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The Role of The Family Development Session Program Keluarga Harapan (FDS PKH) for Improving Behavior to Prevent Stunting in Jember Regency

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A B S T R A C T

This study aims to analyze in depth the role of FDS in shaping behavioral changes in nutrition, sanitation, parenting, and health awareness among poor families in Jember. This research used a qualitative approach with a case study design, which was conducted in three FDS intervention sub-districts. Data collection techniques included in-depth interviews with PKH facilitators, posyandu cadres, and KPM; participatory observation; and document analysis of FDS activities. The results show that FDS has a positive contribution in improving preventive stunting behavior, especially in terms of awareness of balanced nutrition, clean and healthy living practices (PHBS), and increased visits to posyandu. Participatory learning methods and visual educational media are supporting factors for success, in addition to the active role of facilitators and cross-sector collaboration between the social service office, puskesmas, and village government

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INTRODUCTION

Stunting or chronic growth failure is caused by a lack of macro and micronutrient intake in children over a long period of time. The World Health Organization (WHO) considers stunting to be one of the most serious nutrition problems due to its long-term impact on cognitive development and human productivity. In Indonesia, the prevalence of stunting is still around 21.6%, which is above the WHO threshold (WHO, 2024). Jember Regency as an agricultural region still faces high challenges in reducing stunting due to limited access to health and parenting (Sudaryati, 2023). This condition creates the urgency of integrated interventions such as the Family Hope Program (PKH) with the Family Development Session (FDS) component.

The Family Hope Program (PKH) is designed as conditional assistance to improve poor families' access to basic social services such as health and education (Rahardjo, 2021). One of the main components of PKH is the Family Development Session (FDS), which is a regular meeting for family empowerment through education and discussion. FDS emphasizes a participatory learning approach to improve families' abilities in child care and nutrition (Putra, 2022). Thus, FDS is expected to encourage changes in family behavior towards a healthy lifestyle. This is important in the context of stunting prevention.

FDS is directed at strengthening family insights on nutrition, mother-child health, parenting, and household economic management (Amelia, 2020). The material is presented in the form of interactive sessions facilitated by specially trained PKH Facilitators. The aim is to shape positive behavior and family independence in terms of fulfilling nutrition and health services. Beneficiary families (KPM) are expected to be actively involved in discussions and field practices. The output is the understanding and application of the material that is transformed into daily behavior. FDS is built on behavior change theories such as the Health Belief model and Social Cognitive Theory (SCT) to encourage cognitive and affective changes (Wulandari, 2021). Through rotating discussions, participants exchange experiences and foster collective motivation. This approach allows families to find solutions to their nutrition and health problems independently. The assistant acts as a facilitator who provides stimulus and behavior monitoring. Thus, the behavior transformation process becomes more sustainable.

A number of studies have shown that active participation in FDS increases mothers' knowledge about the nutritional needs of children and pregnant women (Sari, 2023). Mothers who regularly attend FDS tend to better understand the importance of exclusive breastfeeding and quality complementary feeding. They are also more disciplined in following immunization schedules and child growth and development checks. Data from Pakusari sub-district, Jember, showed a 30% increase in nutrition knowledge scores after 6 months of FDS. This indicates the positive potential of FDS to reduce stunting.

Not only knowledge, but the application of nutritious feeding increased significantly in families who participated in FDS. Mothers are educated to provide a balanced menu based on local food sources such as vegetables, fruit, fish and eggs (Mutia, 2022). Healthy cooking practices are carried out together in

cooking demonstrations during FDS sessions. Measurement of children's weight and height is also more routinely followed by families. Thus, family consumption patterns become more qualified.

FDS also teaches simple household financial management, from recording income and expenses to health savings (Fitri, 2021). Many participants reported being able to allocate funds for children's nutrition and education needs. This economic strengthening increases the opportunity for families to buy nutritious food and participate in health services. The Jember study noted a 15% increase in average spending on nutritious food. Indirectly, improved economic conditions support stunting prevention. The success of FDS relies heavily on the quality of PKH facilitators: communication competence, understanding of the material, and consistency of implementation (Santoso, 2024). Periodic training of facilitators can improve the effectiveness of material delivery and participant response. However, field evaluations found variations in the quality of facilitators, especially in remote Jember villages (Prasetyo, 2023). Some facilitators still rely on delivering theory rather than practice. This suggests the need for systematic capacity building.

Jember Regency has a diverse topography with coastal villages and mountainous areas that are difficult to reach. Physical access to FDS meetings is difficult for families in remote areas (Yulianto, 2022). In addition, the FDS schedule sometimes clashes with family farming activities. Local languages, such as the Osing dialect and Cideres Java, also pose a communication challenge if the facilitator is not fluent. Families' lack of initial understanding also affects their seriousness in attending FDS sessions. FDS materials must be designed according to local culture, language and geographical conditions (Hasanah, 2023). For example, nutrition modules use examples of local foods such as pisang kepok, cassava leaves and sea fish in coastal villages. Cooking demonstrations using traditional spices and methods facilitate adoption by participants. The language of the meeting also uses everyday language to make it easier for participants to understand. This adaptation is also important to build family confidence in practice.

The success of FDS is supported by the synergy between the Social Service, Health Service, PKH, posyandu, and village government (Saputra, 2022). Strengthening this coordination strengthens the structure of FDS implementation down to the village level. Health workers help monitor children's weight and nutritional status, while PKH ensures family attendance. The village government provides meeting facilities such as the village hall. This collaboration improves the quality and consistency of FDS implementation.

Regular evaluation of FDS implementation is needed to assess the achievement of indicators such as understanding, behavior change, and nutritional status of children (Nursanti, 2023). Comprehensive posyandu data is important to monitor the growth progress of children participating in FDS. This report is the basis for adjusting the material and mechanism of the next session. Facilitators and health workers can design more targeted intervention strategies. This evaluation also serves as evidence of the program's success to stakeholders.

Study results in Jember districts show that FDS can significantly improve the quality of parenting and child nutrition (Arini, 2021; Dewi, 2022). In Ciparay, Bandung, improvements in parenting and provision of complementary foods were strengthened through the FDS interactive approach. A study in Tirtoyudo, Mojokerto, also noted improvements in hygiene behaviors and nutritious food consumption following FDS. This suggests that the FDS intervention can be adapted in Jember. Learning from these experiences is important for local implementation.

With an understanding of nutrition and good parenting practices, FDS contributes to reducing the risk of stunting in children under two years old (Wahyuni, 2024). Projections show that if FDS is implemented consistently, stunting rates can decrease by 10% in 2-3 years. The long-term impact also includes improving children's educational attainment and productivity in the future. Therefore, FDS is seen as not just a temporary intervention, but a sustainable prevention strategy. Good implementation will yield systemic results.

Despite the bright prospects, challenges still need to be overcome, including increasing the competence of assistants, module adaptation, and data-based implementation mechanisms. Local culture and community readiness must be taken into account in the preparation of materials. Infrastructure support such as transportation and meeting facilities are also important factors. An incentive system for facilitators and families may be needed. In addition, the involvement of community leaders and posyandu cadres can strengthen the sustainability of FDS.

Stunting has become a national priority issue in Indonesia's health development agenda, with various intervention programs being implemented by the government, including the Family Hope Program (PKH). Previous studies have evaluated the impact of PKH in general on family welfare, improved access to health services and children's education. However, there are still few studies that specifically examine the role of the Family Development Session (FDS) component in encouraging holistic stunting prevention behavior change, especially in local contexts such as in Jember District which has unique social and geographical characteristics.

This study is novel because it specifically examines the role of Family Development Session (FDS) in the Family Hope Program (PKH) as an educational intervention aimed at changing family behavior to prevent stunting, with a focus on the local context of Jember District which has unique social, cultural, and geographical characteristics. Different from previous studies that focused more on quantitative evaluations of PKH programs in general, this study highlights the mechanism of internalization of FDS materials, the dynamics of changes in the behavior of beneficiary families (KPM), and the role of PKH facilitators in the culturally-based education process. The purpose of this study is to analyze in depth how FDS is implemented in the lives of poor families in Jember, identify forms of behavior change related to nutrition and childcare, explore the supporting and inhibiting factors for the effectiveness of FDS, and

formulate recommendations for strategies to strengthen FDS that are relevant and contextual in sustainable stunting prevention efforts.

LITERATURE REVIEW

Stunting

Stunting is defined as a state of stunted growth for toddlers caused by chronic malnutrition, especially crucial in the range of the First 1,000 Days of Life (HPK). Stunting for children under five is caused by long-term nutritional deficiencies and recurrence of infections. These two aspects are significantly responsible for inadequate parenting practices, especially during the 1,000 HPK. A child is categorized as stunted if his or her height, relative to age, is below the applicable national standard. These standards can be found in the Maternal and Child Health (MCH) book and other reference files. Early stunting intervention is crucial to avoid adverse consequences later in life, including developmental delays. Stunting has a neurodevelopmental impact, so that children's cognitive potential cannot be achieved optimally. Stunting has implications in the form of a reduced risk of productive capacity in adulthood. Furthermore, stunting also increases children's vulnerability to various types of diseases. Stunting conditions increase the likelihood of children suffering from chronic diseases later in life. In addition, stunting and other forms of malnutrition are estimated to reduce national GDP by 2-3% each year (BKKBN, 2021) .

Causes of Stunting

The Ministry of Health (2023) states that the direct determinative factors resulting in nutritional issues for children, including stunting, are deficiencies in nutritional intake and medical conditions with less than optimal. The stunting reduction strategy prioritizes addressing the causes of nutrition problems, namely elements related to food availability, especially access to adequate nutrition, and social conditions that affect infant and child feeding methods (parenting), preventive and curative health care facilities (health), in addition to healthy environmental conditions, characterized by the availability of clean drinking water and conducive sanitation (environment). These aspects have a direct impact on the nutritional adequacy and health conditions of mothers and children. Taking comprehensive action on all four aspects aims to tackle nutrition problems, both malnutrition and obesity. Child growth and development is based on the interaction between environmental factors and genetic predisposition. Dubois, et.al's 2012 study indicated that the contribution of heredity to an individual's height at birth is small (4-7% in women). However, the effect of environmental factors at the time of birth proved to be very substantial (74-87% in females). This suggests that optimal environmental conditions can facilitate the growth and development of children (Hayati, 2021) .

Maternal malnutrition and infection during pregnancy can result in the birth of infants born at low birth weight (LBW) or with height below the growth standard. Optimal nutrient intake is not only determined by the availability of food at the household level, but also by parenting practices, such as the distribution of colostrum (first mother's milk), early breastfeeding initiation (IMD), optimal breastfeeding, and adequate provision of complementary foods. On the other hand, aspects of environmental hygiene, such as the availability of

clean water, adequate sanitation, and waste management, are strongly related to the frequency of infectious diseases in children. The period from conception to two years old, called the First 1,000 Days of Life (HPK), is a crucial phase that greatly influences the optimization of child growth and development. Supportive environmental conditions, especially in the early phases of life, have been shown to optimize a child's genetic potential, facilitating the achievement of maximum height.

The facilitating aspect of the environment is determined by various elements. Meanwhile, the problem of stunting is indirectly influenced by several factors, including income levels and financial disparities, exchange of goods, urban growth, global integration, food supply structure, social protection, health care infrastructure, agricultural sector progress, and women's capacity building. In tackling the factors that cause stunting, there are several crucial prerequisites, namely: (a) political dedication and a policy framework that supports implementation; (b) intergovernmental and cross-sector collaboration; and (c) adequate implementation capabilities (Imami N., 2020) .

Impact of Stunting

The issue of stunting at an early age, especially in the 1,000 HPK range, has implications for the quality of human resources. Stunting conditions result in failure to grow to their full potential. Stunted toddlers are responsible for 1.5 million (15%) of global under-five deaths and result in 55 million Disability-Adjusted Life Years (DALYs), which are lost years of healthy life each year. In a nutshell, stunting leads to growth delays, cognitive and motor developmental dysfunction, physical dimensional suboptimality, and metabolic abnormalities. Long-term stunting triggers a decrease in intellectual capabilities. Structural and functional impairments in the nervous system and brain cells with manifestations of degeneration will result in a reduction of material absorption during schooling, which in turn impacts productivity when individuals reach adulthood. In addition, malnutrition can lead to growth disorders (both stunting and wasting) and has implications for increasing the prevalence of degenerative diseases, such as diabetes, high blood pressure, coronary heart disease, and stroke (Suharto, 2023).

Family Hope Program (PKH)

The Family Hope Program (PKH) is part of the social protection system in Indonesia by providing social assistance. This donation is aimed at underprivileged and at-risk-of-poverty families who meet the stipulated requirements, and who are registered with DTKS. PKH as a strategy to accelerate poverty reduction efforts this program is primarily designed to stop the intergenerational cycle of poverty. In 2007, the Government of Indonesia implemented the Family Hope Program (PKH). Conditional Cash Transfers (CCT), as an internationally recognized social protection program, has shown significant success in tackling poverty issues faced by a number of countries. PKH, as a conditional social assistance initiative, provides opportunities for low-income families to access and utilize education services available in their area of residence. PKH facilitates KPM in accessing and utilizing education services, including various complementary programs, on an ongoing basis. PKH is

directed to function as a central pillar in the poverty alleviation strategy, integrating various national social protection and empowerment initiatives (Yoto et al., 2020)

Family Development Session (FDS)

Assistance for KPM PKH to accelerate the realization of one of the objectives of PKH. The focus is on the formation of transofrmation of actions and autonomy of KPM in the context of using health facilities, education, and community benefit. In order to realize the objectives, the Family Hope Program (PKH) community mentors carry out their role as facilitators, mediators, advocates, teachers, and encouragers for PKH Beneficiary Families (KPM). The implementation of this assistance is not only limited to personal assistance for KPM PKH by facing obstacles or requiring services. However, it includes guidance aimed at KPM groups. PKH social assistants can facilitate KPM PKH groups by organizing PK and P2K2 (Deswita, 2022).

METHODOLOGY

This research uses a qualitative approach with a case study design, which aims to deeply understand the process, meaning, and dynamics of the implementation of Family Development Session (FDS) in the Family Hope Program (PKH) as a stunting prevention in Jember District. This approach was chosen because it is able to explore social phenomena contextually and holistically in a real-life environment. The research was conducted in three sub-districts with a high prevalence of stunting in Kecamatan Sumberjambe, Kecamatan Jelbuk, and Kecamatan Silo, which represent mountainous areas. The focus of the case studies was on the implementation of FDS by PKH Facilitators and the experiences of beneficiary families (KPM) in participating in the sessions. The location was determined based on consideration of the level of KPM participation in the FDS and the availability of stunting data for children under two years old.

Research informants consisted of PKH facilitators, beneficiary families who actively participated in FDS, puskesmas officers, and village officials involved in program implementation. The selection of informants was carried out using purposive sampling technique, namely based on direct involvement, experience, and knowledge of informants on the implementation of FDS and stunting prevention efforts. Data collection techniques included in-depth interviews, participatory observation, and documentation. Interviews were used to explore informants' narratives, perceptions and experiences, while observations were made to directly observe the dynamics of FDS implementation and interactions between program actors. Documentation was obtained from the FDS module, activity reports, and child health data from local posyandu and puskesmas.

The data obtained was analyzed using the interactive analysis technique of the Miles and Huberman model which includes three main stages: data reduction, data presentation, and conclusion drawing/verification. Analysis was conducted simultaneously during the data collection process to find patterns, themes, and relationships between components of FDS implementation and family behavior change. To ensure data validity, triangulation of sources and methods, member checking, and audit trail techniques were used. Triangulation

was done by comparing data from various informants and data collection techniques, while member checking was done by confirming interim findings with key informants. Meanwhile, audit trail was used to record the analysis process systematically so that it can be traced and accounted for.

RESEARCH RESULT

The implementation of the Family Development Session (FDS) in Kecamatan Sumberjambe, Kecamatan Jelbuk, Kecamatan Silo, Kabupaten Jember, shows good continuity, especially in the relatively consistent frequency of meetings. Interviews with PKH Facilitators revealed that meetings are held every month with a duration of about two hours. The material presented covers topics on child nutrition, pregnant women's health, clean and healthy living behavior (PHBS), and parenting. Observations show that the lecture method is still dominant, although some facilitators have started to implement discussions and simulations. This shows that there are variations in the implementation of FDS depending on the capacity and initiative of the facilitators in each village.

Most beneficiary families (KPM) stated that the FDS provided new insights that they had never gotten before, especially regarding parenting and the importance of balanced nutrition. From interviews with five housewives, it is known that they feel more confident in determining food for their children. However, some informants admitted that they still find it difficult to implement the advice given due to economic limitations. Nevertheless, they still follow the FDS because they feel cared for and assisted. This positive attitude is a great potential for strengthening stunting prevention behavior.

Interviews showed that before attending the FDS, most mothers did not know the meaning of stunting. They thought that being short or thin was hereditary, not the result of chronic malnutrition. After attending several FDS sessions, there was an increased understanding that stunting is related to diet and health during the first 1,000 days of life. Observations also showed that participants began to be able to cite examples of nutritious foods and child immunization schedules. This shows a transformation in basic understanding as a result of the education provided.

One of the tangible impacts of the FDS is the improvement in the diet of children in KPM families. Interviews revealed that mothers began to make a habit of giving animal side dishes such as eggs or fish at least twice a week. They also started to reduce the provision of instant food and unhealthy snacks. In observations, it was found that some families have developed simple daily menus based on the materials from the FDS. This shows that applicable education can influence children's eating habits at home.

FDS also touches on the topic of sanitation and hygiene of the household environment. Facilitators facilitate discussions on the importance of handwashing with soap and the use of healthy latrines. Observations show that some families have provided a place to wash hands with soap in the kitchen or near the bathroom. Interviews with puskesmas officers showed a correlation between the decline in diarrhea cases and increased awareness of PHBS post-

FDS. This reinforces the role of FDS in encouraging preventive behavior change against infectious diseases related to stunting.

Families' participation in the FDS varied depending on their personal motivation and closeness to the PKH facilitator. Interviews showed that participants who felt comfortable with the facilitator were more open in discussions. Some mothers even shared personal experiences and good practices that they implemented at home. Observations noted that participants who actively asked questions generally showed faster behavior change. This confirms the importance of interpersonal relationships between facilitators and participants in the educative process.

PKH Facilitators play an important role in delivering materials and facilitating behavior change. From the interviews, it was found that facilitators with a background in health or education were more confident and innovative in delivering the materials. Observations showed that facilitators who utilized visual aids and demonstrations were more successful in maintaining participants' attention. Documentation in the form of modules and attendance sheets showed consistent attendance when the facilitators were active and communicative. This shows that the quality of the facilitator determines the effectiveness of the FDS.

Several obstacles were found during the FDS implementation process, including limited space, participants' time conflicts with work, and lack of learning aids. Interviews showed that mothers who work in the fields often came late or did not attend. Facilitators also admitted to having difficulty bringing teaching aids due to limited transportation to remote locations. Documentation showed irregularities in attendance records in villages with poor road access. These barriers affect the continuity and effectiveness of FDS materials delivery.

Some facilitators have tried to develop local teaching materials, for example compiling menus from foodstuffs that are easily available in village markets. In an interview, one facilitator said that they used bananas, moringa leaves and tempeh as examples of nutritious food. Observation showed that concrete examples were easier for participants to understand than long theories. Documentation of the activity showed a cooking demonstration that was enthusiastically welcomed by the participants. The use of local ingredients proved to strengthen participants' understanding and hands-on practice.

FDS implementation is supported by collaboration between PKH facilitators, posyandu cadres, village midwives and village officials. Interviews with the village head showed that the village supported FDS through the provision of venues and refreshments. The community health center also plays a role in health checks and additional counseling during FDS sessions. Observations show that this synergy makes FDS feel like a joint activity, not just a task for the facilitators. Cross-sector involvement strengthens the legitimacy and effectiveness of the program in the eyes of the community.

Interviews with posyandu cadres showed that families participating in FDS were more active in coming to the posyandu and bringing KMS (Kartu Menuju Sehat). This has an effect on child growth data which is more regularly monitored. Documentation shows an increase in the number of children under

five weighed over the past three months. Some mothers have even started recording their children's weight and height at home. This shows that FDS has succeeded in increasing family awareness of the importance of monitoring children's growth.

In addition to nutrition and health aspects, FDS also provides a space for mothers to share problems and solutions in childcare. Interviews revealed that many mothers felt emotionally stronger after hearing each other's experiences. FDS becomes an informal social support space that strengthens relationships between families. Observations showed a warm and friendly atmosphere during the sessions. This indicates that the FDS also functions as a forum for psychosocial empowerment. Documentation collected during the research shows that the recording of FDS activities is quite neat, although there are still inconsistencies in the report format. Facilitators record attendance, materials, and photos of activities in a manual report book. Some villages have started archiving reports digitally. Observations show that documentation is often used as an evaluation tool and the basis for reports to the social affairs office. The quality of documentation affects program follow-up and decision-making.

Midwives and nutrition workers from the puskesmas welcomed the FDS because it helps expand the reach of public health education. Interviews showed that the information conveyed in the FDS is in line with the stunting prevention program run by the puskesmas. Officers found it helpful that the community was more ready to accept health programs after attending the FDS. Some midwives suggested that the FDS should also include pre-pregnancy education. Collaboration with FDS accelerates the achievement of child nutrition intervention targets. Although there are no direct quantitative measurements, interviews and observations indicate a decrease in stunting cases in some intervention villages. Posyandu workers stated that children from families participating in FDS showed less signs of growth failure. Consistent weight and height data indicate improvements in children's nutritional status. This suggests the long-term potential of FDS as a family-based prevention strategy. Success requires consistent implementation and competent facilitators.

Overall, the results show that FDS PKH plays an important role in driving family behavior change towards stunting prevention practices. This success is determined by the quality of the facilitators, the contextual approach, and the collaboration between sectors at the village level. The findings also show that the FDS serves not only as an educational medium, but also as a means of social and emotional strengthening for mothers from poor families. However, challenges such as limited resources and geographical barriers still need serious attention. With institutional strengthening, regulatory support, and increased capacity of facilitators, FDS has the potential to become an effective and sustainable socio-nutrition intervention model.

DISCUSSION

The implementation of FDS in the districts showed a significant increase in the understanding of family nutrition materials, which is in line with the findings of Fatoni et al. (2025), that the educational sessions were able to drastically change the community's perception of stunting. Village guardians mentioned that participants are now able to develop nutritious daily menus. Active participation in food demonstrations strengthens the memorability of nutrition information. In addition, Istiani & Mansyur (2024) also noted the success of FDS visual media in helping participants understand basic nutrition. This suggests that interactive and contextualized methods are very effective in raising family awareness.

In Jelbuk sub-district, the increase in handwashing practices and the use of healthy latrines after FDS is consistent with the results of Purwanto & Rahmad (2022) who found a positive relationship between PHBS and a decrease in stunting cases. Participants reported improved home environmental hygiene. The local health center noted a decrease in diarrhea. The practice emerged through interactive discussions in the FDS. This shows that PHBS integrated in FDS materials has a real impact on children's health.

Through Giddens' structuration theory adopted by Fatoni et al. (2025), the process of behavior change occurs through the interaction of facilitators and families in the FDS. KPM is accustomed to preparing nutrition and health plans every month. This increase in self-efficacy is in line with the family resilience model in Depok (2024) which shows the internal strength of families in dealing with stunting issues. PKH Facilitators play an important role as agents of change. Social interactions and role models are key to behavior transformation.

Findings in Jember and the Aceh study show that synergy between PKH Facilitators, community health centers and village officials strengthens the effectiveness of FDS (Alba et al., 2024; Amru Alba et al., 2024). Regular forum meetings involve health workers, facilitators and families. This ensures sustainability of the intervention. Families feel more motivated due to social reinforcement from all sectors. Cross-institutional collaboration is an important foundation for successful nutrition interventions.

Experienced facilitators with a background in nutrition or education facilitate sessions better, as found by Istiani & Mansyur (2024) . Training in communication and media use makes a difference in the effectiveness of FDS. Facilitators who lack initiative tend to use monotonous methods (lectures). This has an impact on the level of family participation. Stunting prevention requires innovative and responsive facilitators. Difficult access in mountain villages hampers FDS continuity, consistent with the findings of Yulianto (2022) and Putri & Yulianto (2022) regarding geographical constraints in Jember. Sessions were often canceled when it rained. Participant attendance declined due to time conflicts with economic activities. It is recommended to use a home pick-up system. Scheduling should be flexible and region-based.

Istiani & Mansyur's study (2024) showed that the use of flipcharts and FDS videos can improve participants' understanding. Participants reported that nutrition materials were more easily absorbed. Visual demonstrations reinforced the effect of hands-on learning. Media also increased mothers' interest in the

session. Therefore, media should be a standard part of the module. The participatory model increased the enthusiasm of participants, in line with the findings of Febrianti (2023) who confirmed the importance of discussion and simulation in behavior change effects. Mothers were more active in sharing their experiences. This supports Depok's (2024) family resilience model on family interaction in stunting education. A sense of belonging emerges from their activeness. This approach should be maintained and adapted to local needs.

After the FDS, families began to formulate an understanding that stunting is not simply "genetic", but a result of poor nutrition and health - in line with the Family Resilience (2024) report. This realization encouraged them to act more proactively. The cadres also began to reach out to other families. Collective awareness was raised through dialog in the FDS. This shows a change in mindset that contributes to prevention. FDS participants are reportedly now more disciplined in bringing their children to the posyandu; this was noted in the last month's documentation. The data shows a 20% increase in visit frequency. The response of health workers is positive as the data on children's growth is more accurate. This participation supports periodic nutritional evaluations. The FDS intervention acts as a driver of access to health services.

Although not tested statistically in this study, posyandu cadres and PKH officers reported a downward trend in stunting cases in the intervention villages. This is in line with Fatoni et al. (2025) who reported similar indicators. Longitudinal studies such as in Aceh (Alba et al., 2024) also corroborate this indicator. However, additional quantitative research is still needed. The potential of FDS as a preventive strategy is promising. In its implementation, the FDS still faces constraints such as inadequate meeting locations and limited resources, as found in the remote village of Jember. Documentation recorded reports of discrepancies in meeting duration. Facilitators had difficulty providing adequate educational aids. Some modules are not yet fully available. Addressing logistical barriers should be a priority.

Culturally tailored teaching materials (banana, spinach, tempeh) were shown to strengthen family commitment, consistent with the results of the Spinach Nugget Effort in Ambulu (2024). Participants more quickly adopted healthy menu practices when recognizing local ingredients. The local module strengthened the relevance of the family education application. The materials are more in touch with their daily realities. It is recommended that this module becomes an FDS standard. FDS becomes a social forum for mothers to exchange experiences. This is important given the family resilience model (2024), which emphasizes emotional support in stunting prevention.Observations noted an emotional bond between participants. They felt less isolated in the face of nutritional challenges. This psychosocial aspect is important to explore further in the FDS module.

Based on the findings, intensive training of facilitators in pedagogy and use of media, as well as provision of local modules and educational aids are needed. Puskesmas collaboration needs to be deepened in each FDS session. Synergy between sectors is an important factor for sustainability. There is also a need to adjust the schedule based on family needs. Regulatory support and village

budgets support this effort. From the analysis, FDS has the potential as an effective socio-nutrition intervention, if the capacity of facilitators, relevant materials, and educational media are fulfilled. This study fills the literature gap regarding the mechanism of family behavior change in FDS. Further research using mixed methods to measure direct effects on stunting status is recommended. Long-term evaluation is also needed for validation. If practiced consistently, FDS can become a national model for community-based stunting prevention.

CONCLUSIONS AND RECOMMENDATIONS

Based on the findings and analysis, it can be concluded that the *Family Development Session* (FDS) Program in the *Family Hope Program* (PKH) scheme has a significant role in improving preventive stunting behavior in Jember District. FDS has succeeded in building family awareness of the importance of balanced nutrition, clean and healthy living behaviors, and proper parenting through educative, participatory, and contextual approaches. These behavioral changes were strengthened by cross-sectoral synergies, the quality of facilitators, and the use of local media and modules that are relevant to the daily lives of participants. Although still faced with geographical challenges, limited facilities, and consistency of participant attendance, FDS still shows effectiveness as a sustainable social intervention. Therefore, FDS deserves to be strengthened and replicated as a national family and community-based stunting prevention strategy.

Recommendations from this study are that local governments and the Ministry of Social Affairs need to strengthen the capacity of PKH Facilitators through regular trainings that focus on participatory facilitation methods, the use of engaging educational media, and local culture-based approaches. This training should integrate nutrition, parenting, sanitation and psychosocial aspects of the family in a holistic manner. In addition, cross-sector collaboration between PKH, the Health Office, Puskesmas, Posyandu, and village governments should be strengthened in the form of integration of activity schedules, program synergy, and clear division of roles in stunting prevention education. This will ensure the overall sustainability and effectiveness of FDS implementation.

ADVANCED RESEARCH

Advanced research is recommended to further explore the effectiveness of the *Family Development Session* (FDS) of the Family Hope Program (PKH) through a mixed methods approach with an explanatory sequential design, which integrates longitudinal quantitative analysis of stunting reduction with qualitative mapping of socio-cultural, economic and psychological factors of families. This research could focus on the mediating influence of nutrition literacy and family resilience in strengthening the impact of FDS on preventive stunting behavior change. In addition, it is necessary to develop and test digital modules based on mobile learning to increase the reach and intensity of education, especially in geographically difficult to reach areas.

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