

Health Communication Strategy for Stunting Prevention in Kapuas Barat District, Kapuas Regency

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Abstract: This study examines how health communication is planned, implemented, mediated, and received within the stunting-prevention program in Kapuas Barat District, Kapuas Regency. A descriptive qualitative design was conducted at Mandomai Community Health Center. Data were collected through semi-structured in-depth interviews, direct observation, and documentation involving ten informants representing health professionals, health workers, a posyandu leader, village government, pregnant women, mothers of toddlers, and a newly married community member. Data were analyzed through reduction, display, conclusion drawing, and verification. Lasswell's communication model and Rogers' diffusion of innovations theory guided interpretation. The findings show that communication is active but embedded in routine maternal and child health services rather than organized through a written, segmented, and outcome-based strategy. Trusted face-to-face interaction through health workers and posyandu actors remains the dominant channel, supported by maternal and child health books, posters, leaflets, and limited digital media. Messages are practical and broadly accepted, but preconception audiences, spouses, and families are reached inconsistently. Knowledge and persuasion are more visible than sustained implementation and confirmation because economic conditions, time, distance, and service access constrain action. The study's original contribution is an integrated diagnostic framework that links Lasswell's five communication elements with Rogers' adoption stages to identify where message delivery fails to develop into stable preventive behavior. The study recommends life-stage audience segmentation, coordinated multichannel reinforcement, stronger local communicators, ethical and non-stigmatizing communication, and outcome-based evaluation.

Keywords: Health communication, Stunting prevention, Community Health

Abstrak: Penelitian ini bertujuan untuk menganalisis perencanaan, pelaksanaan, mediasi, dan penerimaan komunikasi kesehatan dalam program pencegahan stunting di Kecamatan Kapuas Barat, Kabupaten Kapuas. Penelitian menggunakan pendekatan deskriptif kualitatif yang dilaksanakan di Puskesmas Mandomai. Data diperoleh melalui wawancara mendalam semi-terstruktur, observasi langsung, dan dokumentasi dengan melibatkan 10 informan yang terdiri atas tenaga kesehatan, kader posyandu, pemerintah desa, ibu hamil, ibu balita, serta anggota masyarakat yang baru menikah. Data dianalisis melalui tahapan reduksi data, penyajian data, penarikan kesimpulan, dan verifikasi dengan menggunakan model komunikasi Lasswell dan teori difusi inovasi Rogers sebagai kerangka interpretasi. Hasil penelitian menunjukkan bahwa komunikasi kesehatan telah berjalan aktif, tetapi masih terintegrasi dalam pelayanan rutin kesehatan ibu dan anak dan belum didukung strategi komunikasi yang tertulis, tersegmentasi, serta berorientasi pada hasil. Komunikasi tatap muka melalui tenaga kesehatan dan kader posyandu menjadi saluran utama, didukung buku kesehatan ibu dan anak, poster, leaflet, serta media digital yang masih terbatas. Pesan kesehatan umumnya dapat diterima, tetapi jangkauan kepada kelompok prakonsepsi, pasangan, dan keluarga belum konsisten. Tahap pengetahuan dan persuasi lebih dominan dibandingkan implementasi dan konfirmasi berkelanjutan karena kendala ekonomi, waktu, jarak, dan akses pelayanan. Penelitian merekomendasikan segmentasi sasaran berdasarkan tahapan kehidupan, penguatan komunikasi multisaluran, peningkatan peran komunikator lokal, komunikasi yang etis dan tidak menstigmatisasi, serta evaluasi berbasis hasil.

Kata kunci: Komunikasi kesehatan, Pencegahan stunting, Kesehatan masyarakat

INTRODUCTION

Stunting remains a major public-health and human-development problem because it reflects chronic nutritional deprivation during critical periods of growth. In 2024, an estimated 150.2 million children under five were affected by stunting worldwide, showing that progress remains insufficient to meet the 2030 target (UNICEF, World Health Organization, & World Bank Group, 2025). Stunting is associated not only with reduced linear growth, but also with impaired cognitive development, lower educational performance, greater vulnerability to illness, and reduced productivity in adulthood (Victora et al., 2021). Its consequences therefore extend beyond the health sector and affect the long-term quality of human resources and sustainable development.

The determinants of stunting are multidimensional. Maternal nutrition, infant and young-child feeding, infection, sanitation, household food security, access to health services, education, and socioeconomic conditions interact over time. Because these factors are embedded in everyday family and community practices, clinical and nutritional interventions alone are insufficient. Prevention also requires people to understand risks, trust the source of information, interpret recommendations correctly, and apply healthy practices consistently. Health communication is therefore a central mechanism for connecting public policy and health services with decisions made in households (Schiavo, 2014).

Effective health communication is more than the delivery of information. It involves the systematic selection of communicators, messages, channels, audiences, timing, and desired effects. Messages must be understandable and culturally relevant, while communication should allow dialogue, clarification, and repeated reinforcement. Health literacy is especially important because people need not only to receive information, but also to access, interpret, evaluate, and use it in practical decisions (Nutbeam & Lloyd, 2021). When messages are too general, overly technical, or disconnected from daily constraints, increased awareness may not develop into sustained behavior.

Indonesia has placed stunting reduction within national development and health policy. Presidential Regulation No. 72 of 2021 requires accelerated action for adolescents, prospective brides and grooms, pregnant women, breastfeeding mothers, and children aged 0-59 months, supported by convergent action across government levels (Presiden Republik Indonesia, 2021). The 2024 Indonesian Nutritional Status Survey reported that national stunting prevalence declined from 21.5 percent in 2023 to 19.8 percent in 2024. This progress is important, but nearly one in five children under five remains affected, and uneven local implementation still requires context-specific communication and service strategies (Kementerian Kesehatan Republik Indonesia, 2025).

Kapuas Barat District presents a relevant local setting because its communities are predominantly rural, access to services and information varies, and the Mandomai Community Health Center serves eleven villages and one urban village. Health workers and posyandu actors have implemented maternal and child health services, growth monitoring, education, and family assistance. Nevertheless, differences in participation, educational background, economic capacity, and geographical accessibility affect how messages are received and practiced. The local challenge is therefore not simply whether communication occurs, but whether it is planned, segmented, repeated, and supported by channels that reach different groups.

Recent Indonesian research confirms that health communication contributes to stunting prevention through interpersonal, group, outreach, print, and digital channels, but it also reveals recurring weaknesses in planning, evaluation, cadre capacity, family involvement, and equitable participation (Ridho et al., 2023; Suminar et al., 2023; Maranditya et al., 2025; Sukmawati et al.,

2025). These studies establish the value of community-based communication, yet they often examine communication activities, communicator roles, or knowledge outcomes separately. Less attention has been given to how communicator, message, channel, audience, and effect operate as one system across the stages from first exposure to sustained adoption. A further gap concerns preconception audiences, spouses, and household decision makers, although prevention should begin before pregnancy and requires support beyond mothers who already attend health services.

This study addresses those gaps by analyzing how health communication is planned, delivered, and received within the stunting-prevention program in Kapuas Barat District. It asks how messages and channels are selected, how different community groups understand and respond to them, and how communication contributes to knowledge, decisions, practices, and continued participation. The study's novelty lies in combining Lasswell's structural communication model with Rogers' diffusion of innovations framework in a single empirical diagnostic. This integration distinguishes the availability of communication from the quality of audience segmentation and from progress across knowledge, persuasion, decision, implementation, and confirmation. It also produces practical indicators that local health and village actors can use to identify where communication loses continuity before preventive behavior becomes stable.

Lasswell's model explains communication through five interrelated questions: who communicates, what is said, through which channel, to whom, and with what effect (Lasswell, 1948). In a health program, the "who" dimension concerns the credibility, competence, and social proximity of health workers, cadres, village officials, and other communicators. "Says what" concerns the accuracy, clarity, relevance, and persuasive quality of messages. "In which channel" identifies interpersonal, group, print, and digital pathways. "To whom" requires audience segmentation, while "with what effect" directs attention to changes in knowledge, attitudes, intentions, practices, and health outcomes (Littlejohn et al., 2022).

Rogers' diffusion of innovations theory adds a temporal and behavioral dimension. An innovation is communicated through particular channels over time among members of a social system (Rogers, 2003). Stunting-prevention information can be treated as an innovation when it introduces or reinforces practices such as preconception preparation, antenatal nutrition, exclusive breastfeeding, appropriate complementary feeding, growth monitoring, sanitation, and timely use of services. Adoption develops through knowledge, persuasion, decision, implementation, and confirmation rather than occurring immediately after exposure to a message.

The two frameworks are complementary. Lasswell identifies the structure of the communication process and helps diagnose weaknesses in communicators, messages, channels, audiences, and effects. Diffusion theory explains why the same message may be accepted at different speeds by different groups and why reinforcement, social support, perceived compatibility, and practical feasibility affect implementation. Health literacy links both frameworks by influencing the ability of audiences to understand messages and translate them into decisions (Nutbeam & Lloyd, 2021).

The analytical framework used in this article therefore follows a chain from trusted communicators and contextual messages to accessible channels, segmented audiences, and measurable effects. The expected effect is not limited to increased knowledge. Communication should progressively support positive attitudes, decisions to use preventive services, implementation of recommended practices, and confirmation of those practices as stable family and community norms.

Table 1. Integrated Analytical Framework for Stunting-Prevention Communication

Communicator	Message	Channel	Audience	Effect
Health workers, posyandu actors, village government, and trusted community figures	Maternal nutrition, breastfeeding, complementary feeding, growth monitoring, sanitation, and service use	Face-to-face counseling, posyandu, maternal-child health books, posters, leaflets, village forums, and digital media	Newly married couples, pregnant women, mothers of toddlers, spouses, and families	Knowledge, persuasion, decisions, implementation, confirmation, and sustained preventive behavior

Source: Developed by the authors based on Lasswell (1948) and Rogers (2003).

METHOD

The study used a descriptive qualitative design to obtain an in-depth account of how health communication was planned, implemented, and received in the stunting prevention program. A qualitative approach was appropriate because the study focused on experiences, meanings, interactions, and local implementation processes rather than hypothesis testing or causal estimation (Creswell & Poth, 2018; Merriam & Tisdell, 2015). The research site was Mandomai Community Health Center in Kapuas Barat District, Kapuas Regency. Fieldwork was conducted for approximately four and a half months during 2025.

The participant group consisted of ten informants representing the principal actors and audiences in the program. They included a district professional health-organization leader, health workers, a posyandu leader, a village-government representative, two pregnant women, two mothers of toddlers, and one newly married community member. The article reports participant codes rather than repeating personal names in the analytical sections.

Table 2. Informant Groups and Analytical Roles

No.	Informant Group	Code(s)	Analytical Role
1	Professional health organization	HH	Policy direction and professional perspective
2	Health workers	YN, L	Service delivery and direct health communication
3	Posyandu/community health actor	PB	Community-based communication and participant engagement
4	Village government	KD	Local facilitation, mobilization, and coordination
5	Community recipients	AL, MY, NL, NA, AY	Pregnant women, mothers of toddlers, and a newly married adult

Source: Compiled from the study informant table.

Data were obtained through direct observation, semi-structured in-depth interviews, and documentation. Interviews followed a flexible guide organized around three research questions: communication planning; message and channel selection; and community response, understanding, and acceptance. Observation was used to understand communication in service settings, while documents and program records provided contextual information about the study area and stunting-prevention activities. A mobile phone was used to record interviews and document field activities, and the collected material was organized for analysis.

Analysis followed an interactive process of data reduction, data display, conclusion drawing, and verification. Information was first grouped according to planning, implementation, media and channels, community response, and behavioral effects. It was then interpreted deductively through the five elements of Lasswell's model and the five stages of diffusion described by Rogers. The analysis distinguished the availability of communication activities from evidence of deeper understanding and consistent behavior.

The study is bounded to one district and one community health-center service area. Its findings are intended to explain local processes and implementation mechanisms rather than estimate population prevalence or a causal program effect. Participant codes are used instead of personal names in the analytical sections, and quotations are presented selectively to illustrate dominant patterns and differences between implementers and community recipients. The interpretation also avoids assigning responsibility to mothers alone by examining how economic, geographical, service, and household conditions enable or constrain recommended behavior.

RESULT AND DISCUSSIONS

Program Context and Stunting Monitoring

The stunting prevention program in Kapuas Barat was implemented as part of national and local efforts to integrate nutrition-specific and nutrition-sensitive interventions. At district level, the community health center functioned as the main technical implementer, while village government and posyandu actors supported mobilization, routine growth monitoring, maternal and child health services, education, and assistance to families at risk. Communication was embedded in these activities rather than organized as a separate program component.

Local program documentation showed a substantial gap between the number of target children and those reached through monitoring. In Sei Kayu, 118 of 180 target children were monitored and 26 were identified as stunted. In Saka Mangkahai, 72 of 263 target children were monitored and 15 were identified as stunted. In Mandomai, 132 of 390 target children were monitored and 31 were identified as stunted. Across the three locations, only 322 of 833 target children were monitored. These figures should not be interpreted as prevalence estimates because the monitoring denominator was incomplete; instead, they demonstrate the importance of participation, outreach, and communication in connecting families with routine services.

Table 3. Selected Child-Growth Monitoring Data Reported for 2025

Village	Target Children	Monitored	Monitoring Coverage	Identified as Stunted
Sei Kayu	180	118	65.6%	26
Saka Mangkahai	263	72	27.4%	15
Mandomai	390	132	33.8%	31

Village	Target Children	Monitored	Monitoring Coverage	Identified as Stunted
Total	833	322	38.7%	72

Source: Study documentation based on the 2025 fourth-quarter Nutrition Performance Index report; coverage percentages were calculated from the reported figures.

Communication Planning as an Embedded Activity

Communication planning followed the general maternal and child health program rather than a dedicated communication strategy. Health workers prepared information according to routine service themes, such as nutrition during pregnancy, exclusive breastfeeding, complementary feeding, growth monitoring, and childhood health. The plan was operational: it identified what material would be delivered during a service activity, but did not consistently specify measurable communication objectives, audience segments, channel combinations, reinforcement schedules, or indicators of behavioral effect.

“Counseling and education are already included in the activities, but there is no separate communication plan.” (HH)

HH explained that health education was already included in program activities, but a separate communication plan had not been developed. This finding indicates that communication was recognized as necessary while remaining subordinate to service delivery. The arrangement is understandable in settings with limited staff and time, but it reduces the ability to evaluate whether a message reaches the intended group and produces the desired effect.

At posyandu level, planning was flexible and responsive to problems observed in the field. Cadres adapted their explanations when a child failed to gain weight or when a mother had difficulty understanding feeding recommendations. This contextual responsiveness is a strength because it makes messages immediately relevant. However, reliance on situational judgment can produce inconsistency between villages, sessions, and communicators when there is no shared message map or follow-up protocol.

Audience mapping was also incomplete. Pregnant women and mothers of toddlers were treated as the principal recipients, while newly married couples and other preconception groups received less systematic attention. Village government mainly supported activities designed by the health center and cadres. This pattern confirms that the program had actors and activities, but had not yet integrated them into a communication architecture that clearly assigns roles across the stages from preconception to early childhood.

Strategic health communication requires the program to define the specific behavior expected from each audience, the barriers to that behavior, the most trusted communicator, the message frame, the channel, and the reinforcement mechanism (Schiavo, 2014). In Kapuas Barat, the absence of this structure helps explain why information was repeatedly delivered but behavioral outcomes remained uneven.

Communicators, Messages, and Audience Segmentation

Health workers and posyandu actors were the main communicators. Their credibility came from professional knowledge, direct involvement in maternal and child services, frequent interaction, and social proximity to families. Community recipients preferred direct explanations because they could ask questions and relate the message to the condition of a pregnancy or child. This is consistent with the importance of source credibility and relational trust in community health communication (Schiavo, 2014).

“We explain it slowly so mothers understand and are not afraid to ask.” (PB)

Cadres played a particularly important bridging role. They translated technical information into everyday language and communicated in a less formal setting. PB described a deliberate effort to explain information gradually so mothers would understand and feel comfortable asking questions. Such interaction allows the communicator to observe confusion, adapt examples, and correct misunderstandings in real time.

The most frequent messages concerned maternal nutrition, balanced diets, antenatal care, exclusive breastfeeding, age-appropriate complementary feeding, child weight and height, growth monitoring, and regular attendance at posyandu. These topics address essential practices, but the message structure was often informational and uniform. Participants understood practical instructions more readily than the long-term, multidimensional meaning of stunting. Messages therefore worked better at the level of “what to do now” than at the level of explaining why sustained action matters before pregnancy and throughout the first thousand days of life.

Message uniformity also limited relevance. Pregnant women needed information linked to pregnancy, mothers of toddlers needed feeding and growth-monitoring guidance, and newly married couples needed preconception information. Treating these groups as one audience reduces the opportunity to frame benefits, risks, and recommended actions according to life stage. Tailored communication is more likely to be processed when it reflects the recipient's immediate concerns, literacy, resources, and readiness to act (Hawkins et al., 2008).

Family members and spouses were mentioned as influential because decisions about food, transport, time, and use of services are not always made by mothers alone. Nevertheless, the observed strategy centered largely on women who attended health services. A broader household and community approach would distribute responsibility for stunting prevention and reduce the risk that messages are directed to people who do not control the resources required to act.

Channels and Media Use

Face-to-face communication was the dominant channel. Messages were delivered during antenatal examinations, child weighing, posyandu sessions, health-center visits, and occasional family assistance. YN noted that direct communication made it possible to explain information while providing a service and to respond immediately when recipients did not understand. Interpersonal communication was therefore both a delivery channel and a mechanism for building trust.

Posyandu functioned as the central community communication space. Its value came from routine contact, proximity, and integration of measurement with counseling. Repetition across monthly visits helped mothers remember basic recommendations. However, dependence on attendance created a coverage problem: families who did not regularly come to posyandu were less likely to receive reinforced messages. The monitoring gaps shown in Table 2 illustrate why a service-based communication strategy needs outreach beyond the facility or scheduled meeting.

Print media such as maternal and child health books, posters, leaflets, and information displayed at service sites were used as supporting materials. Informants considered these resources less effective when used without explanation. The finding does not imply that print media are unimportant; rather, their value depends on active use. A health worker or cadre can point to a growth chart, demonstrate a feeding practice, mark an action plan, or ask the recipient to explain the message back in her own words.

Digital media were not used systematically. A newly married participant sometimes obtained information from social media but found that sources were mixed and not always clear. This creates both an opportunity and a risk. Digital channels can reach people who do not attend services, but uncurated content can increase confusion. A local multichannel strategy should therefore combine trusted interpersonal communication with short, verified digital messages distributed through channels already used by residents.

Community Response, Understanding, and Behavioral Effects

Community response was generally positive. Pregnant women and mothers of toddlers valued information that was directly connected to pregnancy, child weight, food, and growth. Understanding improved when communicators used simple language, concrete examples, and repeated explanations. Participants also reported greater awareness of stunting and increased attention to routine monitoring compared with earlier periods.

The depth of understanding nevertheless varied. Many recipients understood practical actions - bringing a child to posyandu, monitoring weight, or providing nutritious food - but did not fully understand stunting as a chronic condition with long-term cognitive, educational, and economic consequences. Information density was another barrier; one pregnant participant found explanations clear but difficult to remember when too many points were delivered at once. Communication therefore needs prioritization, repetition, and visual reinforcement rather than a single comprehensive explanation.

"I only recently learned that stunting prevention can begin before pregnancy." (AY)

The preconception gap was especially visible. AY reported that she had only recently learned that stunting prevention can begin before pregnancy. This indicates that the current audience structure reaches people after a critical preventive stage has already begun. Preconception communication should be included in marriage preparation, village forums, youth and family programs, and routine community channels.

Changes in attitudes and practices were visible but gradual. Some mothers became more attentive to growth measurements, tried to attend posyandu regularly, and adjusted feeding practices. Yet knowledge did not always become consistent behavior. Economic limitations, time constraints, distance, access to services, and competing household responsibilities affected implementation. This knowledge-behavior gap demonstrates that communication cannot be evaluated independently from the conditions that enable or constrain action (Rimal & Lapinski, 2009).

The desired effect should therefore be defined at several levels. Immediate indicators include message comprehension and recall. Short-term outcomes include intention, attendance, dietary changes, and use of maternal and child services. Longer-term outcomes include sustained practices and improved growth. Without this distinction, the program may interpret positive responses during counseling as proof of behavioral change even when follow-through is inconsistent.

Lasswell-Based Synthesis of the Communication Process

The findings show that all five Lasswell elements were present, but they were not equally developed. Communicators were available and trusted; core messages were delivered; interpersonal channels were active; and the principal maternal-child audiences were reached. The main weakness was integration. The program did not consistently connect a specific audience and behavioral objective with a tailored message, channel combination, follow-up schedule, and effect indicator.

Table 4. Synthesis of Findings Using Lasswell's Communication Model

Element	Empirical Evidence	Strength	Limitation	Strengthening Priority
Who	Health workers, posyandu actors, and village support	Professional credibility and social proximity	Roles depend on routine service and individual initiative	Communication training, shared roles, and supervision
Says What	Nutrition, pregnancy, breastfeeding, and growth monitoring	Relevant practical content	Messages are general and information-heavy	Life-stage messages, simple action points, and benefit-risk framing
In Which Channel	Face-to-face services, posyandu, print materials, and limited social media	Dialogue and immediate clarification	Limited reach beyond regular service users	Coordinated interpersonal, outreach, print, and verified digital channels
To Whom	Primarily pregnant women and mothers of toddlers	Focus on high-priority groups	Newly married couples, spouses, and families are less systematically reached	Audience segmentation from preconception to early childhood
With What Effect	Positive response, increased basic knowledge, and some practice changes	Early awareness and service participation	Understanding and behavior remain uneven	Indicators for comprehension, attendance, practice, and sustained change

Source: Authors' analysis based on interview, observation, and documentation data.

The “effect” dimension is the most important test of whether communication is strategic. The study found evidence of attention, knowledge, and positive attitudes, but only partial evidence of stable implementation. In Lasswell's terms, this means the communication process succeeded in delivering messages but did not yet demonstrate consistent effects across all audience groups. Improvement therefore requires outcome-oriented planning rather than simply increasing the number of counseling sessions.

The findings also support a dialogic interpretation of Lasswell's model. Although the original formulation is often presented linearly, effective community health communication should include feedback. Questions, misunderstanding, local examples, family constraints, and service problems should be recorded and used to revise messages and channels. Feedback transforms communication from one-way instruction into an adaptive program process.

The comparison with prior studies sharpens the contribution of the Kapuas Barat case. Suminar et al. (2023) identified continuous program evaluation as a central need in Garut, while the present findings specify what must be evaluated: audience-stage fit, message comprehension, channel reinforcement, service attendance, and sustained practice. Ridho et al. (2023) showed that multiple communication modes can support prevention; this study adds that the mere availability of several channels is insufficient when they are not coordinated around a defined behavior and follow-up schedule. Sukmawati et al. (2025) emphasized cadre communication skills and family engagement, which is consistent with the bridging role observed here, but the Kapuas Barat data show that individual cadre skill cannot fully compensate for the absence of a shared message map

and referral protocol. The limited involvement of spouses also parallels the gender participation gap reported by Maranditya et al. (2025). Thus, the principal problem is not a complete absence of communication, but weak integration between trusted actors, segmented audiences, adoption stages, and conditions that make action feasible.

Diffusion of Stunting-Prevention Information

From the perspective of diffusion of innovations, the program had progressed most strongly through the knowledge and persuasion stages. Mothers who repeatedly attended services recognized the term stunting, understood several preventive practices, and generally accepted the value of growth monitoring and maternal-child nutrition. Interpersonal communication supported this stage because health workers and cadres could explain the relative advantage of recommended practices and relate them to the condition of a child.

The decision stage was present but uneven. Some recipients decided to attend posyandu more regularly, monitor a child's growth, or change feeding practices. Decisions were more likely when recommendations were simple, compatible with daily routines, and supported by trusted figures. They were less likely when adoption required resources, travel, time, or changes that conflicted with household conditions.

Implementation was partial. Participants described practical changes, but the study also identified barriers that interrupted consistency. Rogers (2003) emphasizes that adoption does not end with an initial decision; individuals continue to evaluate an innovation while using it. Follow-up counseling, reminders, problem solving, and family support are therefore necessary to help recipients continue a practice when difficulties arise.

Confirmation was the least developed stage. Preventive practices had not yet become stable norms across the community, and newly married groups remained at an early knowledge stage. Without continued reinforcement, people may discontinue a practice or revert to previous routines. Confirmation requires repeated positive experience, visible benefits, social approval, and communication that responds to setbacks (Dearing, 2009; Valente, 2012).

Table 5. Diffusion Stages, Observed Status, and Required Communication Response

Diffusion Stage	Observed Status	Evidence	Main Barrier	Communication Response	Suggested Indicator
Knowledge	Moderate to strong among regular service users	Recognition of stunting and basic nutrition/growth messages	Uneven exposure and information overload	Prioritized messages, repetition, and visual explanation	Recall and correct explanation of key actions
Persuasion	Generally positive	Interest increases when messages relate to the mother or child	Long-term risks remain abstract	Concrete benefits, local examples, and trusted messengers	Perceived relevance and intention to act
Decision	Partial and unequal	Some families decide to attend services and follow recommendations	Economic, time, and access constraints	Action planning, family involvement, and referral support	Service attendance and stated action plans

Diffusion Stage	Observed Status	Evidence	Main Barrier	Communication Response	Suggested Indicator
Implementation	Gradual but inconsistent	Some dietary and monitoring practices are adopted	Difficulty sustaining practices	Follow-up, reminders, problem solving, and peer support	Repeated practice over several months
Confirmation	Not yet stable	Healthy behavior has not become a consistent community norm	Limited reinforcement and social support	Community norms, recognition, and continuous feedback	Sustained practice and reduced drop-out

Source: Authors' synthesis based on Rogers (2003) and the study findings.

The diffusion analysis clarifies why increased knowledge should not be treated as the final outcome. Different audience groups were positioned at different stages. Regular posyandu participants often reached persuasion and partial implementation, while newly married participants had only begun to acquire knowledge. A single message or channel cannot support all stages equally. Early-stage audiences need awareness and relevance; decision-stage audiences need practical options; implementation-stage audiences need support; and confirmation-stage audiences need reinforcement and social validation.

This stage-based approach also improves evaluation. Instead of asking only how many people attended counseling, the program can assess where each audience group is located in the adoption process and what barrier prevents progress to the next stage. Such information can guide the choice of message, communicator, and channel and make limited communication resources more effective.

Strengthening a Contextual and Sustainable Communication Strategy

The first priority is to develop a written communication plan linked to the stunting program. The plan should define behavioral objectives for each life stage, map audiences and influential family members, identify barriers, specify core messages, assign communicators, combine channels, and establish a reinforcement schedule. A concise plan can improve consistency without creating an excessive administrative burden.

The second priority is segmentation. Preconception audiences require messages about nutritional preparation, anemia prevention, reproductive health, and early service use. Pregnant women need trimester-relevant guidance, mothers of infants need breastfeeding and complementary-feeding support, and families of toddlers need growth monitoring and responsive feeding. Spouses and other household decision makers should receive messages about resource support, transport, food choices, and shared responsibility.

The third priority is a multichannel approach. Direct counseling should remain central because it is trusted and interactive. It should be reinforced through actively used maternal and child health books, simple visual materials, home or village outreach for families who miss services, and short verified digital messages. The objective is not to replace interpersonal communication, but to extend reach and provide reminders between service contacts.

The fourth priority is communicators' capacity. Health workers and posyandu actors need practical skills in audience assessment, plain-language explanation, teach-back, motivational dialogue, visual demonstration, and referral. Village government and community figures can

support mobilization and social norms, while technical health content remains coordinated with the community health center. A shared message guide can reduce contradictions across actors.

The fifth priority is outcome-based monitoring. Communication records should distinguish exposure, comprehension, persuasion, service use, implementation, and sustained behavior. Monitoring can include attendance by audience segment, missed-service follow-up, simple comprehension checks, reasons for non-adoption, and repeated practice over time. These indicators should be interpreted together with access and socioeconomic constraints so that communication is not blamed for barriers outside its control.

Finally, communication should become a learning cycle. Feedback from mothers, couples, cadres, and village actors should be reviewed regularly to identify confusing messages, inaccessible channels, and practical barriers. The program can then revise content and outreach. This adaptive process is essential because community needs, media habits, and service conditions change over time.

Policy, Implementation, and Ethical Considerations

The regulatory implication is direct. Presidential Regulation No. 72 of 2021 defines prevention as a convergent responsibility that begins with adolescents and prospective brides and grooms and continues through pregnancy, breastfeeding, and early childhood (Presiden Republik Indonesia, 2021). The limited communication received by newly married participants therefore represents not only a channel gap but also a mismatch between local practice and the national life-course approach. At district level, the community health center, village government, posyandu actors, and the stunting-reduction coordination team need a common audience map, agreed messages, referral routes, and a schedule for following up families who miss routine services.

Implementation barriers should be treated as part of the communication design rather than as external excuses. Limited staff time, dependence on posyandu attendance, distance, transport costs, uneven digital access, and household decision-making power affect whether information can be used. A realistic strategy should therefore combine brief counseling with outreach, reminders, family involvement, service referral, and practical options that match local resources. The purpose is to reduce the gap between knowing a recommendation and being able to carry it out.

Ethically, stunting communication should inform and support families without stigmatizing children, blaming mothers, or presenting poverty-related constraints as individual failure. Communicators should protect the confidentiality of growth-monitoring information, use plain and culturally respectful language, verify digital content before distribution, and avoid fear-based claims that may weaken trust. Equity also requires alternative routes for remote families, people with limited literacy, and those who cannot attend scheduled services. These principles strengthen both program legitimacy and the likelihood that recipients will continue recommended practices.

Research Limitations and Implications

The study has several limitations. It was conducted in one district and relied on a small qualitative participant group, so the findings should not be generalized statistically to all communities in Kapuas Regency. The evidence was based primarily on interviews, observation, and program documents and did not include longitudinal measurement of behavior or child-growth outcomes. The study also did not compare villages systematically or measure exposure to individual communication channels.

These limitations provide a focused research agenda. Future studies can combine qualitative interviews with audience surveys, service-attendance data, message-comprehension measures, digital-channel analytics, and longitudinal observation of preventive practices. Comparative research across villages and districts should test whether stage-matched messages and coordinated follow-up improve movement from knowledge to implementation and confirmation. For practice, the community health center should coordinate technical messages and evaluation; posyandu actors should provide dialogue, teach-back, and follow-up; village government should support outreach, transport, and family mobilization; and district stakeholders should monitor coverage and inequity by audience segment. Communication should therefore be treated as a designed, ethical, and evaluated program function rather than an informal addition to routine services.

CONCLUSION

Health communication in the stunting prevention program in Kapuas Barat District was active but remained primarily operational. Communication occurred through maternal and child health services, posyandu, direct counseling, and supporting print materials. Health workers and posyandu actors were trusted communicators, and messages on nutrition, breastfeeding, complementary feeding, growth monitoring, and service attendance were broadly accepted. The program had not yet developed a fully systematic strategy connecting behavioral objectives, audience segments, contextual messages, channel combinations, reinforcement, and effect indicators. Pregnant women and mothers of toddlers were reached more consistently than newly married and preconception groups. Community knowledge and attitudes improved, but understanding was often practical rather than comprehensive, and behavioral implementation remained uneven because communication interacted with economic, time, access, and household constraints. A stronger strategy should begin before pregnancy, involve spouses, families, village institutions, and local health actors, retain trusted face-to-face communication, and use verified multichannel reinforcement. It should also protect confidentiality, avoid blame and stigma, and evaluate progress from exposure and comprehension through implementation and confirmation. By integrating Lasswell's communication elements with Rogers' adoption stages, this study provides a practical and original framework for diagnosing where routine communication succeeds, where it loses continuity, and what local stakeholders can change to support sustained preventive behavior.

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