MAKING THE INVISIBLE VISIBLE

How Community Health Workers identify high-risk mothers and children before they fall through the cracks.

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EXECUTIVE SUMMARY

Who gets identified first often determines who receives support first.

A rapid, AI-assisted qualitative study with 103 Community Health Workers (CHWs) in Rote Ndao and Timor Tengah Selatan (TTS) found that CHWs play a critical but often overlooked role in preventing stunting: they identify mothers and children at risk long before those risks become visible in routine health data.

While growth monitoring, antenatal care records, and Posyandu attendance provide important information, many vulnerable families remain outside formal systems. Pregnant adolescents may hide their pregnancies, families may stop attending Posyandu, mothers may discontinue supplements, or households may seek private care without informing local health services. These families often become visible only when problems have already emerged.

CHWs bridge this gap. Through home visits, local knowledge, community relationships, and continuous follow-up, they identify risks early and connect families to support before poor outcomes become entrenched.

"CHWs function not only as service providers, but they are the health system's frontline detection network, making invisible risks visible before they become crises."

THE FIVE INVISIBLE GROUPS

Some of the highest-risk households are also the least visible. CHWs consistently identify groups that formal systems struggle to reach, yet CHWs frequently know exactly who they are, and actively seek ways to reach them.

1. **Pregnant adolescents & unmarried women**
   Conceal pregnancies due to stigma, delaying identification and care entirely.

2. **Chronic Posyandu absentees**
   Families who repeatedly miss sessions because of distance, work, or competing responsibulities.

3. **Remote households**
   Living in locations that are physically difficult to access, even for CHWs.

4. **Private healthcare users**
   Receiving services from private providers without informing local health workers.

5. **Silent non-adherers**
   Mothers who appear healthy but have quietly stopped taking recommended micronutrient supplements, invisible to every formal record.

Several CHWs described visiting households outside formal targeting lists because they recognised emerging risks within their communities. This ability to combine community intelligence with formal health data lets CHWs reach vulnerable families who would otherwise be missed entirely.

WHAT HAVE BEEN DONE IN ROTE AND TTS:

FINDING RISK BEFORE IT APPEARS IN THE DATA.

1000 Days Fund Village Task Force/Satgas Model is a collaborative action group, one key for CHW home visit.

The home visits targets are determined through coordination between task forces that included health workers, village heads, key community figures, and community health workers (CHW). When deciding who to visit, CHWs do far more than following household lists given by the formal system. They combine the formal information that consist of posyandu registers, Kartu Menuju Sehat, growth charts, and health-facility data from health workers, with informal signals gathered from the community.

CHW try their best to visit all the targets on time. They manage workloads through planning adjustments and shared tasks.

They pay attention to repeated Posyandu absences, changes in household circumstances, concerns raised by neighbours, and early signs that a pregnant woman or child may need additional support. These decisions reflect a sophisticated understanding of risk and prevention that goes well beyond routine service delivery.

"CHWs combine formal health data with community intelligence, identifying risk that never appear on an official list."

HOME VISITS TRANSFORM DETECTION INTO PREVENTION

Identifying risk is only the first step. Once a family is identified, CHWs use home visits to understand the barriers affecting maternal and child health. Unlike facility-based services, home visits let CHWs observe the realities families face such as feeding challenges, food insecurity, caregiving constraints, and social barriers that stay invisible during routine clinic visits. This enables support tailored to each family's circumstances.

WHAT HAPPENS DURING A HOME VISIT

1. **Assess maternal & child health**
   Review condition, growth data, and symptoms.

2. **Counsel caregivers**
   Advise on feeding, dietary diversity & pregnancy behaviours.

3. **Support supplementation**
   Reinforce iron-folic acid and micronutrient use.

4. **Identify nutrition barriers**
   Uncover food availability and feeding challenges.

5. **Promote service attendance**
   Encourage Posyandu and antenatal care adherence.

6. **Refer high-risk cases**
   Connect families to Puskesmas, midwives, or nutritionists.

"Unlike clinic visits, home visits surface the realities families actually face and give CHWs the context they need to provide genuinely tailored support."

FIVE KEY FINDINGS FROM THE FIELD

Some of the highest-risk households are also the least visible. CHWs consistently identify groups that formal systems struggle to reach, yet CHWs frequently know exactly who they are, and actively seek ways to reach them.

1. Coordination works and can be further strengthened

Home visits emerge from coordination across midwives, nutritionists, village task forces, and CHWs, using pre-agreed visit lists and schedules. the presence of a task force/satgas helps facilitate alignment and shared agreement on available data, particularly in determining and prioritizing targets for home visits.

Implication:

A functioning collaborative model already exists, the 1000 Days Fund task-force approach can be strengthened and standardised, not built from scratch.

2. Targeting is data-driven, but training sharpens it

CHWs use KMS cards, Posyandu registers, and health-worker records to prioritise households with stunting, growth faltering, low birth weight, and poor attendance. Some cases are deliberately handed back to Posyandu to conserve visit capacity, thoughtful rationing, not random coverage.

Implication:

Focused investment in regular training and simple coordination tools could sharpen who gets reached, when, and with what intensity.

3. The hardest-to-reach remain under-identified

Three groups consistently fall through: adolescents hiding pregnancies; women who quietly stop taking supplements; and families repeatedly missing Posyandu due to distance, cost, or competing demands, even when they know a session is scheduled.

Implication:

Closing these gaps requires both social and operational solutions, norm-sensitive outreach, proactive supplementation follow-up, and practical strategies for remote households.

4. CHWs are going beyond the formal system

CHWs repeatedly describe visiting households not on official lists when they know a high-risk family has missed Posyandu. Even without a scheduled visit, they provide counselling and encourage families back into routine services. They share workloads & adjust plans to cope with distance, terrain, & staffing limits.

Implication:

Strong intrinsic motivation already exists; targeted support will amplify this behaviour, not create it.

5. Digital tools are already in use

WhatsApp groups are the de facto coordination platform for tracking high-risk targets. Some CHWs are - experimenting with AI tools to answer questions or clarify information on the spot.

Implication:

There is an opportunity to build structured, light-touch digital support on tools CHWs already use, including AI voice-note tools and standardised WhatsApp workflows.

THE EQUITY CHALLENGE

The greatest challenge facing CHWs is not identifying risk, it is reaching households consistently. More than half of respondents in this study named household reach and engagement as their biggest obstacle.

The families most in need of support are often those least visible and least accessible to formal services.

Long distances, difficult terrain, seasonal work, caregiver/target absence, and limited transportation frequently prevent timely contact with vulnerable families. Households that are hardest to reach enter the system later, receive fewer preventive contacts, and face greater risk of being overlooked. The greatest equity gap is not whether vulnerable families eventually receive support, it is how early they enter the system.

KEY STAKEHOLDERS IN THE HOME-VISIT SYSTEM

Stakeholder	Roles
Village (Village Government)	Coordinates visit schedules and community engagement strategies.
Village Midwife (Bidan)	Verifies data and serves as the clinical referral point.
Village Support Cadres (KPM)	Reinforce health messages and follow up off-list households.
Family Accompanying Team (TPK)	Provides additional human resources for visits.
Puskesmas Nutritionist	Confirms risk data; ensures high-risk names are included.
Village Task Force (Satgas)	First line for community concerns and follow-up.
Community members	Identify at-risk households and provide contextual information that never reaches formal records.

RECOMMENDATIONS

Direct, tangible investments that make it physically and socially possible for CHWs to reach those most at risk, including young women and children almost invisible in routine systems.

1

Formalise & expand village task forces
Bring together CHWs, midwives, nutritionists, village government, and community representatives in every target village.

2

Introduce standard operating procedures
For compiling high-risk lists, agreeing monthly visit priorities, and tracking completion and outcomes.

3

Provide targeted training & mentorship
On risk stratification, growth-data use, non-judgmental adolescent engagement, and supplementation adherence.

4

Provide a basic home-visit kit
Transport support, anthropometric tools where needed, and counselling assisting materials tailored to adolescents.

5

Layer on simple digital supports for CHW
WhatsApp checklists, reminders, or AI-supported decision tools to track missed visits and trigger follow-up.

6

Test, refine, and scale
Consolidate the model in Rote Ndao and TTS, then package it for other NTT districts and beyond.

7

Evaluate rigorously
Measure changes in coverage, timeliness of first contact, and Posyandu re-engagement the metrics that prove earlier reach translates into earlier support.

NEXT STEPS

With multi-year, flexible funding, 1000 Days Fund and partners can:

- Consolidate and document a replicable model for task-force-driven, data-informed home visiting in rural Indonesia.
- Generate rigorous evidence on the impact of improved targeting on child growth, maternal nutrition, and service utilisation.
- Share lessons with village, district, and national stakeholders to inform policy and scale through government systems.

CONCLUSION

Community Health Workers are far more than service providers. They are the health system's frontline detection mechanism for stunting risk. Through growth monitoring, household outreach, community intelligence, and personalised home visits, CHWs identify vulnerable mothers and children early enough for preventive action to be taken.

Continued investment in CHW training, supervision, transportation, digital tools, and community-based targeting can significantly strengthen the ability of local health systems to find high-risk families earlier, intervene more effectively, and ultimately reduce childhood stunting in Nusa Tenggara Timur.

"In communities where every missed pregnancy, missed Posyandu visit, or missed growth warning can have lifelong consequences, CHWs serve as the bridge between risk and prevention."

ABOUT THIS STUDY

A rapid, AI-assisted qualitative study conducted in Rote Ndao and Timor Tengah Selatan districts, NTT Province, Indonesia. 103 community health workers (kader) and field officers participated, April–May 2026. A joint initiative of 1000 Days Fund (Yayasan Seribu Cita Bangsa) and Colectiv.