

Community Involvement in Stunting Prevention in Gelangsar Village West Lombok

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Article Info	Abstract
Article history: Received: Revised: Accepted: Available online: Keywords: Community Involvement; Stunting Prevention; Posyandu; Family Participation; Village Empowerment	<i>This study examined community involvement in stunting prevention in Gelangsar Village, Gunungsari District, West Lombok, and identified enabling and constraining factors. A qualitative case study was conducted from February to July 2026. Data were collected through overt observation, structured interviews, and documentation involving village government, health cadres, family assistance personnel, parents, youth, and community members selected purposively until information was considered sufficient. Credibility was strengthened through source and technique triangulation, while analysis followed data collection, reduction, display, and verification. Community involvement took the form of monthly integrated health-post attendance, supplementary feeding, family development and father classes, parental nutrition and caregiving practices, youth health awareness, and collective environmental cleaning. Village records reported 23 stunted children among 224 targeted children in 2025, or 10.27%. Participation was supported by village programs, cadres, health workers, local food resources, and assistance for vulnerable households. Constraints included uneven health information, limited paternal involvement, traditional beliefs, passive participation, low household income, restricted program budgets, and inadequate waste disposal. Sustainable prevention requires shared planning, stronger father and youth engagement, sanitation improvement, continuous education, and community participation in monitoring and evaluation.</i>

Kata kunci:	Abstrak
Keterlibatan Masyarakat; Pencegahan Stunting; Posyandu; Partisipasi Keluarga; Pemberdayaan Desa	Penelitian ini mengkaji keterlibatan masyarakat dalam pencegahan stunting di Desa Gelangsar, Kecamatan Gunungsari, Lombok Barat, serta faktor pendukung dan penghambatnya. Studi kasus kualitatif dilaksanakan pada Februari-Juli 2026. Data diperoleh melalui observasi terstruktur, wawancara terstruktur, dan dokumentasi dengan pemerintah desa, kader kesehatan, Tim Pendamping Keluarga, orang tua, remaja, dan masyarakat yang dipilih secara purposif hingga data dinilai memadai. Kredibilitas diperkuat melalui triangulasi sumber dan teknik, sedangkan analisis meliputi pengumpulan, reduksi, penyajian, dan verifikasi data. Keterlibatan masyarakat diwujudkan melalui kunjungan posyandu bulanan, pemberian makanan tambahan, kelas BKB dan kelas ayah, praktik gizi dan pengasuhan keluarga, pemahaman kesehatan remaja, serta gotong royong lingkungan. Data desa mencatat 23 anak stunting dari 224 sasaran pada 2025 atau 10,27%. Faktor pendukung mencakup program desa, kader, tenaga kesehatan, pangan lokal, dan bantuan bagi keluarga rentan. Hambatannya mencakup informasi tidak merata, keterlibatan ayah

terbatas, kepercayaan tradisional, partisipasi pasif, pendapatan dan anggaran rendah, serta masalah pembuangan sampah. Pencegahan memerlukan perencanaan bersama, penguatan ayah dan remaja, sanitasi, edukasi, dan pemantauan partisipatif.

INTRODUCTION

Stunting is a condition of impaired linear growth associated with long-term nutritional deprivation, recurrent infection, inadequate caregiving, and unfavorable environmental conditions. Its consequences extend beyond height. Children may experience delayed cognitive development, reduced learning capacity, lower immunity, and greater health risks later in life (Rahmadhita, 2020; Ariati, 2019). Prevention therefore requires attention to nutrition, care, health services, sanitation, and social conditions across the course of life.

Stunting is often treated as a technical health issue, yet the factors that sustain it are embedded in everyday family and community practices. Decisions about food, breastfeeding, health-post attendance, early marriage, waste disposal, water and sanitation, paternal responsibility, and the use of public services are shaped by income, knowledge, gender norms, social relationships, and local institutions. A health service can be available without being used consistently, and nutrition information can be delivered without changing household practice.

Community involvement is important because prevention activities depend on behavior that occurs outside clinics. Families provide daily food and care, fathers influence resources and emotional support, health cadres monitor children and communicate with households, youth carry knowledge into future families, community leaders shape legitimacy, and village government allocates resources and coordinates programs. Effective prevention emerges from interaction among these actors rather than from a single institution.

Integrated health posts or posyandu provide a practical platform for community-based prevention. They connect growth monitoring, nutrition education, supplementary feeding, immunization, maternal and child services, and referral. Cadres are particularly important because they live close to families and can identify missed visits or emerging risks. The effectiveness of the platform nevertheless depends on trust, regular attendance, adequate training, clear records, and follow-up action (Mediani et al., 2020; Destiarni, 2024).

Gelangsar Village is in Gunungsari District, West Lombok Regency, and consists of six hamlets. Village and health-service information showed a marked decline from an earlier report of 101 stunting cases in 2023 to 23 children in 2025. The 2025 table recorded 224 targeted children, one classified as very short and 22 as short, producing a village prevalence of 10.27%. This was above the reported health-center area aggregate of 8.85% and indicated that continued local action remained necessary.

Village interventions included supplementary feeding, local food initiatives, family development classes, father classes, posyandu services, health counseling, and assistance to vulnerable households. Youth groups also carried out environmental cleaning and some adolescents participated in youth health

activities. These activities suggest that stunting prevention had become a shared agenda, but participation varied across actors and was affected by time, information, economic conditions, traditional beliefs, and infrastructure.

Prior studies have highlighted the value of participation, cadre empowerment, sanitation, and family education in stunting prevention (Haryono & Marlina, 2021; Hasanah et al., 2023; Pateda et al., 2023). Less attention is often given to how multiple local actors divide roles, how community assets support programs, and why residents remain passive despite program availability. A village case study can illuminate these relationships and provide context-sensitive recommendations.

This study addressed two questions: how community members and local institutions participated in stunting prevention in Gelangsar Village, and what factors enabled or constrained that involvement. The analysis used structural functionalism and an asset-based community development perspective to interpret coordination, role differentiation, adaptation, community resources, and the sustainability of collective action.

Community Participation in Stunting Prevention

Participation includes more than attendance. It may involve receiving information, contributing labor or resources, changing household practices, joining decision making, monitoring implementation, and evaluating results. These forms represent different levels of agency. Attendance at a service is important, but participation becomes stronger when residents help define problems, shape activities, and hold institutions accountable.

In stunting prevention, participation begins in the household. Parents decide which foods are purchased and prepared, whether children attend growth monitoring, how illness is treated, and how water and sanitation are maintained. Fathers may control household income and can share caregiving responsibilities. When prevention is defined only as maternal responsibility, an important source of practical and emotional support is lost.

Community cadres translate formal programs into local interaction. They record growth, distribute supplements, provide counseling, conduct home visits, and connect families with professional services. Their social proximity can reduce communication barriers, but it can also create workload and role ambiguity if programs depend excessively on unpaid labor. Training, supervision, recognition, and accurate data systems are therefore essential.

Youth participation has an intergenerational dimension. Adolescents need knowledge about nutrition, anemia, reproductive health, delayed marriage, and healthy family formation before becoming parents. Their participation in environmental action also contributes to sanitation and collective responsibility. Youth programs can integrate health education with activities that are meaningful to adolescents rather than treating them only as future mothers or fathers.

The village government provides coordination, legitimacy, and resources. It can integrate health, social protection, sanitation, education, and community empowerment within village planning. Effective governance requires clear targets, transparent budgeting, routine monitoring, and channels for community feedback.

Government support should strengthen local capacity rather than turn residents into passive recipients.

Structural Functional and Asset Based Perspectives

Structural functionalism views society as a system of interdependent parts. Parsons four functional requirements - adaptation, goal attainment, integration, and latency - offer a useful lens for analyzing village prevention. Adaptation concerns the use of available resources and adjustment to health risks. Goal attainment refers to collective objectives and program direction. Integration concerns coordination among families, cadres, health workers, youth, and government. Latency concerns the maintenance of values and patterns that sustain healthy behavior.

This framework helps explain why one program cannot operate independently. Supplementary food has limited effect without regular monitoring, caregiving, clean water, infection prevention, and household follow-through. Likewise, community cleaning cannot replace adequate nutrition but can reduce environmental exposure that contributes to illness. Each actor performs a different function, and weakness in one part affects the wider system.

Asset Based Community Development begins with resources already present in a community. Assets may include people, associations, institutions, knowledge, local food, land, social networks, volunteerism, and public facilities. In Gelangsar, parents, cadres, youth groups, posyandu, village funding, local crops, and mutual assistance were potential assets for prevention. Mapping and connecting these assets can reduce dependence on short-term external programs (Habib, 2021).

An asset orientation does not deny need or structural inequality. Limited income, inadequate waste facilities, uneven information, and restricted budgets are real constraints. The value of the approach lies in combining recognition of these problems with a practical inventory of capacities that can be mobilized. Prevention becomes a process of strengthening agency while advocating for services and resources that communities cannot provide alone.

RESEARCH METHODS

The research used a qualitative case-study design to develop an in-depth understanding of community involvement in stunting prevention within its natural village context. The case was bounded by location, program activities, and the February-July 2026 research period. The design was appropriate because involvement was expressed through relationships, practices, meanings, and institutional arrangements that could not be captured through prevalence figures alone.

The study was conducted in Gelangsar Village, Gunungsari District, West Lombok Regency. The village comprises six hamlets and relies substantially on agriculture and daily labor. Local health and administrative records, community facilities, sanitation conditions, program documentation, and stunting data were used to describe the context.

Primary information came from purposively selected people with direct knowledge of prevention activities. Informant categories included the village head, health cadres, Family Assistance Team personnel, parents of young children, youth representatives, and community members. Recruitment continued as needed until the researcher considered the information sufficient. The source document did not report a single consolidated informant count, so the analysis emphasizes roles and convergence of evidence rather than numerical representation.

Data collection combined overt observation, structured interviews, and documentation. Observation examined posyandu and family-class activities, community participation, environmental conditions, and youth collective action. Interviews addressed roles, participation, understanding of stunting, caregiving, nutrition, sanitation, barriers, and program support. Documents included health statistics, village programs and budgets, administrative records, photographs, and activity evidence.

Credibility was strengthened through source triangulation and technique triangulation. Statements from families were compared with cadres, village government, youth, and program personnel. Interview information was checked against observation and documentation. Time triangulation was not used because fieldwork opportunities were limited. The researcher therefore relied on cross-source and cross-method convergence.

Analysis followed the Miles and Huberman sequence described by Sugiyono (2023): data collection, data reduction, data display, and conclusion drawing or verification. Field material was organized around forms of involvement, actor roles, enabling factors, constraining factors, and implications. Findings were repeatedly compared with field notes and documents before themes were finalized.

Ethical practice in community research requires informed participation, respect for privacy, careful handling of health information, and non-stigmatizing language. The article reports roles and themes without identifying children or linking individual families to stunting status. Quotations were translated or paraphrased for clarity while preserving their substantive meaning.

Data Sources and Analytical Focus

Table 1

Data Sources and Their Contribution to the Case Study

Source	Focus	Contribution to Analysis
Village government	Programs, coordination, budgeting, father involvement, and policy direction.	Explained institutional support and governance constraints.
Health cadres and family assistance personnel	Posyandu, growth monitoring, supplementary feeding, counseling, family classes, and follow-up.	Described operational prevention and contact with households.
Parents and caregivers	Attendance, food provision, caregiving, paternal support, sanitation, and health information.	Revealed household practices and barriers.
Youth and youth-group representatives	Stunting knowledge, youth health activity, environmental cleaning, and volunteering.	Shown intergenerational and environmental involvement.
Observation	Posyandu classes, participation, environmental behavior, and collective cleaning.	Checked whether reported activities were visible in practice.
Documents	Stunting figures, village programs, administrative records, budgets, and photographs.	Provided contextual and program evidence.

RESULT AND DISCUSSION

Village Health Context

The 2025 health table listed 224 children as the target population in Gelangsar. One child was categorized as very short and 22 as short, resulting in 23 recorded stunting cases and a prevalence of 10.27%. Across the eight service-area villages, 212 of 2,396 targeted children were recorded as stunted, or 8.85%. Gelangsar therefore remained above the area aggregate despite a reported decline from 101 cases in 2023.

The reduction suggests progress but does not by itself identify which intervention produced the change. Records from different years may also reflect updates in measurement, target populations, or reporting. The qualitative findings are used to explain current practices and perceived contributions rather than to claim that community involvement alone caused the numerical decline.

Table 2

Stunting Profile in Gelangsar and the Health Service Area in 2025

Area	Target Children	Very Short	Short	Recorded Stunting	Prevalence
Gelangsar Village	224	1	22	23	10.27%
Eight-village service area	2396	42	170	212	8.85%

Nutrition Services and Family Learning

Community involvement was visible in supplementary feeding, family development classes, father classes, and monthly posyandu activities. The village government and health actors provided supplementary food, including locally based food and support for children at risk. Cadres used posyandu gatherings to bring mothers together for counseling on caregiving, nutrition, and child development.

Observation of a family development class at a posyandu in March 2026 recorded approximately 20 participating mothers. The class discussed caregiving and child health. Participants were not only recipients of information; their attendance created a regular contact point where cadres could identify needs, reinforce messages, and connect families with services.

Parents described routine monthly attendance and provision of foods such as tempeh, carrots, and potatoes. Four posyandu service points operated in the village, and the source estimated participation at approximately 230 community members. These figures indicate broad service reach, although attendance quality and the consistency of household practice were not uniform.

The father's class responded to a recurring perception that childcare belonged mainly to mothers while fathers were responsible only for income. Village actors attempted to involve younger fathers in health checks, caregiving, and nutrition. Some mothers reported that husbands contributed money, watched children, and supported food provision, but village officials considered paternal involvement incomplete.

Youth Involvement and Environmental Action

Youth participants generally recognized stunting as a growth problem related to inadequate nutrition, although depth of understanding varied. Several saw knowledge as important because adolescents would become future parents and could help interrupt intergenerational risk. Around 50 adolescents were reported to participate in youth health activities, but school and work schedules limited regular attendance.

Youth organizations also contributed through weekly or conditional collective cleaning around the mosque, roads, drains, and nearby public areas. Observation in May 2026 documented young people sweeping, mopping, cleaning windows and drainage, and removing construction debris. Participants linked the activity with cleanliness, solidarity, and responsibility.

Environmental action has an indirect relationship with stunting prevention. Cleaner surroundings and better waste management can reduce exposure to infection, while collective work strengthens social ties that support other village programs. The activity should not be overstated as a substitute for nutrition and health services, but it demonstrates a community asset that can be integrated into sanitation education.

Forms of Community Involvement

Table 3

Community Roles in Stunting Prevention

Actor	Observed or Reported Role	Preventive Contribution
Village government	Funded supplementary food, organized programs, coordinated services, and promoted father involvement.	Provided resources, legitimacy, and cross-actor direction.
Health cadres and TPK	Monitored growth, counseled families, organized classes, distributed support, and followed vulnerable households.	Connected formal health services with everyday family practice.
Mothers and caregivers	Attended posyandu, joined family classes, prepared food, and practiced caregiving.	Supported nutrition, monitoring, and early response.
Fathers	Provided household resources and, in some families, shared childcare and monitoring.	Expanded caregiving support, though participation remained uneven.
Youth	Joined youth health activities, learned about stunting, and cleaned public spaces.	Strengthened future-parent knowledge, sanitation, and solidarity.
Community members	Participated in collective action and supported village programs.	Created social support and shared responsibility.

Constraining Factors

The first constraint was uneven information and awareness. Some residents understood stunting only as short stature or heredity and did not recognize long-term cognitive and health consequences. Information delivered at posyandu did not always reach residents who were absent or had limited involvement. A program may therefore exist without producing a shared understanding across the village.

Paternal involvement was a second constraint. Village leadership described many fathers as seeing income provision as their main obligation, leaving health monitoring and daily care to mothers. This gendered division increased maternal responsibility and reduced the household's capacity to act consistently. Father classes had begun to address the issue, but participation was described as only partial.

Traditional beliefs and earlier caregiving patterns also shaped behavior. Examples included avoidance of nutritious foods based on beliefs about smell or suitability and the assumption that a short or thin child was simply following family characteristics. Such beliefs do not disappear through one lecture. Respectful dialogue, trusted messengers, demonstration, and repeated discussion are needed to connect local understanding with health evidence.

Participation was sometimes passive. Residents attended or received assistance but were less involved in planning, evaluation, and problem solving. This weakened ownership and encouraged the view that prevention belonged to government and health workers. Involvement needs to progress from receiving services toward identifying needs, deciding priorities, monitoring delivery, and evaluating results.

Economic conditions affected food choice, sanitation, and time. Many households depended on farming or daily labor and prioritized immediate necessities. Low income made it difficult to improve latrines, drainage, or waste systems and could restrict dietary diversity. The findings also emphasized that stunting was not limited to low-income households; inadequate care, early marriage, work demands, and poor feeding practice could affect families with more resources.

Environmental infrastructure was another barrier. Some residents disposed of waste in gardens, rivers, or areas near their homes because designated waste facilities were unavailable. Burning was used to reduce accumulated waste. These practices exposed the gap between asking households to maintain clean behavior and providing a feasible waste-management system.

Village cadres also identified budget limitations. Incentives, transport support, supplementary food, classes, and follow-up require stable funding. Short-term or insufficient budgets can narrow coverage and make participation dependent on small rewards. Sustainable financing should prioritize core prevention functions while avoiding a program model that relies entirely on incentives.

Enabling Factors

Village commitment was a central enabling factor. The government allocated attention and resources to supplementary food, family development, father classes, and coordination with the health center. Assistance for vulnerable families supported basic needs, while village funding allowed local activities to complement district and health-service programs.

Health cadres and community figures created relational access. Cadres lived close to families, understood local language and routines, and could combine monitoring with counseling. Community figures could strengthen legitimacy and help address beliefs that formal health messages alone might not change. Their collaboration allowed programs to reach the household as the smallest social unit.

Education and counseling provided repeated opportunities to build knowledge. Posyandu, family development classes, father classes, youth health activities, and home communication were complementary channels. Repetition across these settings was important because residents differed in age, availability, responsibility, and prior understanding.

Local food and mutual assistance were community assets. Supplementary feeding based on local ingredients could improve feasibility and cultural acceptance. Household gardens, agricultural products, volunteer labor, and youth organizations represented resources already available within the village. Connecting them with nutritional guidance and health monitoring could strengthen sustainability.

Summary of Enabling and Constraining Conditions

Table 4

Conditions Shaping Community Involvement

Dimension	Enabling Conditions	Constraining Conditions	Priority Response
Knowledge	Counseling through posyandu, BKB, father classes, and cadres.	Uneven information and limited understanding of long-term effects.	Use repeated, household-level, and culturally responsive education.
Family roles	Mothers attendance and emerging father-class participation.	Care burden concentrated on mothers; fathers participation incomplete.	Expand father engagement and shared caregiving commitments.
Programs	Village support, supplementary food, cadres, TPK, and health-center cooperation.	Budget limits and passive receipt of programs.	Use participatory planning and transparent monitoring.
Economy and food	Government assistance and locally available foods.	Low income and restricted dietary diversity.	Link social protection with practical local-food guidance.
Environment	Youth mutual assistance and community cleaning.	No adequate waste disposal; dumping and burning.	Develop village waste and sanitation systems.
Youth	Awareness of intergenerational risk and volunteer action.	School and work schedules limit regular participation.	Design flexible youth activities linked to health and environment.

DISCUSSION

The case shows that community involvement in stunting prevention operated through a network of household, service, governmental, and associational roles. Parents provided daily care, cadres connected services with families, village government supplied coordination and resources, health workers provided technical support, and youth contributed knowledge and environmental action. The pattern supports the view that prevention is a social system rather than an isolated health intervention.

Within Parsons functional framework, adaptation was visible in the use of local foods, assistance, posyandu, and household adjustment to child-health needs. Goal attainment appeared in the shared objective of reducing stunting and in village programs directed toward that objective. Integration was expressed through coordination among government, cadres, health workers, parents, TPK, and youth. Latency was evident in efforts to sustain clean living, caregiving responsibility, mutual assistance, and youth awareness across generations.

The framework also reveals points of dysfunction. Weak paternal participation concentrated responsibilities in mothers and reduced role complementarity. Uneven information prevented shared understanding. Passive participation weakened integration because residents were linked to programs as

beneficiaries rather than partners. Inadequate waste infrastructure limited adaptation by making healthy environmental behavior difficult.

The asset-based perspective identifies resources that can be mobilized: cadres, parents, youth organizations, mutual assistance, local food, village funding, posyandu facilities, community leaders, and health-center relationships. These assets already support prevention. The strategic task is to connect them around jointly defined priorities and strengthen capacities that remain weak.

Supplementary feeding was an important response for children at risk, but food distribution should be linked with growth monitoring, counseling, illness prevention, and household food practice. Otherwise, benefits may end when assistance stops. Local ingredients and family cooking demonstrations can make the program more transferable to daily life. Follow-up should assess whether caregivers understand portions, frequency, food diversity, and responsive feeding.

Father classes address a structural gap in caregiving. Involving fathers can improve financial decision making, maternal support, attendance, sanitation investment, and response to health advice. The classes should avoid presenting fathers only as providers. Practical topics may include feeding, play and stimulation, accompanying growth monitoring, supporting breastfeeding, sharing domestic work, recognizing danger signs, and planning household health expenditure.

Youth participation is promising because prevention begins before pregnancy. Adolescents need accurate information about nutrition, anemia, reproductive health, healthy relationships, and delayed marriage. Youth groups can help communicate messages, organize environmental activities, and develop peer education. Flexible scheduling is essential because school and employment affect attendance.

Environmental findings confirm that behavior-change messages require infrastructure. Residents cannot consistently dispose of waste safely when no practical collection or disposal option exists. Community cleaning can reduce visible waste temporarily, but a village-level system is needed for collection, sorting, transport, disposal, and accountability. Sanitation planning should be coordinated with health and nutrition programs.

The 2025 prevalence figure of 10.27% offers a monitoring baseline, but program evaluation requires consistent measurement, clear denominators, data quality checks, and attention to individual follow-up. A decline from 101 cases in 2023 to 23 in 2025 is encouraging, yet differences in target populations or reporting procedures should be examined before attributing the change to specific interventions.

Participation quality should become an explicit indicator. Counting attendance is useful, but it does not show whether residents understood information, changed practice, influenced decisions, or benefited equitably. Village monitoring can include household follow-up, father participation, youth involvement, sanitation conditions, completion of referrals, and community feedback on program design.

Implications for Inclusive Community Education

Stunting prevention is an educational process as well as a health intervention. Inclusive community education must reach mothers, fathers, adolescents, caregivers, low-literacy residents, working families, and households in different hamlets. Information should be available through oral discussion, visual materials, demonstrations, local language, home visits, and digital messaging where access permits.

Messages should be specific and actionable. General advice to provide nutritious food may be difficult for households with limited income. Facilitators can demonstrate affordable menus using local ingredients, discuss safe food preparation, and help families plan to feed frequency. Sanitation messages should be linked with realistic community systems rather than placing responsibility entirely on individual households.

Participation should be designed around residents' schedules. Posyandu and youth activities are held only during school, or work hours exclude some people. Rotating schedules, small neighborhood sessions, father meetings after work, and short digital reminders can widen access. Outreach should identify who is repeatedly absent and understand the reason rather than labeling families as uncooperative.

Community learning also needs feedback. Parents and youth should be able to ask questions, challenge unclear messages, report barriers, and propose solutions. Cadres require channels to bring recurring problems into village planning. This two-way process can transform education from information delivery into collective problem solving.

Recommendations for Village Action

First, the village should establish a coordinated prevention forum or strengthen an existing team with representation from government, health services, cadres, fathers, mothers, youth, community figures, and vulnerable households. The forum should review data, agree on priorities, coordinate schedules, and publish simple progress information.

Second, father and youth engagement should be expanded. Father classes can combine short education with practical caregiving commitments, while youth programs can integrate anemia prevention, reproductive health, nutrition, and environmental action. Participation targets should measure continuity and learning, not only attendance.

Third, a village sanitation and waste-management plan are necessary. The plan should map dumping points, drainage, household practices, available land, collection options, and responsible actors. Community cleaning remains valuable but should support, not replace, a functional system.

Fourth, supplementary feeding and assistance should relate to household counseling and follow-up. Cadres can use simple monitoring cards to record attendance, growth status, referrals, feeding challenges, and agreed actions. Data should guide support without stigmatizing children or families.

Fifth, evaluation should combine health outcomes with participation indicators. Examples include regular posyandu attendance, fathers accompanying

care, adolescent participation, completion of referrals, household sanitation improvements, and involvement in planning meetings. Qualitative feedback should explain why indicators improve or remain weak.

Limitations and Future Research

The case study provides contextual depth but does not support statistical generalization. Informants were selected purposively, and the source report did not consolidate the exact number by category in one methodological table. Future studies should report on the recruitment process, participant characteristics, interview duration, saturation decisions, and ethical procedures more explicitly.

The study relied on participant accounts, observation, and documents collected within a limited period. Social desirability may have influenced descriptions of participation, and some activities could not be observed repeatedly. Longer engagement, member checking, negative-case analysis, and independent coding would strengthen credibility.

Stunting data were drawn from administrative records. Future research should document measurement procedures, dates, denominators, and changes in recording systems when comparing years. Mixed-method research could combine household surveys, longitudinal growth data, service-use records, and qualitative analysis of participation.

Comparative research across villages could examine how governance, geography, infrastructure, social networks, and economic conditions shape participation. Action research could test participatory planning, father engagement, youth peer education, local-food demonstrations, or community waste systems while documenting implementation and outcomes.

CONCLUSION

Community involvement in Gelangsar Village was expressed through monthly posyandu attendance, supplementary feeding, family development and father classes, parental nutrition and care, youth health awareness, environmental cleaning, cadre work, village support, and cooperation with health services. These roles formed a local prevention system that connected households with institutions and contributed to continued attention to stunting.

The system was supported by village programs, cadres, health workers, social assistance, local foods, mutual assistance, and youth organization. Its effectiveness was constrained by uneven information, limited paternal involvement, traditional beliefs, passive participation, low income, restricted budgets, and inadequate waste disposal. The 2025 record of 23 stunted children among 224 targets, or 10.27%, shows that prevention remained an urgent village priority.

Sustainable progress requires participation beyond attendance. Residents should be involved in planning, implementation, monitoring, and evaluation. Village action should strengthen father and youth roles, provide continuous and inclusive education, connect supplementary food with household practice, improve sanitation and waste infrastructure, support cadres, and use reliable data

for follow-up. These measures can transform prevention from a set of separate activities into a coordinated community responsibility

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