



Exploration of Stunting Reduction Program Implementation at Rantau Badauh Community Health Center, Barito Kuala

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Abstract

This study explored the implementation of the stunting reduction program at the Rantau Badauh Community Health Center, Barito Kuala District. A descriptive qualitative design was employed involving ten purposively selected participants, including health center managers, health workers, community health volunteers, mothers of children with stunting, and a district nutrition officer. Data were collected through in-depth interviews and participatory observation and were analyzed using thematic analysis. The findings showed that the program was implemented through structured nutrition interventions, regular monthly evaluations, and financial support from multiple funding sources. Communication and health education were delivered through formal coordination meetings and community-based activities, which improved public understanding of stunting prevention. However, cultural practices related to child feeding, caregivers' occupational demands, and geographical barriers reduced participation in community health activities and adherence to nutrition interventions. Limited nutrition personnel also constrained service delivery, although teamwork and adequate facilities supported program continuity. Cross-sector collaboration among health services, local government, and village authorities strengthened program implementation. Overall, organizational capacity, community behavior, and intersectoral coordination influenced the program's effectiveness. Strengthening human resources and culturally responsive community engagement was considered essential for improving program outcomes.

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Introduction

Stunting remains one of the most important public health challenges in Indonesia despite various national and local interventions aimed at reducing its prevalence. Stunting is closely associated with chronic nutritional deprivation, recurrent illness, inadequate child-feeding practices, and limited access to essential health services, particularly during the first years of life. Its consequences extend beyond impaired physical growth and may affect cognitive development, educational achievement, and future productivity. Although the prevalence of stunting has gradually declined, its persistence in several regions indicates that policy implementation and intervention effectiveness remain important concerns (Fathoni, 2025). National health data further indicate that stunting remains a major public health issue requiring sustained, coordinated interventions across different levels of government and health services (Badan Kebijakan Pembangunan Kesehatan, 2023). Previous studies have also demonstrated that stunting is influenced by interconnected nutritional, social, economic, and cultural determinants rather than nutritional factors alone (Firdausyi et al., 2025). Therefore, reducing stunting requires an integrated approach that considers not only the availability of nutrition interventions but also the social and institutional conditions that determine whether these interventions can be implemented effectively at the community level.

At the local level, stunting also remains an important concern in Barito Kuala District. Local government data concerning children experiencing stunting demonstrate the continuing need for systematic monitoring and coordinated interventions involving health services, local government, and community-level institutions (Kementerian Dalam Negeri Republik Indonesia, 2023). This local context highlights that the availability of stunting reduction policies and programs does not necessarily guarantee their effective implementation. Examining how these programs translate into routine health services and community practices is therefore important for understanding the factors that support or constrain stunting reduction efforts in specific local settings.

Community Health Centers (Puskesmas) have a strategic role in translating national and district-level stunting policies into practical services for families and children. Through growth monitoring, nutritional assessment, supplementary feeding, nutrition counseling, health education, early identification of growth problems, and community-based activities, Puskesmas serve as an important link between government policies and household practices. However, program availability does not automatically guarantee effective implementation. Organizational capacity, communication mechanisms, human resources, financing, infrastructure, community participation, and coordination among stakeholders may influence program effectiveness. Previous research indicates that conventional approaches emphasizing medical and nutritional interventions alone may be insufficient because they often overlook behavioral, cultural, and community participation factors (Tari et al., 2025). Consequently, evaluating stunting reduction requires understanding how formal policies and interventions translate into routine practices and how local communities respond.

Sociocultural factors are particularly important because household traditions, community norms, beliefs, and perceptions about appropriate food and child care influence child-feeding practices. Previous studies have shown that local cultural influences have not always received

sufficient attention in stunting prevention strategies (Meiyenti et al., 2025). Adequate food availability does not necessarily result in appropriate nutritional intake because food selection and feeding practices may be shaped by cultural values and social preferences (Costlow et al., 2025). Caregivers' beliefs about child feeding, household food-sharing practices, and established dietary preferences may therefore influence adherence to nutrition recommendations. In addition, caregivers' occupational responsibilities may reduce their ability to attend community health activities, growth-monitoring sessions, and nutrition counseling. These circumstances show that community participation is not determined solely by awareness but is also shaped by the practical and sociocultural conditions families experience. Accordingly, stunting reduction programs need to adopt communication and engagement strategies that are responsive to local cultural practices and household realities.

Geographical accessibility, human resources, and financial capacity also represent important determinants of program implementation. Families living in geographically dispersed areas may experience difficulties accessing health facilities or regularly participating in community-based health activities because of distance, transportation limitations, or other environmental barriers. Such conditions can affect the continuity of growth monitoring, nutrition counseling, and follow-up interventions. At the organizational level, limited nutrition personnel may increase workloads and constrain health centers' capacity to provide comprehensive services. Nevertheless, teamwork among health workers and community health volunteers can help extend the reach of nutrition programs through community mobilization, monitoring, health education, and identification of children requiring follow-up. Financial support from different sources may also contribute to program continuity by supporting operational activities, nutrition interventions, community engagement, and monitoring. However, effective management, communication, and coordination must support financial resources and facilities to ensure sustainable program implementation. Thus, stunting reduction programs should be examined through the interaction between institutional capacity and the accessibility and participation of the communities served.

Cross-sectoral collaboration is another essential component because the determinants of stunting extend beyond the health sector. Although Puskesmas provide essential nutrition and child-health services, issues involving food security, sanitation, clean water, education, poverty, social protection, and village development require contributions from multiple sectors. Collaboration among health services, district government, village authorities, community health volunteers, and community organizations can strengthen resource mobilization, information sharing, case identification, referral, and follow-up interventions. Nevertheless, an important research gap remains in understanding how organizational, communication, resource, sociocultural, geographical, and intersectoral factors operate simultaneously within specific local settings. Existing studies have frequently focused on stunting prevalence, nutritional determinants, or individual interventions. At the same time, relatively limited attention has been given to the broader implementation process at the Community Health Center level. In particular, the interaction between cultural practices, caregiver occupational demands, geographical barriers, limited nutrition personnel, and cross-sectoral coordination remains insufficiently explored in the context of Barito Kuala District. Examining these dimensions is therefore important for understanding why programs may operate effectively in some aspects while encountering barriers in others.

This study addresses this gap by exploring the implementation of the stunting reduction program at Rantau Badauh Community Health Center, Barito Kuala District, from an integrated organizational and community perspective. The study's novelty lies in examining program implementation not only in terms of the availability of nutrition interventions but also through the interconnected dimensions of policy implementation, communication and health education, organizational and human-resource capacity, sociocultural and geographical barriers, community participation, and cross-sectoral collaboration. Using qualitative exploration of the experiences of health center managers, health workers, community health volunteers, mothers of children with stunting, and district nutrition officers, the study seeks to identify factors that support or constrain program continuity. Accordingly, this study aimed to explore how the stunting reduction program was implemented at Rantau Badauh Community Health Center and to identify the organizational, behavioral, sociocultural, geographical, and intersectoral factors influencing its implementation. The findings are expected to provide contextually relevant evidence to strengthen culturally responsive community engagement, improve human-resource capacity, and enhance collaboration among health services, local government, and village stakeholders in future stunting reduction efforts.

Materials and Methods

Study Design

This study employed a qualitative descriptive design to explore the implementation of the stunting reduction program at the Rantau Badauh Community Health Center, Barito Kuala District. A qualitative descriptive approach was appropriate because it provided a comprehensive description of participants' experiences and perceptions of program implementation in its real-world context. The study followed a policy implementation framework that examined five key dimensions: policy implementation, communication and education, sociocultural and geographical barriers, resource capacity, and cross-sectoral collaboration. These dimensions informed the development of the interview guide and served as the analytical framework during thematic analysis.

We recruited ten participants using purposive sampling based on their direct involvement in the stunting reduction program. Participants included the head of the community health center, nutrition personnel, a midwife, a community health volunteer, five mothers of children with stunting, and one nutrition officer from the District Health Office. Data were collected through semi-structured in-depth interviews and participatory observation. The interviews explored participants' experiences and perceptions related to each implementation dimension, while field observations corroborated the interview findings. The researcher served as the primary research instrument and applied reflexive field notes throughout data collection and analysis to enhance the credibility of the findings.

Research Team and Reflexivity

A researcher with experience in qualitative research and a background in public health conducted the study. Throughout the study, the researcher served as the primary research instrument and maintained direct interaction with participants to understand their experiences and perspectives on implementing the stunting reduction program. To enhance the trustworthiness of the findings and minimize potential researcher bias, the researcher maintained reflexive field notes throughout the research process. In addition, the researcher conducted peer debriefing with

members of the research team to discuss emerging interpretations and ensure consistency between the collected data and the resulting themes.

Participants

Informants were selected using a combination of purposive sampling and snowball sampling to ensure data depth. Participants were categorized into three groups, namely a Key Informant consisting of the Head of the Rantau Badauh Community Health Center (1 person), Main Informants comprising nutrition program managers, midwives, community health volunteers, and mothers of children with stunting in the Rantau Badauh Health Center service area (total of 8 persons), and a Triangulation Informant, which included a technical nutrition officer from the District Health Office of Barito Kuala (1 person). Inclusion criteria included active involvement in stunting-related programs, effective communication skills, and voluntary participation. All participants received detailed information about the study and provided informed consent before data collection, without coercion or financial incentives.

Data Collection

Data were collected between June and July 2024 through semi-structured in-depth interviews, participatory observation, and document review. Semi-structured in-depth interviews were conducted face-to-face with all ten participants and lasted approximately 45–60 minutes. An interview guide was developed based on the study objectives and covered policy implementation, communication and education, resource capacity, sociocultural and geographical barriers, and cross-sectoral collaboration. All interviews were audio-recorded with participants' permission and transcribed verbatim.

Participatory observation was conducted during community health service activities and program implementation to understand interactions between health workers, community health volunteers, and community members. Relevant program documents, including monthly reports, monitoring records, and program guidelines, were also reviewed to corroborate information obtained from interviews and observations. Data collection continued until no new information emerged, indicating data saturation.

Data Analysis

Data were analyzed inductively using thematic analysis procedures. The stages included: (1) familiarization through repeated reading of transcripts, (2) data reduction to select relevant information, (3) coding and categorization into key themes, and (4) concluding cross-verification. Manual coding was applied to identify patterns in participants' responses. Data saturation was reached when no new categories or information emerged from additional interviews.

Trustworthiness and Rigor

Research credibility was ensured through source triangulation and methodological triangulation. Data from different informant levels (management and field implementers) were compared and validated with field observations. Member checking was conducted by presenting key findings back to participants to confirm interpretive accuracy (confirmability). An audit trail was maintained through transcripts, field notes, and photographic documentation of activities.

Ethical Consideration

This study was conducted in accordance with ethical principles in health research. The Health Office of Barito Kuala District granted official research approval under permit number 070/0492/Dinkes/2024. Participant anonymity and confidentiality were strictly maintained through coded identifiers in all research documents. Written informed consent was obtained from all participants after they were informed of their right to withdraw from the study at any time without penalty.

Results and Discussions

Results

Participant Characteristics

The study involved 10 purposively selected participants to evaluate the implementation of stunting reduction programs within the UPTD Puskesmas Rantau Badauh service area. The informants represented a multi-level perspective, ranging in age from 26 to 59 years. The composition included a male Key Informant (IK 1) serving as the Head of the Puskesmas and several Main Informants (IU), including a Nutrition Coordinator, a Midwife, and a Posyandu Volunteer.

To capture grassroots impact and cultural dynamics, five mothers of toddlers with stunting (IU 4 to IU 8) were also interviewed. A Triangulation Informant (IT 1) from the District Health Office's Nutrition Department was also included to verify the synchronization between district-level policy and field-level execution. All participants provided rich, contextual data based on their direct involvement in the stunting intervention programs (Table 1).

Table 1. Demographic Characteristics of Participants

Participant	Gender	Age (Years)	Position/Role
IK (1)	Male	59	Head of Community Health Center Rantau Badauh
IU (1)	Female	42	Nutrition Coordinator, Puskesmas Rantau Badauh
IU (2)	Female	48	Midwife, Community Health Center Rantau Badauh
IU (3)	Female	51	Volunteer Community Health Center Rantau Badauh
IU (4)	Female	42	Mother of Toddler with Stunting
IU (5)	Female	35	Mother of Toddler with Stunting
IU (6)	Female	26	Mother of Toddler with Stunting
IU (7)	Female	37	Mother of Toddler with Stunting
IU (8)	Female	40	Mother of Toddler with Stunting
IT (1)	Female	47	Nutrition Department District Health Office Barito Kuala

Themes Identified

Figure 1 illustrates the thematic framework derived from the data analysis, presenting the main themes, sub-themes, and categories related to implementing the stunting reduction program.

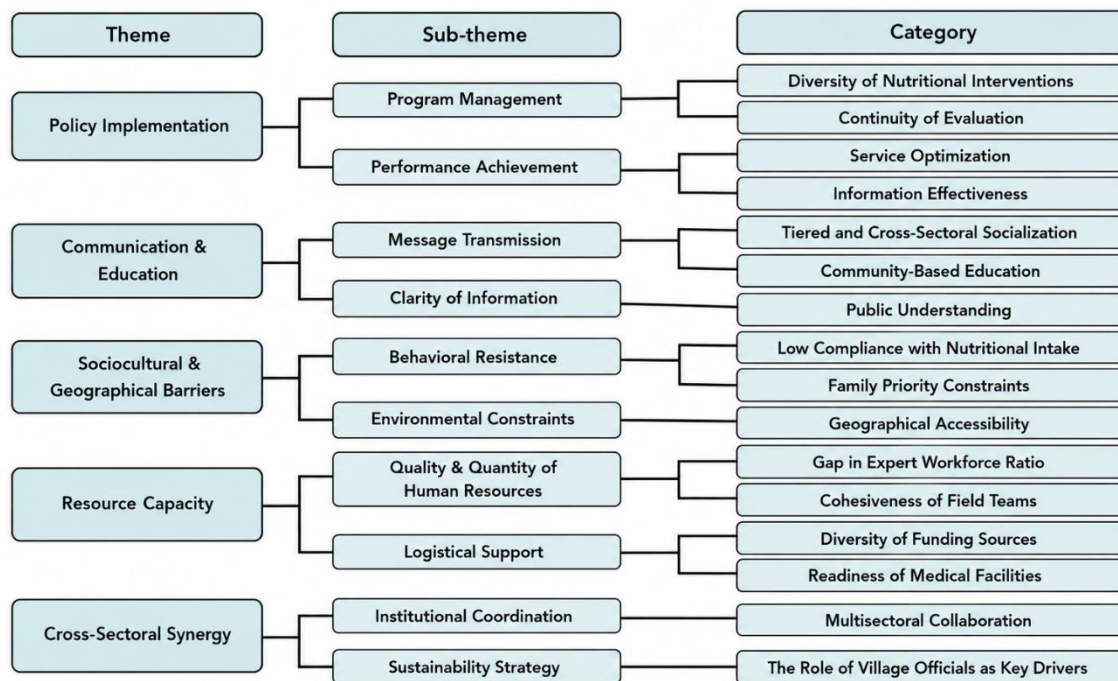


Figure 1. Themes and Categories of Stunting Reduction Program Implementation

Theme I. Policy Implementation

The Rantau Badauh Community Health Center implemented the stunting reduction program through structured management of nutrition-specific and nutrition-sensitive interventions. Activities included child growth monitoring through integrated community health service posts, supplementary feeding, nutritional supplementation for priority groups, and routine monitoring of children identified as at risk of stunting. Monthly program evaluations supported these activities by monitoring implementation progress and identifying operational challenges. As stated by the Head of the Community Health Center:

"We conduct monthly evaluations to identify problems encountered during program implementation and to determine the necessary follow-up actions." (IK 1)

Policy communication was implemented through regular coordination meetings involving health workers, community health volunteers, and village authorities. Most participants reported that the program objectives and implementation procedures were communicated clearly, enabling health workers to perform their assigned responsibilities. However, several participants indicated that consistent communication with community members remained challenging because attendance at community health service activities was often low due to occupational commitments and the distance between villages and health facilities.

Resource availability also influenced program implementation. Although funding from multiple government sources and adequate anthropometric equipment supported service delivery, participants consistently reported that the limited number of nutrition personnel increased workload and reduced the capacity to conduct intensive follow-up activities for all children requiring nutritional monitoring. These findings suggest that while the policy framework was implemented

systematically, its effectiveness was still affected by communication challenges and human resource limitations. Key Informant (IK 1) and Main Informant (IU 3) stated:

"One of the programs is conducting growth monitoring at Posyandu, along with the provision of supplementary foods such as biscuits, milk, and eggs."

This statement indicates the diversity of nutritional interventions designed to support accelerated stunting reduction efforts. In addition, the program was supported by routine and continuous evaluation mechanisms. Evaluation was considered essential to ensuring effective program implementation. As expressed by IK 1 and IU 2:

"Of course, we always conduct evaluations. What is the point of implementing activities without evaluating them? Evaluations are conducted every month."

These regular evaluations served as indicators of continuous program monitoring and institutional commitment to service improvement. Regarding performance achievement, informants perceived that the program had been implemented optimally within available capacity. IU 1 and IK 1 explained:

"It has been implemented optimally, and hopefully the results will also be optimal."

Effective information dissemination to the community further supported successful policy implementation. Clarity of information was considered important in enhancing public understanding of stunting and its prevention efforts. IK 1 and IU 3 explained:

"It is clear, because whenever someone asks, we always provide explanations, and mothers already understand what stunting is."

These findings show that policy implementation focused not only on technical execution but also on strengthening public understanding through effective communication.

Theme II. Communication and Education

Communication and education were identified as essential components in supporting the success of the stunting reduction program. Message transmission was conducted through tiered socialization mechanisms involving cross-program and cross-sector collaboration. IU 1 explained:

"This socialization is conducted through cross-sectoral meetings involving both regional government agencies and cross-program coordination."

This approach demonstrates that information dissemination was conducted systematically by involving multiple stakeholders. In addition to formal meetings, educational activities were also implemented directly through community-based approaches, including maternal classes, Posyandu counseling sessions, and home visits. IU 2 and IU 3 stated:

"Communication is carried out during maternal class meetings and counseling sessions at every Posyandu activity."

Community-based educational approaches were perceived as effective in strengthening relationships between health workers and the community, thereby making health messages easier to understand. This finding was reinforced by IU 5, who stated:

"The information delivered by the Rantau Badauh Community Health Center regarding the stunting reduction program was quite clear."

Therefore, clear and continuous communication played a significant role in building community understanding and participation in stunting prevention programs.

Theme III. Sociocultural and Geographical Barriers

Although the program had been actively implemented, several sociocultural and geographical barriers remained evident. One primary obstacle was low compliance with the nutritional interventions provided to beneficiaries. IK 1 and IU 1 revealed:

"The obstacle is that the supplementary food is sometimes not consumed by the child but instead eaten by the parents, and adolescent girls often do not consume the supplement."

This statement indicates behavioral resistance and limited adherence to supplementation and supplementary feeding programs. Furthermore, the community's socioeconomic conditions also influenced family participation in health service activities. IU 3 stated:

"Parents often do not attend Posyandu at the Rantau Badauh Community Health Center because they are busy. Most people here are farmers and plantation workers."

Occupational demands caused some families to prioritize work activities over participation in Posyandu services. Another identified barrier was geographical accessibility. IU 3 further explained:

"The obstacle is that parents often do not bring their children to Posyandu at Rantau Badauh because their homes are located far away."

These findings indicate that geographical conditions and limited accessibility significantly affected community access to healthcare services.

Theme IV. Resource Capacity

Resource capacity was identified as an important factor in supporting the implementation of stunting reduction programs. In terms of human resources, a disparity remained between the number of nutrition professionals available and the service demands within the health center's working area. IK 1 stated:

"Actually, our staffing is still insufficient because at the Rantau Badauh Community Health Center we only have one nutrition officer, whereas ideally there should be three."

The shortage of nutrition personnel increased workload pressures and potentially affected service optimization. Nevertheless, strong teamwork among field staff continued to support program implementation. IU 1 explained:

"In this stunting reduction effort, we work as teams, and there are approximately five teams involved."

In addition to human resources, logistical and financial support also constituted important aspects of program implementation. Funding for the stunting reduction program was derived from multiple sources, as explained by IU 1 and IU 2:

"The funding sources include central government non-physical Special Allocation Funds (DAK), regional budgets (APBD), Health Operational Assistance Funds (BOK), and Village Funds."

The diversity of funding sources demonstrates government support across multiple administrative levels. Regarding medical facilities, the availability of anthropometric equipment was considered adequate to support child growth monitoring activities. IK 1 stated:

"The anthropometric measuring equipment is already sufficient, and since the equipment is still new, it functions properly."

This finding indicates that the readiness of medical facilities contributed to effective program implementation in the field.

Theme V. Cross-Sectoral Synergy

Strong cross-sectoral synergy also supported implementation of the stunting reduction program. Institutional coordination was carried out through collaboration between the community health center, subdistrict government authorities, village officials, and security personnel. IK 1 stated:

"We collaborate with cross-sectoral parties, including the Subdistrict Head, the military unit (Koramil), village supervisory officers (Babinsa), and the police. Every three months, we conduct joint evaluations."

This multisectoral collaboration demonstrates that stunting management was viewed as a shared responsibility requiring the involvement of various stakeholders. Furthermore, the program's sustainability strategy positioned village officials as key actors in community mobilization. IK 1 explained:

"The solution is to strengthen cooperation, especially with village officials because they are the frontline actors in the field."

These findings indicate that the success of stunting reduction programs depends not only on the health sector but also on institutional support and the active participation of village governments in mobilizing community involvement.

Discussions

The findings reveal five interrelated themes in implementing the stunting reduction program at Rantau Badauh Community Health Center: policy implementation, communication and education, sociocultural and geographical barriers, resource capacity, and cross-sectoral synergy. These themes demonstrate that the interaction between organizational capacity, community behavior, and the broader socio-institutional environment shapes program implementation. Overall, the effectiveness of the stunting reduction program is not solely determined by technical health interventions, but also by communication quality, resource availability, and the strength of multi-sector collaboration.

These findings are consistent with previous empirical studies of maternal and child health programs in low- and middle-income countries, which reported that structured nutrition interventions combined with regular monitoring improved program accountability and service-delivery effectiveness (Martin et al., 2020). Similar evidence from global child nutrition programs shows that integrated primary health care services are critical in improving stunting-related outcomes through continuous evaluation and adaptation of services (Sakti et al., 2022).

Furthermore, these results align with established policy implementation theory, which explains that successful implementation depends on clear communication, resource availability, bureaucratic structure, and implementers' disposition (Dakhi et al., 2026). Previous studies in public health policy also emphasize that periodic evaluation is a key mechanism to ensure program consistency and alignment with policy objectives, particularly in decentralized health systems that are useful for addressing stunting issues (Yusnita et al., 2024).

However, differences were also observed when compared with some previous studies. While previous research highlighted that strong implementation structures directly result in improved nutrition outcomes, this study shows that procedural implementation alone is not sufficient to ensure optimal outcomes (Oyugi & Kallander, 2025). Previous studies also argued that community-level behavior remains a limiting factor in addressing stunting (Doriana & Pardosi, 2026). This shows that even though well-established administrative systems and monitoring mechanisms have been implemented to address stunting, program effectiveness can still vary depending on household behavior and community involvement (Aidillah & Puspitasari, 2025).

Communication and education strategies are key to the program's success, integrated through formal institutional coordination and grassroots empowerment through mother classes, home visits,

and the role of Rantau Badauh Community Health Center cadres. This dual approach reflects an effort to bridge institutional communication with grassroots engagement. This dual approach aligns with previous research showing that behavior change communication is influenced by message clarity, repetition, and trust in the information source (Friando & Sunuantari, 2025). Educational interventions that integrate nutrition-related knowledge with community-based learning have also shown potential in improving knowledge of stunting prevention among community health actors and adolescents (Kusumawati et al., 2025). The involvement of community health workers and cadres has further been shown to strengthen interpersonal communication and facilitate the delivery of health information within community settings (Rahmatillah et al., 2025). Other findings also show that clear, consistent information delivery increases public understanding of stunting (Gebreyohanes & Dessie, 2022).

This study found that sociocultural and geographic factors remain significant barriers to implementing stunting reduction programs. These barriers include low adherence to nutrition interventions, competing household priorities due to work demands, and limited access to health services due to geographic distance.

These findings are consistent with previous empirical studies highlighting the strong influence of social determinants of health on child nutritional outcomes. Similar studies have reported that household economic activities, particularly farming and informal employment, often limit caregivers' time to access health services, resulting in irregular attendance at community health activities (Son & Kayaoglu, 2026). In addition, geographic barriers have been widely documented as a persistent challenge to using rural health services, particularly in geographically dispersed areas (Evans et al., 2022).

However, this study also showed findings that differ from some previous research. While previous studies emphasized that improving service accessibility alone can significantly increase program acceptance, the current findings suggest that increasing accessibility may still be insufficient when cultural practices and household decision-making patterns influence how nutrition interventions are used (Agustina et al., 2025). Other research also emphasizes that the redistribution of supplementary food within families reflects intra-household dynamics that studies focused on service provision do not always capture (Wibowo et al., 2015).

Resource capacity emerged as a critical factor influencing the effectiveness of program implementation. The study found a shortage of nutrition experts, which increases workload pressure and potentially limits service optimization. This finding is consistent with previous studies emphasizing that human resource availability is a key determinant of health system performance, particularly in primary care settings (Ridgely et al., 2020). Similar studies have shown that shortages of nutrition experts often lead to increased workloads, reduced service coverage, and limited capacity for follow-up activities in child nutrition programs (Degefa et al., 2025).

In addition to human resources, the availability of various funding sources, including central government funds, regional budgets, operational health funds, and village funds, indicates strong financial support for the stunting program (Indra & Khoirunurrofik, 2022). Adequate anthropometric equipment also supports accurate growth monitoring and early detection of stunting cases. This aligns with previous research showing that infrastructure readiness contributes to improved service delivery quality, although its impact remains dependent on workforce capacity (Oniyire et al., 2025).

The results highlight that cross-sector synergy plays a crucial role in supporting stunting reduction efforts. Collaboration between the health sector, sub-district governments, village governments, and security agencies demonstrates a multi-stakeholder approach to addressing stunting as a complex public health problem. This finding is consistent with previous studies on collaborative governance, which emphasize that complex public health problems require coordinated action across multiple sectors (Goi et al., 2024). Similar research shows that involving local governments and community-level actors strengthens the reach of stunting programs, increases community engagement, and improves accountability in implementation (Maharani et al., 2025).

Village government involvement: Government officials as frontline actors are important because they serve as the closest administrative link to the community and play a key role in mobilizing and influencing behavior (Dipa & Kus, 2025). Regular coordination meetings and periodic evaluations further strengthen accountability and shared responsibility among stakeholders in addressing stunting (Save the Children Indonesia, 2024).

This study has several limitations that should be acknowledged. First, it was conducted in a single location, the Rantau Badauh Community Health Center (Puskesmas), which may limit the applicability of the findings to other contexts with different geographic, sociocultural, and health system characteristics. Second, the study relied on qualitative data from selected informants, which may introduce subjectivity, recall bias, and social desirability bias in participant responses. Third, the study focused on the program implementation process without examining long-term program outcomes, limiting conclusions about a causal relationship between implementation and stunting reduction. Future research should adopt a mixed-methods approach and expand to different regions to provide a more comprehensive, comparative evaluation of stunting reduction program implementation and its impact on nutritional outcomes.

Conclusion

This study showed that the stunting reduction program at the Rantau Badauh Community Health Center was supported by structured policy implementation, routine communication, and adequate financial resources. However, the program continued to face important challenges, including limited nutrition personnel, low participation in community health service activities because of occupational demands, household food-sharing practices that reduced adherence to supplementary feeding, and geographical barriers that restricted access to health services. These findings indicated that successful program implementation depended not only on communication and resource availability, as emphasized in policy implementation theory, but also on sociocultural practices and sustained cross-sector collaboration at the community level. Therefore, this study extends existing policy implementation perspectives by demonstrating that local cultural context and community engagement are critical determinants of implementation effectiveness in primary health care settings. Future studies should include multiple study sites and mixed-methods approaches to improve the transferability of findings and examine the relationship between implementation processes and long-term reductions in stunting prevalence.

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Conflict of Interest

The authors declare no conflicts of interest regarding the publication of this study.

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