



Nutrition Assistance, Household Economic Relief, and Maternal Well-Being: A Qualitative Study of the Free Nutritious Meal Program in Bekasi, Indonesia

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Abstract. This study examines how breastfeeding mothers perceive the Free Nutritious Meal Program (MBG) as nutrition assistance, household economic relief, and support for maternal well-being in Perwira Village, Bekasi, Indonesia. Using a descriptive qualitative case study design, data were collected through in-depth interviews, observation, and documentation involving three breastfeeding mothers and two posyandu cadres. The data were organized and interpreted through NVivo-assisted coding, data condensation, categorization, and thematic analysis. The findings show that beneficiaries perceived MBG positively because it provided ready-to-consume meals, reduced breakfast expenses, saved preparation time, and eased morning domestic burdens. Mothers also associated the program with better nutritional intake, maternal stamina, perceived breast milk quality, infant health, and stunting prevention. Posyandu cadres played a central role in beneficiary identification, information dissemination, food distribution, data updating, and complaint handling. However, several constraints limited program effectiveness, including monotonous menus, inconsistent food freshness, changing distribution schedules, limited nutrition education, and communication gaps. The study concludes that MBG can strengthen maternal and child welfare when food provision is integrated with nutrition literacy, predictable services, dignified communication, and systematic beneficiary feedback. These improvements are essential for sustainable community-based nutrition policy and household resilience.

Keywords: Breastfeeding Mothers; Household Economic Relief; Maternal Well-Being; Nutrition Assistance; Posyandu Cadres.

1. BACKGROUND

Maternal and child malnutrition remains a multidimensional problem in low- and middle-income countries, where inadequate dietary intake interacts with poverty, education, sanitation, and unequal access to services (Black et al., 2013). Improving maternal and child nutrition requires targeted, affordable, and scalable delivery mechanisms that reach vulnerable groups (Bhutta et al., 2013). Nutrition-sensitive programs can strengthen social protection by addressing poverty, food insecurity, and the caregiving burdens borne by women (Ruel & Alderman, 2013). This is economically important because growth failure in early life has long-term consequences for productivity, income, education, and intergenerational well-being (Hoddinott et al., 2013).

Breastfeeding occupies a central position within this development logic. Breastfeeding contributes to child survival, cognitive development, and maternal health, but its success depends on maternal nutrition, psychosocial support, and household resources (Victoria et al., 2016). Improving maternal, infant, and early childhood nutrition during the first 1,000 days requires dietary diversity, adequate energy intake, and access to nutrient-rich foods (Dewey, 2016). Maternal nutrition is closely linked to neonatal and child health, as pre- and postnatal

deficiencies can impact birth outcomes, infant growth, and subsequent development (Christian et al., 2015). Therefore, food assistance for breastfeeding mothers should not be viewed simply as charity, but as an investment in maternal well-being, child health, and household resilience.

Low food security underscores this issue's health and economic dimensions. Low household food security among pregnant women is associated with psychosocial stress and socioeconomic vulnerability (Laraia et al., 2006). Broader evidence links food insecurity to poorer health outcomes and a higher public health burden, making it a policy issue for health and social protection systems (Gundersen & Ziliak, 2015). A recent review showed that food insecurity during pregnancy and postpartum is associated with stress, poor diet quality, and inequitable access to care (Pasha et al., 2024). Furthermore, maternal food insecurity is associated with poor pregnancy outcomes, particularly mental health problems and gestational diabetes (Bell et al., 2024). Pregnant women experiencing food insecurity often understand healthy eating patterns but are limited by budget constraints, convenience, and the cognitive burden of scarce resources (Zinga et al., 2022). Women are more likely to receive support when services protect dignity, reduce stigma, and are integrated into routine care (Zinga et al., 2024).

Food insecurity before and during pregnancy can also impact postpartum parenting stress and mother-infant bonding, suggesting that nutritional assistance may impact well-being beyond physical intake (Shreffler et al., 2024). Food assistance programs provide useful lessons for designing the Free Nutritional Meals Program. Financial incentives and restrictions in food assistance programs can alter the types of food purchased by low-income households (French et al., 2017). Beneficiaries tend to view food programs positively when they help them obtain healthier foods while remaining practical for household needs (Fagbenro et al., 2022; Rydell et al., 2018). Evidence from the Women, Infants, and Children program suggests that targeted nutrition assistance can improve pregnancy and birth outcomes (Bitler & Currie, 2005; Hoynes et al., 2011). Similarly, research on school feeding frames meal programs as a social safety net that supports consumption and human capital, even when nutritional impacts depend on service quality (Alderman & Bundy, 2012).

In Indonesia, the relevance of qualitative studies on the Free Nutritious Food Program (FBM) is reinforced by ongoing challenges in nutrition and well-being. Determinants of stunting indicate that child nutrition in Indonesia is influenced by maternal health, household socioeconomic status, feeding practices, food systems, and environmental conditions (Beal et al., 2018). Multilevel evidence suggests that child stunting is influenced not only by individual characteristics but also by household and community factors (Mulyaningsih et al., 2021). Maternal education is significantly associated with stunting in children under 2 years of age in

Indonesia, suggesting that household knowledge and skills are crucial for nutritional outcomes (Laksono et al., 2022). Among working mothers, early breastfeeding initiation is strongly associated with exclusive breastfeeding, but breastfeeding success is also influenced by residence, wealth, antenatal care classes, and infant characteristics (Syahri et al., 2024). Meanwhile, dietary diversity is a dominant factor associated with energy intake among breastfeeding mothers, yet many still experience inadequate intake (Santoso et al., 2024).

Based on this debate, the Free Nutritious Meal Program in Bekasi can be studied as a public nutrition intervention with economic implications. The beneficiaries chosen are not passive recipients, but rather actors who interpret whether nutritional assistance reduces household food expenditures, supports maternal stamina, improves perceived breastfeeding quality, and enhances well-being. This study contributes to economic development, human resources, and public service evaluation by explaining how nutritional assistance translates into household economic support and maternal well-being in urban Indonesia.

2. METHOD

This study used a descriptive qualitative design to explore beneficiaries' perceptions of nutritional assistance, household economic support, and maternal well-being. A qualitative design was deemed appropriate because the study aimed to understand beneficiaries' lived experiences, meanings, and interpretations rather than to measure statistical relationships between variables (Creswell & Poth, 2018). This study employed a case study approach, focusing on beneficiaries of the Free Nutritional Lunch Program in Perwira Village, Bekasi City. This approach allows for an in-depth investigation of contemporary social programs in real-world contexts, particularly when the boundaries among the program, beneficiaries, and the local implementation context are closely intertwined (Yin, 2018). The unit of analysis in this study is the perceptions and experiences of breastfeeding mothers who have received or are receiving benefits from the program.

Participants were selected using purposive sampling. Key informants were breastfeeding mothers living in Perwira Village who had knowledge or direct experience with the Free Nutritional Lunch Program. Supporting informants included community health post (Posyandu) cadres who understood the distribution process, beneficiary identification, nutrition education, and technical challenges in program implementation. Data were collected through in-depth interviews, observation, and documentation. In-depth interviews were the primary technique for exploring beneficiaries' perceptions of program benefits, experiences during food distribution, perceived economic assistance, maternal health implications, and barriers to

program delivery. Observations were conducted to understand the social context and program services, while documentation supplemented interview data with relevant notes, program records, and supporting materials.

Data management and analysis were conducted regularly using NVivo as a supporting tool. NVivo was used to organize qualitative data, identify recurring patterns, and support the development of thematic findings; however, interpretation remains the researcher's responsibility. The analytical process followed an interactive qualitative analysis model, including data condensation, data display, and drawing/verifying conclusions (Miles et al., 2014). To ensure data reliability, this study employed source triangulation by comparing information from breastfeeding mothers and Posyandu (Integrated Service Post) cadres. Credibility was strengthened by checking the consistency of interview findings with observations and documentation. Reliability and confirmability were maintained through systematic data coding, transparent categorization, and careful documentation of analytical decisions.

3. RESULTS AND DISCUSSION

Research context and participant characteristics

This research was conducted in Perwira Village, North Bekasi District, Bekasi City, specifically in the Bulak Perwira II area, RW 007. In this context, the Bunga 1 Integrated Health Post (Posyandu) serves as a community-level service point connecting beneficiary identification, information sharing, food distribution, and maternal and child health activities.

Table 1 below summarizes the characteristics of the anonymous participants used in the analysis. The primary informants were breastfeeding mothers who directly received the MBG program or experienced it. Supporting informants were Posyandu cadres who understood beneficiary data collection, outreach, food distribution, and field challenges.

Table 1. Participant characteristics.

Code	Informant status	Role/occupation
IU-1	Main informant	Housewife and content creator
IU-2	Main informant	Housewife
IU-3	Main informant	Housewife
IP-1	Supporting informant	Head of Posyandu Bunga 1
IP-2	Supporting informant	Secretary of Posyandu Bunga 1

At the research site, the MBG program was implemented through relatively structured community mechanisms. First, cadres identified pregnant women, breastfeeding mothers, and toddlers at the neighborhood level. Second, data were compiled through the integrated health service post (Posyandu) and submitted to program organizers. Third, food was distributed

objectives, assessing household practicality, communicating with cadres, and accessing posyandu. The prominence of the word "information" is particularly important because it shows that beneficiaries evaluated the program not only from the food itself, but also from the clarity of messages that accompanied the program. The coding process generated seven main themes: information stimulus, interpretation of MBG benefits, experience of receiving MBG, benefits for breastfeeding mothers, distribution constraints, the role of cadres, and overall perceptions of MBG.

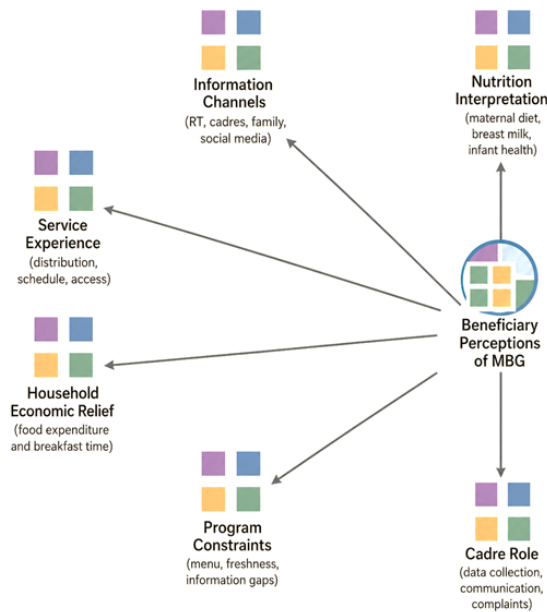


Figure 2. Thematic coding map of MBG beneficiary perceptions.

The first finding shows that beneficiaries generally perceived MBG positively, although their evaluations were not uniform. The program was seen as useful because it provided food support for breastfeeding mothers and helped reduce daily food expenditure. At the same time, positive perceptions were accompanied by critical comments about menu variation, food freshness, schedule clarity, and nutrition information. This finding suggests that beneficiaries were not passive recipients. They actively evaluated the program based on what they consumed, how they accessed it, and whether it matched their needs as breastfeeding mothers.

The initial stimulus about the program came from multiple sources. One informant explained that she first obtained information from the RT officer who visited houses to inform and collect data on potential beneficiaries, while also seeing additional information through social media (IU-1, interview, 12 May 2026). Another informant first heard about MBG from her mother-in-law, who said cadres contacted the family for beneficiary data (IU-2, interview, 12 May 2026). A third informant received information directly from posyandu cadres (IU-3, interview, 13 May 2026). These accounts show that local communication was layered. Formal

channels, such as RT officers and cadres, were complemented by family networks and social media. In the case of IU-2, the information was mediated by the family rather than received directly, illustrating that women's access to program information may depend on their social proximity to local actors.

The informants' initial understanding of MBG was relatively simple. The most memorable phrases were "nutritious and free" and "free meals". IU-1 recalled the program as "nutritious and free" because it was often heard in socialization and media discussions. IU-2 stated that what she remembered most was "free meals" because, for mothers, free food helped reduce household expenses. These expressions are analytically important. They show that, while the program's official aim may relate to nutrition and public health, the most immediate meaning for beneficiaries was receiving food at no cost. This does not mean beneficiaries misunderstood the program. Rather, it shows that their interpretation began with the most concrete benefit: food that could be consumed and savings that could be felt.

As beneficiaries experienced the program, their interpretation expanded. The meals were linked to maternal stamina, breast milk quality, infant health, and reduced food preparation burdens. IU-1 explained that MBG helped improve balanced nutritional intake, including protein and fat, which are considered important for breast milk quality. IU-2 associated the benefits with vegetables, fruit, and protein that supported daily nutritional needs. IU-3 emphasized that what the mother consumed influenced the quality of breast milk and, therefore, the baby's growth. These findings show that beneficiaries connected food assistance to both nutritional and maternal functions.

At the same time, the study found an information gap. IU-3 stated that she was sometimes confused about the detailed nutritional content because notes or explanations did not accompany menus. This indicates that beneficiaries did not only want food; they also wanted understandable information about the food. Nutrition labels, short explanations, or simple educational messages could convert MBG from a food distribution program into a nutrition literacy intervention.

Experience of receiving MBG through posyandu-based distribution

The second finding concerns the daily experience of receiving MBG. Beneficiaries experienced the program as a routine morning activity: coming to posyandu, bringing a food container, following data procedures, receiving food, and assessing whether the menu was suitable. This routine shaped how the program was evaluated. For some informants, the first experience was positive and left them feeling cared for. IU-1 felt surprised and enthusiastic because the program came directly to the community and helped with daily nutritional needs.

IU-3 was happy because, as a breastfeeding mother, she felt recognized by a program focused on maternal nutrition. However, IU-2 reported that her first experience was less satisfying because the chicken dish was not tasty, the rice did not meet expectations, and the menu lacked variation. This shows that first impressions of service quality can influence the emotional acceptance of public programs.

Food distribution was generally facilitated through posyandu. IU-1 considered the process easy because the location was close and she could walk while bringing her own food container. IU-3 also explained that she came directly to the posyandu and followed the existing procedure. Posyandu thus functioned not only as a distribution point but also as a communication space where beneficiaries could receive information, be recorded, and potentially access maternal-child health monitoring. A supporting informant stated that, after MBG was introduced, mothers' participation in posyandu increased because food collection was linked to activities such as weighing and health checks (IP-1, interview, 6 May 2026).

The program was usually received regularly on weekdays. IU-1 initially received MBG from Monday to Saturday, but later only from Monday to Friday. IU-2 received it once a day in the morning, except on Sundays and public holidays. IU-3 also received it regularly from Monday to Friday. This routine had practical consequences for household life. Because food was distributed in the morning, it helped mothers prepare breakfast and reduced the pressure to cook early while caring for children. This finding is relevant to the article's focus on household economic relief because the benefit was not merely financial. It included time, energy, and reduced domestic workload.

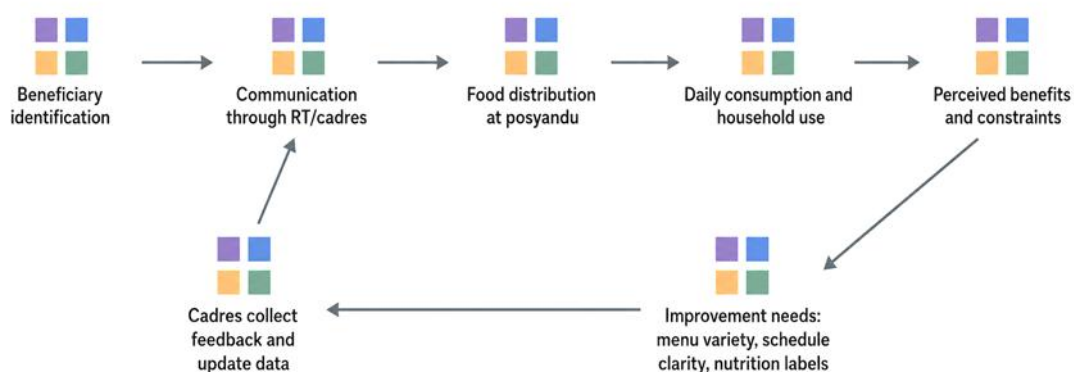


Figure 3. Local implementation pathway and beneficiary experience of MBG.

Figure 3 summarizes the local implementation pathway identified in the data. Beneficiary identification, communication through RT officers and cadres, posyandu-based distribution, daily consumption, and perceived benefits or constraints formed a cycle. The feedback function

of cadres was also important because they collected complaints, updated data, and mediated communication between the community and program implementers.

Benefits for maternal well-being, breastfeeding support, and household economy

The third finding shows that the benefits of MBG were multidimensional. They can be grouped into four categories: nutritional support for breastfeeding mothers; indirect support for infants through improved breast milk quality; household economic relief and reduced domestic work; and increased participation in posyandu activities.

First, beneficiaries perceived MBG as helping them meet their daily nutritional needs. IU-1 stated that the most felt benefit was nutritional intake that supported breast milk production. She associated balanced food, protein, and fat with smoother production and better breast milk quality. IU-3 also stated that the program helped meet nutritious food needs during breastfeeding. These statements indicate that beneficiaries linked program meals to maternal body function, not simply to hunger reduction. However, IU-2 offered a more cautious evaluation: the program helped with breastfeeding, but relying solely on program food was insufficient; nutritious food at home was still needed. This balanced view is important because beneficiaries recognized MBG as supplementary assistance rather than a complete replacement for the household diet.

Second, the program was interpreted as beneficial for infants through the mother. IU-1 linked MBG to stunting prevention because nutritious maternal intake was expected to improve breast milk quality. IU-2 similarly stated that what mothers consumed influenced the breast milk they produced. These interpretations show that mothers understood the interdependence between maternal nutrition and infant well-being. For a program targeting early-life nutrition, this perception is valuable because mothers already possess a basic frame that can be strengthened through clearer education.

Third, beneficiaries emphasized household economic relief. IU-2 said she felt helped because MBG reduced breakfast costs and made mornings lighter by providing food. IU-3 expressed a similar view, explaining that the program helped nutritional intake while reducing the need to prepare breakfast. These statements reveal that the economic meaning of MBG was experienced at the micro-household level. The program reduced small but repeated costs, reduced the time needed to prepare meals, and supported the daily management of caregiving and household work. For breastfeeding mothers who manage both infant care and domestic tasks, ready-to-eat meals have practical value beyond calorie intake.

Fourth, the program contributed to posyandu participation. From the perspective of cadres, the most visible benefit was that mothers became more diligent about attending

posyandu because food collection was linked to posyandu activities. This suggests that MBG can increase attendance at community health services when properly integrated with health monitoring and education. However, this benefit should not remain purely instrumental. Posyandu attendance should be transformed into an opportunity for nutrition counseling, breastfeeding education, and discussions about healthy menus. Otherwise, mothers may attend mainly to obtain food without a deeper understanding of maternal-child health messages.

Program constraints: menu variation, schedule clarity, and nutrition information

The fourth finding relates to obstacles that reduce program satisfaction and effectiveness. The main obstacles were changing or unclear distribution schedules, limited menu variety, inconsistent food freshness, inadequate nutrition education, and uneven understanding among beneficiaries. Schedule inconsistencies emerged repeatedly in interviews. IU-2 explained that the food distribution schedule was not always clear; beneficiaries were often only informed after the food arrived, requiring them to adjust their household chores and caregiving activities. IU-3 also reported that distribution times varied, sometimes around 7 a.m. and other times during the day. Such schedule uncertainty is no small technical issue. For breastfeeding mothers, time management is closely tied to baby care, household chores, and personal rest. Programs that reduce the burden of food preparation can lose some of their value if distribution times are unpredictable.

Variety of menu options was the most prominent complaint among key informants and supporters. IU-1 said the menu was monotonous because it often featured eggs, tofu, or tempeh, while chicken was only served occasionally. IU-2 experienced food that was sometimes not fresh. IU-3 reported that food quality varied, with some items spoiling quickly or tasting unpleasant. The cadres also confirmed that beneficiary enthusiasm depended on the menu. When mothers liked the menu, they were more enthusiastic; when they did not, some did not take the food. This means that menu variety not only affected satisfaction but also participation and consumption.

Lack of nutritional information was another significant obstacle. IU-1 said she received no specific explanation about the benefits of nutritious food for breastfeeding mothers. IU-2 received limited information from her mother-in-law, such as the benefits of katuk (savory spinach), moringa (moringa), and spinach for breast milk, but not from the program. IU-3 searched for information herself online. These findings suggest that the program successfully provided food but did not provide adequate nutritional knowledge. The lack of simple explanations limited the program's ability to generate behavior change beyond the food distribution period.

The final obstacle involved access, distance, and feelings of embarrassment. Although some beneficiaries found the distribution location easily accessible, IU-3 mentioned that her home was relatively far from the integrated health post (posyandu), which sometimes led to scheduling miscommunications. She also initially felt embarrassed and hesitant because she thought she might not deserve assistance. Her discomfort lessened after seeing that many other mothers were also receiving the program.

Cadres as key actors in program communication

The fifth finding confirms that posyandu cadres were central actors in MBG implementation. They conducted beneficiary data collection, delivered information, helped distribute food, updated data, received complaints, and used community forums to reach mothers. IP-1 explained that information was usually delivered through community activities such as arisan, religious gatherings, and RT meetings, as direct face-to-face communication enabled mothers to understand the message and ask questions. IP-2 similarly stated that PKK meetings were effective because women could ask questions immediately if the explanation was unclear.

Cadres, therefore, functioned as community-level health communicators. Their role was not merely administrative. They translated the program into the local language, adopted local schedules, built local trust, and established local routines. However, their role also requires institutional support. Without clear communication materials, cadres may be able to explain procedures but may not systematically convey nutrition messages. Cadres need simple, standardized communication tools that include information on menu content, breastfeeding nutrition, stunting prevention, complaint mechanisms, and schedule updates.

Cadres also helped maintain targeting accuracy. Supporting informants explained that data were collected directly by cadres in each area and updated periodically. This local knowledge is valuable because cadres know which women are pregnant, breastfeeding, or have children under the relevant age category. In this sense, posyandu cadres are not only distributors but also local data actors who support program accuracy and responsiveness.

4. DISCUSSION

The MBG program is not only viewed as a nutrition program but also as a form of household economic assistance. Although the program's tangible outcome is food, beneficiaries interpret it as savings on breakfast expenses, reduced cooking time, and a reduced morning workload. In this study, beneficiaries did not describe the economic assistance in abstract

terms. They described it through their daily routines: no need to buy breakfast, no need to cook early in the morning, and a sense of usefulness in managing household tasks.

This study also showed that breastfeeding mothers interpreted the MBG as supporting maternal well-being. Well-being here includes physical stamina, perceptions of adequate nutritional intake, confidence in the quality of breast milk, and feelings of being recognized as a priority group. Breastfeeding is not only a biological process but also a social and household process that depends on maternal nutrition, family support, time, and access to reliable information. In this study, mothers understood that their food intake affects breast milk and infant health, but they still needed practical nutrition guidance to deepen this understanding.

The link between maternal nutrition, breastfeeding, and child health is supported by global evidence demonstrating the importance of breastfeeding and lifelong maternal-child nutrition (Victora et al., 2016). In the Indonesian context, breastfeeding success is shaped by early initiation, social factors, household resources, and access to services. Therefore, MBG can contribute to maternal well-being not only by providing food but also by strengthening mothers' confidence and practical nutritional knowledge during breastfeeding. The program's impact is likely to be stronger if each food package is accompanied by simple, repeated, and easily understood nutrition messages.

The role of Posyandu (Integrated Service Post) and cadres emerged as central to implementation. Posyandu provides the local infrastructure to integrate food distribution, beneficiary data, maternal and child health monitoring, and interpersonal communication. These findings suggest that MBG should not be separated from the existing public health system. However, the study also cautions that integration with Posyandu must be meaningful. If beneficiaries come to collect food, the program risks remaining a transactional distribution activity. If cadres are trained and supported with communication materials, these same meetings can become moments of health education. This is crucial because beneficiaries trust local cadres and are more likely to understand information conveyed through face-to-face meetings, PKK activities, social gatherings, religious gatherings, and neighborhood-level forums.

The barriers identified in this study demonstrate that acceptance is shaped by service quality. Menu variety, food freshness, taste, clarity of schedules, and dignity are not secondary factors. They directly influence whether beneficiaries take food, consume it, and maintain a positive perception of the program. Beneficiaries in this study appreciated the program, but they also expected food that was fresh, varied, suitable for breastfeeding mothers, and delivered at predictable times.

The issue of shame also underscores the need for food assistance programs to protect dignity. Food support can inadvertently create stigma if framed as charity for poor households. Conversely, when framed as a public nutrition service for priority groups, beneficiaries may feel more entitled, comfortable, and respected.

These findings lead to several practical implications. First, MBG socialization must go beyond technical information. Beneficiaries need to understand why the food is important for breastfeeding mothers, what nutritional components it contains, and how similar healthy eating practices can be continued at home. Second, menu planning should prioritize variety, freshness, safety, taste, and suitability for breastfeeding mothers. Third, distribution schedules should be made more predictable and communicated through easily accessible channels, such as WhatsApp groups, posyandu boards, neighborhood announcements, or messages one day before distribution. Fourth, cadres should receive simple communication guidelines to ensure consistent nutrition messages across neighborhoods. Fifth, beneficiary feedback should be systematically collected and used to improve services.

Nutrition assistance can contribute to human resource development only if the quality of delivery is maintained. Providing food can reduce immediate household burdens, but long-term benefits require nutritional literacy, service reliability, and community trust. In other words, the success of MBG depends on the interaction between material assistance, communication, and local institutional capacity.

5. CONCLUSION

This study concluded that the Free Nutritional Meal Program in Perwira Village, Bekasi, was perceived by breastfeeding mothers as a meaningful form of nutritional assistance and contributed to improving household and maternal well-being. For beneficiaries, the most immediate value of the program lay in its ability to provide ready-to-eat meals while supporting the daily responsibilities of breastfeeding and childcare. Findings indicate that beneficiaries associated the program with improved maternal stamina, perceived breast milk quality, infant health, and stunting prevention. Although mothers understood the relationship between maternal food intake and infant well-being, they also recognized that the program served as supplementary support rather than a complete substitute for household nutrition.

The study also highlighted the strategic role of integrated health posts (Posyandu) and community health workers (cadres) as community-level actors in program implementation. Cadres were crucial in beneficiary identification, information dissemination, food distribution, data updates, and complaint handling. Through face-to-face communication and community

forums, cadres helped translate the program into locally understandable practices. However, several obstacles limited the program's effectiveness and beneficiary satisfaction. These include limited menu variety, inconsistent food freshness, variable distribution schedules, inadequate nutritional information, and potential embarrassment among beneficiaries. These issues demonstrate that service quality, dignity, and clear communication are crucial for the acceptance of nutrition assistance programs.

Overall, the Free Nutritious Food Program has the potential to contribute to household well-being, maternal well-being, breastfeeding support, and community health participation if implemented through reliable service mechanisms and strong community-based communication. Future program improvements should prioritize menu diversity, nutrition labeling, concise educational messages, predictable distribution schedules, capacity building for cadres, and systematic beneficiary feedback.

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