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Abstract Compendium

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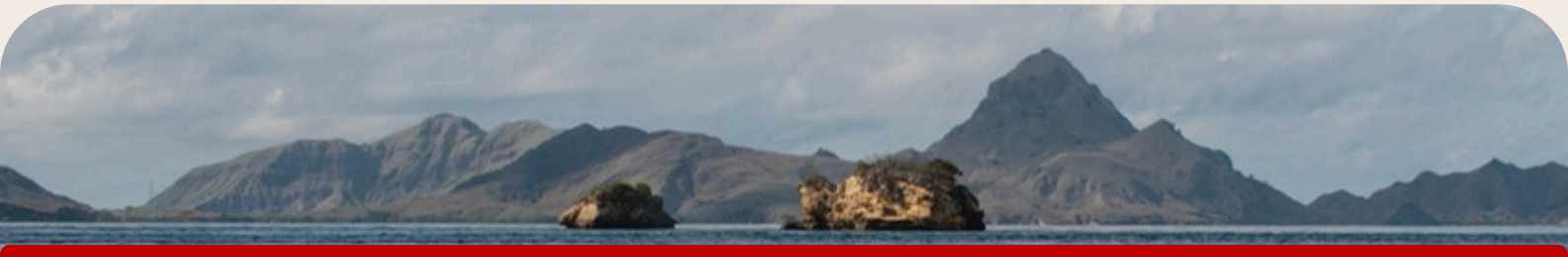

EXECUTIVE SUMMARY

This abstract collection was presented at the Leimena Conference, organized by the Ministry of Health of the Republic of Indonesia through the Primary Health Care Consortium. The abstracts presented multi-method evidence from 1000 Days Fund (TDF) programs across NTT, NTB, and other Indonesian provinces, consistently pointing to one central thread: strengthening the capacity and welfare of community health workers (CHWs) at the village/Posyandu level is a key lever for improving maternal and child health outcomes during the first 1,000 days of life (HPK). The evidence draws on a combination of large-scale quantitative studies (routine surveys, CHW registry data), qualitative process evaluations, and innovative approaches such as AI-assisted WhatsApp interviews.

These findings strengthen the case for replicating the village health system that is included in the Integrated Primary Healthcare (ILP) program, with four recommendation as follows:

- Village-puskesmas cost-sharing financing for community health program
- Systematic strengthening of the CHW 5S framework
- Context-based adaptation of engagement strategies
- Formal certification and career pathways for CHWs as part of national health system recognition.

The village health system in Indonesia will become resilient and sustainable when community health workers (CHW) are treated as a workforce deserving training, supervision, fair incentives with recognized career path. 1000 Days Fund's experiences demonstrated that these are achievable when the programs are co-designed with local government and adapted to local context. We hope these findings, shared at the Leimena Conference, can contribute to the national dialogue on strengthening Integrated Primary Healthcare (ILP) and to continued collaboration among the Ministry of Health, the Primary Health Care Consortium, and civil society partners working toward the shared goal of ending stunting in Indonesia.

Village Financing and Ownership Strengthening as a Sustainability Model for Primary Service Integration: Lessons from the SIKAT Stunting Program

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Abstract

Background

Posyandu and community health workers (CHWs) are the frontline of the village health system, playing a central role in home visits for stunting-risk targets. However, without systematic strengthening, this potential is often not fully utilized. The SIKAT Stunting program was developed to address this gap, in line with the national strategy to accelerate stunting reduction and the Integrated Primary Healthcare (ILP) policy.

Innovation

Initiated by 1000 Days Fund (TDF) in Rote Ndao, SIKAT Stunting strengthens village-level health services at the Posyandu level through tiered training and intensive mentoring for health workers (HW) and community health workers (CHW). The program's innovation lies in its approach, which does not stop at technical training: SIKAT Stunting promotes regulatory advocacy supporting the 5S principle: trained (skilled), supervised, salaried, supplied (with logistics), and sustained, to ensure the ongoing welfare of CHWs. This was achieved by engaging the District Health Office, puskesmas, and village governments as strategic partners from the earliest stages of program design. The foundation for this collaboration was built on TDF's advocacy, which together with the Ministry of Health helped bring about Regent Regulation No. 68 of 2024 on strengthening ILP, providing a policy basis for program sustainability beyond the project period.

Implementation

The program ran from November 2024 to October 2025 in 20 villages in Rote Ndao District. A total of 40 health workers and 304 CHWs were trained to reach 195 pregnant women and 495 children under two (CU2). CHWs conducted home visits, distributed educational media (Poster Pintar / "Smartchart"), and provided counseling to all targets, while health workers and CHWs coordinated to manage high-risk cases which were pregnant women with chronic malnutrition (KEK) and CU2 with weight faltering (2T) or HAZ below -2 SD. TDF's field team also supported advocacy with local governments to ensure program continuity after the project ended.

Results

A qualitative evaluation using the process tracing approach (INTRAC for Civil Society) showed changes on both the target and system sides. First, CHWs proved they were able to educate and identify stunting risk after training, reflected in increased scores on Stunting 101 training module (55%→71%), high-risk case management module (50%→70%), and breastfeeding/complementary feeding practices module (64%→73%), which boosted the quality of Posyandu counseling by 23.8%. Second, stunting-prevention behaviors among families of CU2 improved significantly: adoption of handwashing with soap, exclusive breastfeeding, and deworming medication increased by 20–32%, alongside improvements in iron-folic acid supplementation, animal protein consumption, immunization, and vitamin A supplementation. Third, weight faltering cases dropped by 64% (28→10 children), chronic malnutrition among pregnant women dropped by 33% (24→16 women), and HAZ below -2 SD cases dropped by 37.5% (16→10 children).

On the systems side, 14 out of 20 villages (70%) allocated a village budget line for training and counseling media under a cost-sharing principle, clear evidence that villages are driving the sustainability of health system strengthening beyond the advocacy period. In addition, the District Health Office and puskesmas provided greater support for health worker supervision of CHWs, marked by easier approval for home visits.

Recommendations

SIKAT Stunting demonstrates that tiered training and sustained support for CHWs and village governments are essential for the success of community-based stunting management. The village cost-sharing model proves that programs co-designed from the outset, rather than simply implemented in village locations could generate ownership that drives real sustainability, while also serving as a proof of concept for replicating the ILP policy in other regions.

Keywords

Village health services, Integrated Primary Healthcare, community health workers, village-based financing, process tracing

Building Trust and Context-Based Behavior Change: Evaluation of Community Health System Strengthening for Stunting

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Abstract

Background

Stunting, a childhood growth disorder caused by malnutrition, affects 1 in 5 children in Indonesia. This condition carries substantial health and socioeconomic consequences for both individuals and communities. However, appropriate interventions during the first 1,000 days of life, from pregnancy until a child reaches two years of age can prevent stunting and save children from its effects.

Implementation

1000 Days Fund (TDF) is a nonprofit organization working to eradicate stunting in Indonesia by strengthening village health systems through tiered training, intensive mentoring for health workers and Posyandu community health workers (CHWs), and advocacy for regulations and joint financing schemes with local governments. This evaluation focused on the home-visit component conducted by CHWs for pregnant women and children under two (CU2) at high risk of malnutrition. The program was implemented across five districts in West Nusa Tenggara (NTB) and East Nusa Tenggara (NTT) (North Lombok, Rote Ndao, West Manggarai, Timor Tengah Selatan, and Kupang) from January to September 2025. A mixed-methods approach was used to conduct an implementation and process evaluation: descriptive analysis of routine program data (1,230 trained CHWs and 1,142 home visits to 491 target families), in-depth interviews with 20 CHWs and 20 target individuals, and direct observation of 20 home visits.

Results

Training was shown to increase CHW knowledge by 32%. Among the 491 target individuals visited more than once, 30.5% of pregnant women (n=11/36) no longer experienced chronic malnutrition, 45% of CU2 with weight faltering (n=80/176) achieved minimum weight gain, and 22% of CU2 with an initial height-for-age Z-score (HAZ) below -2 SD (n=20/91) were no longer classified as stunted. Qualitatively, increased knowledge among targets did not always translate into adoption of stunting-prevention behaviors. This was largely influenced by targets' trust in CHWs. At least four trust-building mechanisms were identified from field data, varying by implementation location:

1. **Institutional** — Trust built through the formal health system. This form was most dominant in Kupang, where explicit support from health workers helped CHWs gain family trust within a strong social hierarchy.
2. **Relational** — Trust built gradually through repeated visits and personal closeness. This type was prominent in North Lombok and West Manggarai, which also valued institutional credibility.
3. **Pragmatic/problem-solving** — Gained by helping families resolve concrete, urgent problems. This form was relevant in Rote Ndao and Timor Tengah Selatan, areas with more significant logistical challenges but where communities were generally more open to accepting CHWs.
4. **CHW status authority** — The CHW's position as a Posyandu figure also influenced family acceptance. Social hierarchy could lead to either higher or lower receptiveness, depending on local context.

The most effective CHWs acted not merely as information providers but as family mentors, overcoming stigma and social hierarchy challenges to build target trust. This helped targets become more open in resolving their health issues.

Recommendations

The success of community-based programs depends heavily on trust from target individuals, which is supported by program adaptation to local conditions. There is no single universal approach to building trust. Given Indonesia's rich geographic and cultural diversity, this has implications for scalability: community activities must account for the mediators that influence relationship quality and target needs. Peer mentoring among CHWs can help teach good practices based on experience. These findings have been adopted into TDF's program since 2026.

Keywords

Trust, community health workers, home visits, local context adaptation, stunting

Improving Targeting for Households at Risk of Stunting: Insights from AI-Assisted Interviews with Community Health Workers

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Abstract

Background

Home visits by community health workers (CHWs) are an important component of community-based health systems, particularly for reaching at-risk populations who may otherwise fall outside routine services. Effective home visiting depends not only on CHW effort but also on coordination between CHWs, health workers and village actors. The 1000 Days Fund's village task force (Satgas) model is designed to strengthen this coordination across implementation areas.

Objective

This study explored how CHWs identify, prioritise and reach at-risk pregnant women and children under two for home visits, and the coordination practices and constraints shaping these processes.

Methods

Qualitative interviews were conducted using an AI-assisted approach, in which CHWs responded to semi-structured interviews through a WhatsApp-based chatbot designed by Colectiv. Interviews focused specifically on home visits to at-risk pregnant women and at-risk children under two (households at risk of stunting). To complement these findings, focus group discussions were also conducted with field implementation teams. The study was carried out across two Satgas model implementation areas: Timor Tengah Selatan (TTS) and Rote Ndao, East Nusa Tenggara (NTT).

Results

Data was collected using Colectiv's AI-assisted qualitative interview platform over WhatsApp across five days (17–21 April 2026). A total of 103 CHWs participated, all of whom were actively involved in identifying, prioritizing, or visiting households at risk of stunting. Participants were based in Timor Tengah Selatan (29%) and Rote Ndao (71%), and were evenly split between those affiliated with Satgas (50%) and those who were not (50%).

Five key findings emerged. First, coordination practices (including area-splitting, shared timetables and joint planning with midwives and village teams in Satgas) supported the organisation and coverage of home visits when roles and responsibilities were clear, although reliance on specific individuals could also delay follow-up. Second, Posyandu records, growth-monitoring data and health worker lists provided important sources for identifying and prioritising known at-risk households, but reliance on routine systems left some families less visible. Third, non-attenders, mobile or newly arrived households, concealed pregnancies, and families using private or informal care were particularly likely to be identified late or missed. Fourth, difficulty reaching and engaging households was the most commonly reported challenge, selected by 56% of CHWs; distance, poor access, weather and caregiver absence repeatedly disrupted planned visits. Fifth, CHWs showed strong persistence in maintaining follow-up, using repeated visits, phone calls, WhatsApp, reminders, rescheduling and alternative meeting points, although these workarounds depended heavily on individual effort and local conditions.

Conclusion and Recommendations

The findings highlight the importance of coordinated, team-based approaches to community outreach and identify practical opportunities to strengthen home visiting within Satgas implementation areas. Models such as Satgas may support coordination across CHWs, health workers and village actors, while effective coverage also requires mechanisms to identify households outside routine Posyandu data and reduce practical barriers to reaching them. Appropriate digital tools may further support coordination, tracking and follow-up, complementing resilient local systems and clearly defined roles.

Keywords: Community health service, health service delivery, community health worker, village task force, AI-Interview, qualitative study

Village CHW Capacity, Posyandu Service Quality, and Maternal-Child Health Outcomes in Indonesia's First 1000 Days: A Multilevel Cross-Sectional Analysis

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Abstract

Background

Posyandu community health workers (CHWs) are the frontline community health workforce supporting Indonesia's First 1000 Days agenda, yet evidence on how CHW capacity translates into household-level outcomes remains limited, particularly using routinely collected, large-scale, multilevel data. This study examined associations between village-level CHW capacity, Posyandu service-step compliance, and maternal-child health knowledge and behaviors in seven Indonesian provinces.

Methods

We conducted a cross-sectional multilevel analysis of routine programme monitoring data from a community nutrition programme, comprising three linked instruments: a CHW Survey (n=755), a Household Survey (n=2,082), and a Posyandu Observation Checklist (n=681). After data cleaning and village-code harmonization, a primary analytic sample of 1,819 households nested within 177 villages (linked to CHW data) was constructed, alongside a smaller exploratory sample of 487 households in 16 villages with full three-instrument linkage. A composite CHW capacity index (education, tenure, training exposure, stunting knowledge, equipment completeness) was aggregated to the village level. Two-level random-intercept linear mixed models estimated intraclass correlation coefficients (ICC) and associations between CHW capacity and six household outcomes: stunting knowledge, Posyandu service coverage, a water-sanitation-hygiene (WASH) index, antenatal care (ANC) behavior, child feeding behavior, and preventive service uptake, adjusting for respondent age, education, employment, and income. Sensitivity analyses excluded villages with a single CHW respondent and a disproportionately large village.

Results: ICCs ranged from 0.020 (ANC behavior) to 0.451 (stunting knowledge), indicating substantial between-village heterogeneity for most outcomes. Village CHW capacity was positively and significantly associated with stunting knowledge (β=2.88, 95% CI 2.00–3.77), service coverage (β=1.80, 95% CI 1.25–2.35), the WASH index (β=1.43, 95% CI 0.91–1.95), child feeding behavior (β=0.23, 95% CI 0.01–0.45), and preventive service uptake (β=0.43, 95% CI 0.22–0.65), but not ANC behavior (β=−0.08, p=0.455). Findings were robust across both sensitivity analyses (coefficient change

<7%). In the exploratory 16-village subsample, the direct association between CHW capacity and outcomes persisted, but Posyandu five-step compliance was not significantly associated with outcomes (all p>0.07) and was uncorrelated with CHW capacity (r=−0.01, p=0.96), providing no support for a process-mediated pathway.

Conclusions

Village-level CHW hardware capacity, such as education, tenure, training, knowledge, and equipment, is consistently associated with better household-level nutrition, health knowledge and practices, independent of household socioeconomic characteristics. Strengthening these inputs may be a tractable programmatic lever, although the lack of evidence for a Posyandu-process mediating pathway, the null ANC finding, and several data linkage constraints warrant cautious, hypothesis-generating interpretation pending longitudinal and qualitative follow-up.

Keywords

community health workers; posyandu; village CHWs; stunting; multilevel analysis; maternal and child health; Indonesia; First 1000 Days

Training, supervision, and monetary incentives improve Indonesian community health workers' retention: A retrospective study

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Abstract

Background

An estimated 1.5 million community health workers (CHWs) serve as the front line of Indonesia's primary health system at Posyandu (integrated health posts). However, challenges in CHW retention risk disrupting services,recruitment and training costs. This study aims to identify the determinants of CHW retention in Indonesia.

Methods

This retrospective observational study used 2022-2024 CHW registry data from 1000 Days Fund, covering 746 CHWs across six provinces (East Nusa Tenggara/NTT, West Nusa Tenggara/NTB, Bali, West Java, Banten, and Jakarta). Retention was analyzed dichotomously as long (≥8 years) and short (<8 years), based on the 4S conceptual framework (Skilled, Supervised, Supplied, Salaried) from the Community Health Impact Coalition, in line with WHO recommendations, with an added Secure domain (possession of a contract/village cooperation agreement) drawn from a literature review. Statistical analysis was performed using STATA/BE 19.5. Variables with $p<0.05$ in univariable regression were included in multivariable logistic regression. A sensitivity analysis used a ≥5-year retention cutoff.

Results and Discussion

The majority of CHWs (84.9%, n=633) were women. Retention was influenced by the skilled, supervised, and salaried domains: a greater number of training topics (aOR 1.4; $p=0.001$), supervision by the Puskesmas (community health center)/family planning staff (aOR 2.6; $p<0.001$), and incentives from the village government (aOR 3.9; $p=0.005$) increased the likelihood of retention. The supplied and secure domains were not significant. Age 30-49 years (aOR 8.2; $p=0.047$) and holding a leadership role at the Posyandu (aOR 2.3; $p<0.001$) increased the likelihood of retention, while having a high school education or above decreased it (aOR 0.6; $p=0.005$). Sensitivity analysis results were consistent.

Conclusion

Investment in training, supervision, and financial incentives contributes to CHW retention in Indonesia, in line with global trends and WHO recommendations.

Keywords

Community health workers, retention, training, primary health care

Digital Health Literacy of Community Health Workers and Health Workers in Manggarai Barat District, Nusa Tenggara Timur Province

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Abstract

Background

Amidst the transformation of primary healthcare and health service digitalization, community health workers (CHWs) and health workers (HWs) face a dual burden of manual and digital data reporting. The readiness to access, understand, and utilize digital health information has become crucial. This study aims to assess digital health literacy among CHWs and frontline health workers.

Methods

This cross-sectional study utilized a closed-ended instrument survey, followed by in-depth interviews with informants selected purposely based on inclusion criteria between March and May 2025. The survey included 75 CHWs and 23 HWs in West Manggarai Regency, with 6 informants participating in the in-depth interviews. The instruments deployed were the Indonesian-translated Health Literacy Population Survey 2019—Digital (HLS19-DIGI), HL-DIGI-INT to measure interaction with digital devices, HL-DIGI-DD to gauge the frequency of digital resource usage, and an in-depth interview guide.

Results

The mean digital health literacy score was 60.1 (HWs: 82.0%; CHWs: 52.5%). Most respondents found it easy to search for information using keywords (69.1%), yet demonstrated weak critical skills, such as difficulty judging source credibility (45.4%), detecting commercial content (50.5%), and validating online information (53.6%). In-depth interviews revealed seven key factors: relatively adequate basic technology access; improved work and reporting efficiency; concerns over digital application dependency, emphasizing the continued need for physical diagnosis; a strong preference for face-to-face consultations; concerns regarding information accuracy; security risks and medical data leaks; and uneven digital infrastructure.

Conclusion

CHWs and HWs possess the basic capability to access digital information and utilize technology. However, their skills remain limited, necessitating reinforcement, comprehensive system support, training, and continuous monitoring to optimize digital health implementation.

Keywords

Digital health literacy, community health workers, health worker, Integrated Primary Healthcare, mixed methods, HLS-DIGI

Assessing the Village Health Foundation Using CHW-AIM: Lessons for Strengthening Integrated Primary Healthcare in Indonesia

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Abstract

Background
Assessing the effectiveness of village-level health systems has become crucial with the introduction of the Village/Sub-district Health Service Unit (UPKD/K) as the frontline of service delivery, in which the role of community health workers (CHWs) is a key factor for successful integration of services and community engagement.

Innovation
To map service needs and health system readiness at the grassroots level in line with the primary health service transformation policy, an initial assessment of village health systems was conducted using the Community Health Worker Assessment and Improvement Matrix (CHW-AIM) across 1000 Days Fund's program areas, involving relevant stakeholders.

Implementation
This assessment aimed to measure the functionality level of village health systems as an initial step in program design, covering 61 villages across four program districts: North Lombok, West Manggarai, Rote Ndao, and South Central Timor. Village-level Focus Group Discussions (FGDs) were conducted from August 2025 to July 2026, involving implementing actors and decision-makers within the village health system, including Posyandu CHWs, village midwives, nutrition officers, puskesmas (primary health center) representatives, village heads/ village representatives, and PKK (Family Welfare Movement) representatives. Through these FGDs, ten domains of the village health system related to the role of CHWs were agreed upon for assessment: Role and Recruitment, Training, Accreditation, Equipment and Supplies, Supervision, Incentives, Community Involvement, Opportunity for Advancement, Data, and Linkage to the Health System. Each domain was scored using a four-level functionality scale (Non-Functional to Highly Functional, scores 1–4).

Results
Initial results from 44 villages across four districts showed that the Data domain achieved the highest score (2.75), while Accreditation received the lowest score (1.48). District-level analysis revealed variation: the domains of Linkage with the Health System

(2.7), Training (3.7), Community Support (3.05), and Supervision (3.67) had the highest scores in some districts, while Opportunities for Advancement (1.82) and Accreditation (1.1–1.50) were consistently the lowest-scoring domains. Although the functionality scores generally indicate room for improvement, these assessment results provide clear opportunities to strengthen each domain. Data collection from the remaining 17 villages is ongoing.

Recommendations

Based on these results, strategic follow-up actions are being carried out to strengthen village health systems in line with the Integrated Primary Healthcare (ILP) program, which focuses on bringing the health system closer to the community. This strengthening rests on close coordinative relationships between puskesmas and villages through the use of integrated local area monitoring data to proactively reach target populations. These findings form the basis for program direction, particularly in the co-design process with district governments, puskesmas, and villages, as well as the establishment of Task Forces (Satgas) as the ideal form of community empowerment activity, positioned as the frontline of health services within the Village/Sub-district Health Service Unit (UPKD/K). The findings also point to the need for formal certification pathways and clear career advancement opportunities for CHWs, in line with the World Health Organization (WHO) roadmap, to ensure legal recognition and CHW retention within the health system. Formal certification of 25 core CHW competencies was identified as an important pathway for improving services. The CHW-AIM assessment results show that this tool can be used as an initial assessment for participatory program planning, agreed upon jointly by stakeholders, enabling measurable monitoring of progress, sustainability, and success in the transformation of the village health system.

Keywords

Village health services, Integrated Primary Healthcare, community health workers, task force (Satgas), CHW-AIM, focus group discussion

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