under-five children [18]. This study did not compare the service coverage between 2020 and 2021. This was some of the limitations in this study.

Conclusion

The coverage service of sensitive intervention was lower than specific intervention. Only two out of 11 specific interventions, coverage had reach the target and all sensitive intervention coverage had not reach the target. The specific and sensitive intervention coverage were varied among priority districts. The strengthening of interventions is required to increase coverage service delivery to the targeted household. The local government convergence action and increasing the role of the village authorities were the main keys in accelerating stunting reduction.

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