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Description Of The Implementation Of The Simultaneous Measurement And Intervention Program For Stunting Management In The Banguntapan III Public Health Center Area

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ABSTRACT
Stunting was a chronic nutritional problem that affected the growth and development of children in Indonesia. The prevalence of stunting in Indonesia decreased from 24.4% in 2021 to 21.6% in 2022. However, this figure was still above the national target of 14%. The government implemented the Simultaneous Measurement and Intervention Movement to Prevent Stunting program to accelerate the reduction of stunting. This research aimed to describe the implementation of the Simultaneous Measurement and Intervention Program for Stunting Management in the Banguntapan III Public Health Center area. This study used a qualitative descriptive method with research subjects that included the Stunting Reduction Acceleration Team, cadres, health teams, pregnant women, children aged 0-59 months, and prospective brides in the Banguntapan III Public Health Center working area. Data were collected through participatory observation and documentation, and analyzed narratively. The results showed that the implementation of the Simultaneous Measurement and Intervention Program for Stunting Management in the Banguntapan III Public Health Center had been optimal but required improvements in several areas. Despite good coordination, the target number achieved was only 99.12%. Data showed an increase in stunting cases after the program. In April, there were 24 cases of "Short" stunting, which increased to 37 in July, and cases of "Very Short" stunting increased from 0 to 3. Major obstacles included suboptimal toddler sweeping, ineffective cross-sectoral roles, and inadequate socialization. In-depth evaluation and strategy adjustments were necessary to enhance the program's effectiveness. It was recommended to improve toddler sweeping, increase cross-sectoral coordination, and strengthen program socialization through social media and community engagement to enhance the effectiveness of stunting management.

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INTRODUCTION

Stunting was a major issue of nutritional deficiency among toddlers in Indonesia (Martony, 2023). Stunting was a chronic condition where an individual's height was shorter compared to children of the same age, occurring during growth and development from early life

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(Tauhidah, 2020). This condition could damage a child's long-term health and development (Anggraini & Rachmawati, 2021).

In 2022, it was estimated that stunting continued to affect at least 30% of children in 28 countries, with approximately 22.3% of children under five years old being affected, or more than one in every five children. The global prevalence of stunting was expected to decrease from 33% to 23% between 2000 and 2022, reducing the number of affected children from 204.2 million to 148.1 million (UNICEF, 2023). In Indonesia, the prevalence of stunting decreased from 24.4% in 2021 to 21.6% in 2022 (Kemenkes, 2023). However, this prevalence had not met the target for reducing stunting, which was set at 14% (Rokom Kemenkes, 2023).

In 2023, the prevalence of severe stunting in Indonesia was recorded at 5.4%, and stunting was at 12.9% for children aged 0-23 months. In Yogyakarta, the prevalence of severe stunting was 5.0% and stunting was 13.2% (Kemenkes RI & BKPK, 2023). The prevalence of stunting among toddlers in the Special Region of Yogyakarta (DIY) had continued to decrease since 2018, from 21.41% to 16.4% in 2022. The highest prevalence of stunting in DIY was found in Gunungkidul Regency at 23.50%, and the lowest was in Yogyakarta City at 13.8%. In Bantul Regency, the prevalence of stunting reached 14.9% (Dinas Kesehatan DI Yogyakarta, 2022). However, the prevalence of stunting increased to 20.05% in 2023 (Dinas Kesehatan Kabupaten Bantul, 2024). In 2023, Banguntapan III Health Center recorded 23 cases of stunting in toddlers (1.2%). By the second quarter of 2024, the number of stunting cases in toddlers had risen to 25 cases (1.4%) (Puskesmas Banguntapan III, 2024).

Stunting was influenced by various factors, including gender, maternal education level, vaccination history, and bottle feeding (Fatima et al., 2020). Additionally, maternal factors affecting stunting included birth spacing, nutritional status, weight gain during pregnancy, and infection during pregnancy. Child factors influencing stunting included birth weight, gestational age, exclusive breastfeeding, formula milk intake, and severe infections (Suryati et al., 2020). Poor household environments, including lack of access to clean water and sanitation, could also increase infection risks and contribute to stunting (Nshimyiryo et al., 2019).

Stunting was caused by inadequate nutrition during pregnancy and early childhood. Children who experienced stunting might not have reached their maximum height, and their brain development might not have been fully optimal (UNICEF et al., 2021). Stunting conditions usually became apparent after a child turned two years old and could increase the risk of non-communicable diseases in adulthood, such as diabetes mellitus, cancer, heart disease, hypertension, and others (Kemenkes RI & BKPK, 2023).

To accelerate the reduction of stunting, the government implemented the Simultaneous Measurement and Intervention Movement to Prevent Stunting program. This program included comprehensive data collection, weighing, and measurements with standardized tools to ensure accurate data. After that, data verification and nutritional interventions were conducted for pregnant women, toddlers, and prospective brides. Additionally, the program

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focused on community education about the importance of good nutrition to enhance awareness of child and maternal health. This activity involved various ministries, agencies, local governments, and the community to ensure that interventions were carried out comprehensively and sustainably. The goal was for 100% of targets to receive early detection, education, and nutritional interventions to prevent new cases of stunting and achieve a stunting-free Indonesia. The program was also implemented in the Banguntapan III Public Health Center, Bantul Regency, Special Region of Yogyakarta. This research aimed to describe the implementation of this program in the Banguntapan III Public Health Center area.

METHODS

The type of research used in this study was descriptive qualitative research. Descriptive qualitative research methods were employed to describe and understand phenomena, both those occurring naturally and those resulting from human interventions, with an emphasis on characteristics, interconnections between activities, and their quality (Roosinda et al., 2021). The subjects of this research included the Stunting Reduction Acceleration Team, cadres, health teams, pregnant women, children aged 0-59 months, and prospective brides in the Banguntapan III Public Health Center area. The research and program were conducted in the Banguntapan III Public Health Center area across 26 Posyandu. The program and research were carried out from June 1 to June 15, 2024.

The research flow followed the implementation of the program, which included data collection, weighing, measurement, education, verification, intervention, and education for all pregnant women, toddlers, and prospective brides (bride and groom), which will be explained in the results section. Data collection techniques used in this study were participatory observation and documentation. The research instrument used was an observation sheet adjusted to the guidelines for simultaneous measurement and intervention for stunting prevention. The data were analyzed narratively. Narrative analysis was a qualitative data analysis technique that focused on identifying and interpreting stories or narratives that emerged from the data. These stories or narratives could be identified using various methods, such as looking for patterns or structures in the stories, identifying themes or meanings within the stories, and using theories or concepts to interpret the stories (Handoko et al., 2024).

RESULTS AND DISCUSSION

Result

To accelerate the reduction of stunting and demonstrate a strong commitment to guidance, data collection, monitoring, and evaluation, the government launched the Simultaneous Stunting Prevention Intervention Movement. One of its efforts was to increase the coverage of services received by targets. Posyandu played a crucial role as a basic service center, especially in monitoring the growth and development of infants, toddlers, and examining pregnant women, particularly in rural areas, with support from village resources and budgets. As part of this initiative, the government conducted simultaneous measurements and interventions at Posyandu for infants, toddlers, pregnant women, and prospective brides. In

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the Banguntapan III Public Health Center area, this program was carried out at 26 Posyandu over 15 days, from June 1 to June 15, 2024, with activities taking place from 08:30 to 11:30 WIB.

Based on Table 1, which detailed the implementation of the program at each Posyandu in the Banguntapan III Public Health Center area, the total number of toddlers at 26 Posyandu was 1,931. Of this number, 1,914 toddlers had a Health Card. A total of 1,427 toddlers visited and were weighed at the Posyandu, and the same number, 1,427 toddlers, were weighed for two consecutive months, with growth showing improvement on the Health Card.

Table 1. SKDN Posyandu Bangun Tapan III Community Health Center Area

No	Posyandu	S	K	D	N
1	LANUD	122	122	121	82
2	Agung II Plumbon	29	29	29	25
3	Agung III Plumbon	81	81	80	72
4	AGUNG I PLUMBON	86	86	86	84
5	Akasia I Pringgolayan	108	108	106	63
6	Akasia II Pringgolayan	41	41	41	36
7	Anyelir 1 Wonocatur	121	121	120	68
8	Anyelir 2 Wonocatur	181	181	179	166
9	Ceriia Rusunawa	10	10	10	9
10	Dahlia 1 Modalan	33	33	33	25
11	Dahlia 2 Modalan	37	37	37	35
12	Dahlia 3 Modalan	34	34	34	28
13	Flamboyan KARANG bendo	84	84	84	72
14	Glatik Sorowajan	96	96	94	39
15	Kencursai 1 Tegal Tandan	198	198	197	146
16	Kencursai 2 Tegal Tandan	21	21	21	16
17	Mangga 1 Karang Jambe	53	53	53	14
18	Mangga 2 Karang Jambe	78	78	77	44
19	Mangga 3 Karang Jambe	32	32	32	30
20	raflesia 1 Jaranan	30	30	26	14
21	RAFLESIA 2 JARANAN	66	66	66	53
22	Raflesia 3 Jaranan	34	34	34	31
23	Raflesia 4 Jaranan	41	41	41	29
24	Sungai Barito Jomblangan	207	207	205	164
25	Teratai Pelem wulung	88	88	88	70
26	Wijaya Kusuma Plumbon	20	20	20	12
	Total	1931	1931	1914	1427

Info: S = total number of toddlers in the Posyandu area, K = number of toddlers who had a Health Card (KMS) in the Posyandu area, D = number of toddlers who visited and were weighed at the Posyandu, N = number of toddlers weighed for two consecutive months with growth shown to improve on the Health Card.

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Table 2. Stages of the Implementation of the Simultaneous Measurement and Intervention Program at Banguntapan III Public Health Center

Stage	Activities
Planning and Preparation	a. Coordinated the preparation for simultaneous measurement and intervention with cross-sector teams in the Banguntapan and Banguntapan areas. b. Supported the preparation of measurement and intervention activities at the leadership level of Banguntapan. c. Ensured the allocation of budget responsibilities and secured funding for local food recovery through Additional Food Provision. d. Verified the availability of target data and anthropometric tools in accordance with standards and conducted calibration. e. Assessed the skills of the involved cadres. f. Encouraged active participation from relevant cross-sectoral stakeholders. g. Informed pregnant women, families with toddlers, and prospective brides (catin) to attend the Posyandu before the activities..
Implementation	a. a. Invited the community to ensure that pregnant women, toddlers, and prospective brides attended the Posyandu. b. Conducted Upper Arm Circumference (UAC) measurements on pregnant women, Body Mass Index (BMI) and UAC measurements on prospective brides, and weighed and measured the Length/Height (L/H) of toddlers at the Posyandu using standardized tools. c. Visited the homes of pregnant women, toddlers, and prospective brides who did not attend to invite them to the Posyandu or to perform weighing and measurements at home. d. d. Recorded and reported results on the same day. e. Verified data for abnormal measurement results and referred cases to the Public Health Center if necessary.
Recording and Reporting	a. Weighed and measured the L/H of toddlers, weighed and measured the height of prospective brides, and measured UAC on pregnant women and prospective brides. b. Monitored the provision of PMT daily, toddler weight weekly, toddler L/H monthly, and pregnant women's weight monthly. c. Daily reports of the simultaneous measurement and intervention activities for stunting management were submitted in real-time by the Public Health Center nutrition staff through e-PPGBM and by Family Planning Field Counselors (PLKB) to the Stunting Acceleration Team (TPPS) at the sub-district and district levels.
Monitoring and Evaluation	a. Monitored weighing and measurements daily through a dashboard. b. Supervised the implementation of activities at the Posyandu by the village/kelurahan TPPS. c. Conducted evaluations of activities in mid-June and early July.

Based on Table 2, the stages of the Simultaneous Measurement and Intervention Implementation at the Banguntapan III Public Health Center were as follows:

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1. Planning and Preparation: This included coordination, preparation, and socialization to ensure that activities could be carried out effectively.
2. Implementation: This involved organizing attendance, conducting measurements, weighing, and home visits if necessary.
3. Recording and Reporting: This involved documenting measurement results and regularly monitoring the data.
4. Monitoring and Evaluation: This included monitoring the implementation and conducting evaluations to ensure that activities were carried out as planned.

Based on Table 3, it was found that activities at the Posyandu within the Banguntapan III Public Health Center area were carried out through five main steps: registration, weighing and measurement, recording, services for pregnant women with Chronic Energy Deficiency (CED) and toddlers with nutritional problems, and health counseling. Each step involved coordination among cadres, Family Assistance Teams, and healthcare personnel to ensure that all pregnant women, toddlers, and prospective brides (catin) received optimal health services. Based on the research results, community involvement in health intervention activities at the Banguntapan III Public Health Center has proven to be very important. Active participation from various community elements and cross-sectoral collaboration has successfully increased the coverage of health services. This participation involved TPPS members, cross-sector cooperation with the police, military, local government, KUA, cadres, and healthcare personnel. Additionally, Family Planning Field Counselors (PLKB) were also involved. However, there were challenges related to the absence of some targets, especially prospective brides. Proactive steps such as home visits helped achieve nearly perfect coverage. Evaluation showed that the program reached a participation rate of 99.12% for toddlers being weighed. However, the program did not fully meet the set target of 100%.

Based on the data from Table 4, the evaluation of the stunting intervention program showed varying results. In April, before the program began, there were 24 cases of "Short" stunting with no cases of "Very Short." In May, also before the program, the number of "Short" stunting cases increased to 29, while the number of "Very Short" cases remained at 0. During June, when the program was underway, the number of "Very Short" stunting cases rose to 1, with the number of "Short" cases remaining at 29. However, after the program's implementation in July, there was a significant increase in "Very Short" stunting cases to 3, and the number of "Short" cases increased to 37. The increase in both "Very Short" and "Short" stunting cases after the program indicates that despite intervention efforts, challenges still need to be addressed. This highlights the need for in-depth evaluation and adjustment of strategies to improve program effectiveness in reducing stunting in the future.

The analysis results show that the implementation of the Simultaneous Measurement and Intervention Program for Stunting Handling in the Banguntapan III Public Health Center area was not entirely optimal. Key obstacles included suboptimal toddler sweeping, ineffective cross-sector roles, and insufficient socialization about the importance of simultaneous intervention due to limited time. High population mobility also posed an additional challenge. To address these issues, intervention steps will include referring

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toddlers with nutritional problems from the posyandu to the public health center, improving coordination with cross-sectors and local working groups, and managing stunted toddlers according to national medical service guidelines. Additionally, stunting prevention will focus on improving the nutritional status of underweight and wasting toddlers through local supplementary feeding, as stunting is a chronic condition that does not occur suddenly.

Table 3. Steps of Implementation for Simultaneous Measurement and Intervention in Posyandu within the Banguntapan III Public Health Center Area

Step	Activity
Step 1: Registration	Cadres registered the targets who attended, including prospective brides, pregnant women, and toddlers, through an attendance list. For pregnant women and toddlers, recording was also done through the maternal and child health book.
Step 2: Weighing & Measurement	Cadres weighed the weight and measured the height/length of toddlers using standardized and calibrated anthropometric tools.
Step 3: Recording	Cadres, accompanied by public health center personnel, plotted the results of weighing and measurement and explained the conclusions to the targets. Cadres referred pregnant women and toddlers with abnormal results for further follow-up. Public health personnel verified the conclusions of the weight and height/length measurements and referred pregnant women, toddlers, and prospective brides with nutritional issues that required follow-up at the Public Health Center.
Step 4: Service for Pregnant Women with CED & Nutritional Issues in Toddlers	Cadres provided education to pregnant women and toddlers on primary food consumption (such as for pregnant and breastfeeding mothers, babies and toddlers, breast milk, and complementary feeding), and referred pregnant women and toddlers with nutritional issues for additional handling from health personnel, including supplementary food and weight monitoring.
Step 5: Health Counseling	Cadres provided health counseling to pregnant women, families with toddlers, and prospective brides on the importance of balanced nutrition and a healthy lifestyle.

Table 3. Data of Toddlers Weighed in the Banguntapan III Public Health Center Area

Category	Male	Female	Total
Number of Toddlers	1,038	893	1,931
Number of Toddlers Weighed	1027	887	1,914
D/S			99.12

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Table 4. Stunting Data Before, During, and After the Simultaneous Measurement and Intervention Program

No	Posyandu	April		May		June		July	
		Very Short	Short	Very Short	Short	Very Short	Short	Very Short	Short
1	Lanud	0	0	0	0	0	3	1	2
2	Agung II Plumbon	0	1	0	1	0	1	0	1
3	Agung III Plumbon	0	1	0	2	0	1	0	1
4	Agung I Plumbon	0	1	0	1	0	1	0	1
5	Akasia I Pringgolayan	0	0	0	0	0	0	0	3
6	Akasia II Pringgolayan	0	0	0	1	0	1	0	1
7	Anyelir 1 Wonocatur	0	0	0	0	0	0	0	0
8	Anyelir 2 Wonocatur	0	1	0	2	0	1	0	2
9	Ceriia Rusunawa	0	0	0	0	0	0	0	0
10	Dahlia 1 Modalan	0	2	0	2	0	2	0	2
11	Dahlia 2 Modalan	0	1	0	1	0	1	0	1
12	Dahlia 3 Modalan	0	1	0	1	0	1	0	2
13	Flamboyan Karang Bendo	0	0	0	1	0	1	0	1
14	Glatik Sorowajan	0	0	0	0	0	0	0	0
15	Kencursai 1 Tegal Tandan	0	4	0	4	0	2	0	5
16	Kencursai 2 Tegal Tandan	0	0	0	0	0	0	0	0
17	Mangga 1 Karang Jambe	0	1	0	0	0	1	0	1
18	Mangga 2 Karang Jambe	0	1	0	4	1	3	1	4
19	Mangga 3 Karang Jambe	0	0	0	0	0	0	0	0
20	Raflesia 1 Jaranan	0	0	0	0	0	2	0	2
21	Raflesia 2 Jaranan	0	1	0	0	0	0	0	1
22	Raflesia 3 Jaranan	0	1	0	0	0	0	0	0
23	Raflesia 4 Jaranan	0	3	0	2	0	2	0	2
24	Sungai Barito Jomblangan	0	4	0	4	0	4	0	3
25	Teratai Pelem Wulung	0	0	0	1	0	0	1	0
26	Wijaya Kusuma Plumbon	0	1	0	2	0	2	0	2
TOTAL		0	24	0	29	1	29	3	37
TOTAL STUNTING		24		29		30		40	

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Discussion

The research findings indicate that the implementation of the Simultaneous Measurement and Intervention Program for Stunting in the Puskesmas Banguntapan III area was not fully optimal. The evaluation shows that although the program involved good coordination among various community elements and sectors, the target achievement rate was 99.12% instead of 100%. Additionally, the data reveal an increase in the number of stunting cases after the program's implementation. In April, before the program began, there were 24 cases of "Short" stunting and no cases of "Very Short." In May, the number of "Short" cases rose to 29, while the "Very Short" cases remained at 0. During June, while the program was ongoing, the number of "Very Short" cases increased to 1, with "Short" cases remaining at 29. After the program, in July, there was a significant rise in "Very Short" stunting cases to 3 and "Short" cases to 37.

These results suggest the need for a thorough evaluation and adjustment of strategies to enhance the program's effectiveness. Major challenges identified include suboptimal implementation of sweeping for toddlers, ineffective cross-sector roles, and inadequate simultaneous intervention socialization. High population mobility also presents an additional challenge. The intervention steps to be taken include referring toddlers with nutritional problems to the health center, improving coordination with cross-sectoral partners, and managing stunted toddlers according to national medical service guidelines (PNPK). Focus will also be given to improving the nutritional status of underweight and wasting toddlers through local supplementary feeding programs, as stunting is a chronic condition that requires sustained attention.

Stunting is a condition of impaired growth in young children due to chronic nutritional deficiencies, particularly during the first 1,000 Days of Life (HPK). The condition is caused by prolonged inadequate nutritional intake and repeated infections, both of which are influenced by inadequate caregiving, especially during the first 1,000 HPK. A child is classified as stunted if their height-for-age is below the applicable national standard (Kemenkes RI & BKPK, 2023).

Stunting is influenced by various interconnected factors. Firstly, gender plays an important role, with boys being more at risk of stunting compared to girls (Fatima et al., 2020). Additionally, poverty is a major risk factor that increases the likelihood of stunting. Poverty creates an environment that does not support healthy growth and development in children, often leading to nutritional problems and increased risk of disease (Berkefeld, 2019; Deshmukh et al., 2013; Dorsey et al., 2018). Limited access to healthcare services also contributes, as it often results in untreated illnesses and malnutrition (Berkefeld, 2019).

Repeated infections, such as respiratory infections and fever, can trigger stunting by causing inflammation and disrupting nutrient absorption (Dewey & Mayers, 2011; Mutasa et al., 2022). Additionally, parasitic infections have been identified as a major cause of stunting in children, although there is scientific debate regarding the relationship between parasitic infections and stunting (Raj et al., 2022). Stunting in children can lead to delays in gross motor skill development (Setianingsih et al., 2020), and also impacts cognitive abilities. The effects of stunting on cognitive development have been studied, revealing that early childhood

stunting is associated with poor psychological function in late adolescence (Ekholuenetale et al., 2020).

To accelerate the reduction of stunting, the government has implemented the Simultaneous Measurement and Intervention Program for Stunting Prevention. This program includes data collection, weighing, measurement, education, verification, and intervention for pregnant women, toddlers, and prospective brides. Cross-sector collaboration is carried out at all levels, from provinces to villages, to ensure that all targets receive the necessary services (Kemenkes RI et al., 2024). Regional governments play a key role in facilitating cross-sector collaboration by coordinating health services, nutrition programs, and educational initiatives to raise awareness about stunting and its prevention comprehensively (Utomo et al., 2023).

Healthcare workers play a role in preventing growth impediments by increasing vigilance, education, identifying at-risk children, providing growth and nutrition monitoring, and counseling pregnant and breastfeeding mothers (Palapessy et al., 2023). Health cadres, who are trained local community members providing basic health services, can be effective change agents in altering community behaviors related to nutrition and child care (Ekholuenetale et al., 2020). Training health cadres can aid early detection and prevention of stunting, which can have long-term impacts on human resource quality and productivity in stunted children as adults (Mediani et al., 2022).

Major challenges in implementing stunting prevention programs include communication issues and resource limitations, such as staff, information, facilities, and authority (Susilawati et al., 2023). The stunting prevention and mitigation process in Indonesia has not been optimal due to various factors such as the COVID-19 pandemic, limited human resources, funding, and inadequate facilities (Azhara et al., 2023). The stunting program in Indonesia has not been fully effective, and adequate human resources, particularly nutrition experts, are needed to achieve its goals (Zaleha & Idris, 2022).

Successful interventions in reducing stunting require political commitment, multisectoral collaboration, community involvement, and broader program coverage and compliance (Hossain et al., 2017). Engaging community members in the planning and implementation of stunting reduction programs can foster a sense of ownership and accountability. Community participation can enhance the effectiveness of interventions by ensuring they align with local culture and meet local needs. Programs involving parents and caregivers in nutrition education have shown promising results in reducing stunting rates (Utomo et al., 2023)

Collaboration in addressing stunting requires a platform that brings together all relevant parties to discuss stunting issues regularly (Sukanti & Faidati, 2021). This cross-sector collaboration must motivate stakeholders, considering that stunting cases tend to decline and there are no new breakthroughs in handling it (Ipan et al., 2023). A combination of interventions, including nutrition education, growth monitoring, immunization, water, sanitation, hygiene, and social safety nets, can effectively reduce stunting in low- and middle-income countries (Hossain et al., 2017).

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Technology was also utilized as an innovation in stunting prevention to predict the likelihood of toddlers experiencing stunting when their nutritional intake was insufficient (Yuliansyah et al., 2022). For example, the Smart Ting application effectively monitored and mapped stunting among toddlers, contributing to stunting reduction and improving health outcomes in Jember Regency (Selviyanti et al., 2022). The implementation of toddler screening was enhanced by scheduling regular check-ups and utilizing digital reporting technologies to ensure that all toddlers received consistent health assessments (Riatma et al., 2023)

CONCLUSION

The research findings indicated that the implementation of the Integrated Measurement and Intervention Program for Handling Stunting at Puskesmas Banguntapan III was generally effective, achieving a toddler participation rate of 99.12%, but still fell short of the 100% target. Despite the program, stunting cases increased: from April to July, "Short" stunting cases rose from 24 to 37, and "Very Short" stunting cases went from 0 to 3. These results highlighted the need for further evaluation and strategy adjustments, particularly in toddler screening, cross-sectoral coordination, and program socialization. Key challenges included suboptimal toddler screening, ineffective cross-sectoral roles, and inadequate intervention socialization, exacerbated by high population mobility. Suggested improvements included regular check-ups with digital reporting for consistent assessments, forming a coordination team for better cross-sectoral collaboration, strengthening socialization through various communication channels, and creating a registration and reporting system for frequently relocating toddlers to ensure service continuity.

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