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Promoting social transformation through basic social work training for the *Nagari* apparatus: a case study in West Sumatra

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Abstract

Purpose: This study aims to analyze why social support has not yet successfully transformed parenting behavior among caregivers of stunted toddlers in Nagari Tanjung, West Sumatra, and to identify internal and external barriers that prevent caregivers from accessing and utilizing the available support. **Methods:** We used an exploratory qualitative approach with a case study design, involving 47 caregivers of stunted toddlers. The findings highlight parenting barriers and provide a compelling argument for promoting Basic Social Work Training (PDPS) among nagari officials, thereby enabling them to integrate various social components within their communities effectively. We collected data through in-depth interviews, participatory observation, and documentation, then thematically analyzed it based on internal and external factor categories. Data collection was conducted in Nagari Tanjung, West Sumatra, in 2024. **Results:** The main barriers include low nutritional literacy, stigma, shame, minimal father involvement, and beliefs in myths such as palasik. Social support from family, community, health workers, and the government has not been effective due to a lack of integration, inadequate cultural contextualization, and insufficient attention to psychosocial aspects. Moreover, the role of community social workers (PSM) at the village level has not been fully optimized, further exacerbating the situation. **Conclusion:** Community- and culture-based interventions are necessary, along with capacity-building for Nagari government officials through PDPS, to enable them to function similarly to social workers. The Ministry of Social Affairs should extend this training to the village or nagari level, not just at the provincial or district level. Strengthening the roles of nagari officials, village midwives, and community cadres (PKK, Posyandu, Family Planning, PPKBD, Human Development Cadres, PSM, and PKH facilitators) can help coordinate a sustainable and culturally contextual parenting support system.

Keywords: health literacy; parenting; social support; social worker; stunting

INTRODUCTION

Stunting is a condition where a child's height is more than two standard deviations below the median of the WHO Child Growth Standards, caused by chronic malnutrition and repeated infections, especially during the first 1,000 days of life [1]. In addition to physical impacts, stunting affects cognitive development, psychosocial well-being, and long-term economic productivity. In Indonesia, stunting remains a national priority in the health sector. Although national data show a decline in prevalence from 36.8% in 2007 to

19.8% in 2024 [2], this figure is only slightly below the WHO threshold of 20%.

Various strategies have been implemented by the Indonesian government and communities, including specific nutrition programs and culturally adapted community-based interventions. However, these programs often face barriers at the household level. In Nagari Tanjung, West Sumatra, for instance, services such as Posyandu, nutrition education, food aid, and counseling are widely available; however, caregiver participation—especially among mothers—remains low [3]. This low participation indicates that the utilization of available social support in efforts to reduce stunting is still suboptimal.

Social support, in the form of emotional (e.g., empathy and affection), instrumental (material or practical help), and informational (advice or guidance) support, is a crucial determinant in improving the quality of parenting [4]. However, the available support has not been fully accessed by caregivers. Internal factors such as shame, stigma, and low health literacy, combined with external factors such as culturally insensitive program design, restrict caregiver access and responsiveness. Additionally, the weakening of extended family (saparuik) support in Minangkabau communities, due to urbanization and the shift toward nuclear family models, has eroded traditional caregiving support networks.

Previous studies have primarily focused on evaluating the effectiveness of nutrition programs and health education, but have rarely addressed the social, psychological, and cultural dimensions that influence caregiving behavior. Few studies have explored how internal and external barriers interact in shaping caregivers' capacity and willingness to access social support. This study aims to fill that gap by examining the internal and external obstacles that hinder caregivers of stunted toddlers from utilizing available social support. It also analyzes how these factors interact to shape caregiving practices.

METHODS

This study employed a qualitative approach using a case study design to gain an in-depth understanding of the social, cultural, and psychological dynamics that influence the caregiving behaviors of caregivers of stunted toddlers in utilizing social support. This approach enables contextual exploration of subjective meanings and the everyday realities of caregivers in complex social environments.

The research was conducted in Nagari Tanjung, West Sumatra Province, an area selected due to its high prevalence of stunting. Out of 126 registered stunted toddlers, 47 caregivers (37.3%) were chosen purposely as research informants. Inclusion criteria included caregivers of children born with normal weight (≥3 kg) and length (≥50 cm), with no maternal anemia during pregnancy, and who were willing to provide honest and open information. These criteria ensured that congenital factors or perinatal complications did not cause stunting.

Data collection techniques included: 1) in-depth semi-structured interviews to explore caregivers' perceptions, experiences, and responses regarding caregiving practices and the use of social support; 2) participatory observation with detailed field notes to understand the social context and environment of caregivers; and 3) descriptive quantitative data covering demographic information such as education, number of children, and household income to support contextual interpretation.

Data were analyzed thematically through four main stages: 1) verbatim transcription of interview recordings to maintain authenticity of informants' narratives; 2) open and axial coding with the aid of qualitative analysis software; 3) categorization of data into two main themes: internal and external factors; and 4) interpretation based on emerging patterns and understanding of the local context.

To enhance data credibility, this study used triangulation of sources and methods, as well as interim result discussions with the research team and key informants to validate interpretations. Ethical approval was obtained from all participants. Each informant received a full explanation of the research's purpose, benefits, and their rights, including the right to refuse or withdraw participation at any time without consequence. Consent was obtained orally. Confidentiality was strictly maintained, and all data were used solely for scientific purposes.

RESULTS

Table 1 shows that the majority of mothers (70.2%) had secondary education or higher, while 29.8% only completed junior high school or lower. Similarly, 68.1% of fathers had at least a senior high school education, while 31.9% had a lower level of education. Education levels are essential indicators of parents' ability to absorb health information and make informed caregiving decisions. To understand the barriers to utilizing social support by caregivers of stunted toddlers, it is essential to examine the family profile of these caregivers. The table below displays the family profiles of 47 caregiver informants.

Table1. Family profile and distribution

Category	n	%
Mother's education		
Senior high school or higher	33	70.2
Junior high school or lower	14	29.8
Father's education		
Senior high school or higher	32	68.1
Junior high school or lower	15	31.9
Instant noodles consumption		
Frequently	40	85.1
Rarely	7	14.9
Income		
≤ Rp1,000,000	9	19.1
Rp1,000,001 – Rp2,000,000	25	53.2
> Rp2,000,000	13	27.7
Lives in their own house		
Single-family	13	27.7
Multiple families	39	83.0
Habit of eating at relatives' houses		
Yes	14	29.8
No	33	70.2
Support from husband		
Yes	12	25.5
No	35	74.5
Support from extended family		
Rice	29	61.7
Money	32	68.1
Vegetables	34	72.3
Support from neighbors		
Vegetables	31	66.0
Lending rice	10	21.3
Support from traditional leaders		
Lending money	9	19.1
Rice	5	10.6
Government aid		
Basic food	25	53.2
BPJS	19	40.4
PKH/BPNT	9	19.1
Not receiving government assistance	11	23.4
Caregiver visit posyandu		
Monthly	30	63.8
Rarely	17	36.2
Participation in Rumah Gadang		
Active	28	59.6
Inactive	19	40.4

Approximately 85.1% of families regularly fed instant noodles to their children, and only 14.9% did not. This reflects limited access to nutritious food, children's food preferences, time constraints, economic factors, and inappropriate caregiving practices. In terms of income, 72.3% of families earned ≤ Rp2,000,000 per month, and 19.1% earned ≤ Rp1,000,000. These economic limitations pose significant challenges in providing nutritious food. Housing structure also reflects social dynamics. A total of 83% lived in single-family homes, while 17% lived in multigenerational households. Only 29.8% maintained the habit of eating at relatives' homes (extended family support), indicating that this cultural practice is fading, reducing traditional food security support systems.

Husband involvement in caregiving was low, with only 25.5% of families receiving support from their husbands. In contrast, support from extended families was relatively strong, with 61.7% receiving rice, 68.1% receiving money, and 72.3% receiving vegetables. Informal support also came from neighbors (66% for vegetables and 21.3% for lending rice). Support from traditional leaders (ninik mamak) was minimal, with only 19.1% lending money and 10.6% providing rice. This indicates a shifting focus of ninik mamak from the extended to the nuclear family.

In terms of formal interventions, 53.2% received government food aid, 40.4% had BPJS, and only 19.1% received PKH or BPNT. Still, 23.4% of families received no government aid at all, pointing to weaknesses in targeting and distribution systems.

Regarding health services, 63.8% of caregivers visited Posyandu monthly, while 36.2% visited it rarely. Cultural participation was also high, with 59.6% of respondents actively involved in *rumah gadang*, indicating a potential for community-based caregiving interventions rooted in local values.

However, regular Posyandu visits did not significantly impact caregiving practices: 85% still regularly fed instant noodles, indicating that health education at Posyandu has yet to change consumption behavior effectively. Even families receiving support from village midwives continued unhealthy practices.

Feeding instant noodles was not entirely due to poverty—only 19.1% of families earned ≤ Rp1,000,000. Some families earning more than Rp5 million still gave instant noodles, sweets, and chocolates. One child was even cared for by a nutrition-aware Posyandu cadre. This study found that caregivers' reluctance to utilize social support is not just technical, but a complex result of psychosocial, cultural, and structural interactions. Even when accessing health worker support, impacts on stunting-related caregiving remained limited.

Table 2 explains that many caregivers rejected the stunting label due to a belief in hereditary causes. Shame and guilt were dominant emotions, fueled by social pressure and gender bias. Fear of side effects often led to rejection of immunization, which was frequently exacerbated by misinformation and myths. Low health literacy delayed proper intervention.

Patriarchal norms and a lack of father involvement placed all domestic and childcare responsibilities on mothers. Some said they feared being judged as poor caregivers. Even educated or higher-income families relied on instant noodles due to habit or child preference.

Table 2. Limited impact of social support on caregiving for stunted toddlers

Theme	%	Interpretive narrative
Denial of stunting diagnosis	38.3	*"My child is small like the father."*
Shame and guilt	89.3	*"I'm ashamed if people say my child is malnourished."*
Rejection of immunization	23.4	*"They say immunizations cause high fever and seizures."*
Low health literacy	68.1	*"I thought stunting just meant being small."*
Patriarchal norms and helplessness	57.4	*"I care for the child, cook, and help my husband—no time for Posyandu."*
Minimal father involvement	76.6	*"My husband never helps; he says it's my duty."*
Belief in traditional myths	44.7	*"We believe it's caused by palasik, not nutrition."*
Lack of education from health workers	61.7	*"The midwife only told us a few times, so I don't understand."*
Disempowering government programs	70.2	*"We fear the aid might stop suddenly."*
Weak community and traditional leader support	63.8	*"The ninik mamak didn't know my child was stunted."*

Limited and unclear communication from health workers further weakened support. Many believed mystical forces, such as *palasik*, caused stunting. Government programs provided aid without empowering individuals, thereby increasing dependency.

Despite these challenges, there is hope in the solidarity of the extended family. While many challenges stem from cultural norms and structural barriers, transforming caregiving requires both systemic and community-based approaches, rooted in empowerment, inclusion, and local traditions.

DISCUSSION

The results of this study indicate that barriers to utilizing social support among caregivers of stunted toddlers in Nagari Tanjung are multidimensional. The data reveal a complex interaction between individual, family, cultural, and institutional factors that influence the low effectiveness of available social support.

According to [4], social support includes four dimensions: emotional, instrumental, informational, and appraisal. In this context, emotional support is minimal, particularly from husbands. As one caregiver expressed:

"My husband never helps, he says it's my job."

Instrumental support from the Saparuik family is sporadic and unsustainable, despite 34 families receiving vegetables and 32 receiving money. Informational support from health workers is also suboptimal. One caregiver said:

"The midwife only explained stunting a few times, so I didn't really understand."

Appraisal support, or self-assessment encouragement, often leads to guilt:

"I feel ashamed if people say my child is malnourished."

According to [5], child development is influenced by interacting environmental systems. In this study, the microsystem (nuclear family) shows minimal father involvement and weak spousal support. The mesosystem (interlinking environments), which includes connections between health workers, community leaders, and cadres, lacks synergy. The exosystem (policy structure) reveals that aid programs create dependency rather than fostering family resilience. One caregiver said,

"We're afraid if the assistance stops."

The macrosystem (culture) presents barriers, such as the belief in palasik, patriarchal norms, and rigid gender roles:

"We believe it's palasik, not nutrition," or "I can't attend Posyandu because of housework."

A study [6] suggests that most caregivers are at low levels of consciousness, such as shame (<50), guilt (30), and fear (100):

"I'm ashamed if people find out my child is malnourished."

"I'm afraid the assistance will stop."

"I don't know what stunting is."

Effective interventions should aim to elevate this consciousness toward empowerment (courage > 200). A caregiver's statement reflects a shift:

"I used to be afraid of Posyandu, but after frequent visits from cadres, I started asking questions."

The government aid without mentoring only fosters dependency. Parenting transformation requires active participation [7]. One caregiver expressed:

"We received assistance, but we were unaware that it was exclusively for children with stunting."

This emphasizes the need for guidance and caregiver capacity building. According to [8], weakened collective

support from the community, ninik mamak, and neighbors reflects diminished social capital, influenced by village governance that excludes them from stunting programs. Even though 59.6% participate in rumah gadang—an adat-based decision-making hub—their roles have not been optimized to support stunting care.

A study [9] stated that patriarchy dominates parenting, where mothers carry full domestic burdens:

"I take care of the kids, cook, wash clothes, no time for Posyandu."

This highlights gender inequality in households, even within matrilineal cultures such as the Minangkabau. Therefore, fathers must be integrated into the caregiving system. This also found that in Minangkabau, men still dominate household decisions and are often not involved in child-rearing [10].

UNICEF Indonesia found that father involvement improves child care outcomes in nutrition, health, and stimulation. Thus, improving parenting quality requires cultural shifts that actively engage fathers, not just as breadwinners but as co-parents [11].

The rejection of immunization and health education shows resistance to innovation:

"They say after immunization the child may have seizures."

Such rejection arises when innovations conflict with local values [12]. It is essential to emphasize that low nutrition and health literacy remain significant concerns. One-way, non-contextual education becomes a barrier. Culturally dialogic education is necessary [13].

Community social workers in India and the Philippines demonstrate remarkable effectiveness in reducing stunting when supported by supervised local cadres [14]. The Ministry of Social Affairs requires regulations to distribute social workers to the nagari level through PDPS training and structured supervision [15]. The Hungarian Pécs Model, which emphasizes community-based innovation and institutional autonomy, could serve as inspiration [16].

CONCLUSION

To address stunting, the Ministry of Social Affairs must expand Basic Social Work Training (PDPS) to the village or nagari level. This training equips local government officials to act as community social workers and integrate midwives, PKK cadres, Posyandu, KB, PPKBD, Human Development Cadres, PSM, and PKH facilitators in supporting stunting-affected families through a social welfare lens. Ideally, national regulations should enable the deployment of professional social workers to villages based on local needs, utilizing either national or village funds. Every stunted child's family must receive integrated family-based assessments and mentoring tailored to parenting patterns and specific child needs.

Nagari governments should also formulate local regulations (PerNag) to empower families in need through cross-cadre coordination and sustainable mentoring systems. Improving health literacy through culturally and community-based approaches involving fathers and Saparuik families is key. This creates a participatory, sustainable social support system at the nagari level, raising caregivers' awareness and improving stunting prevention practices.

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