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PERCEPTIONS OF STUNTING: NEGOTIATING LOCAL AND MEDICAL KNOWLEDGE IN JENEPONTO, SOUTH SULAWESI

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ABSTRAK
Stunting merupakan masalah kesehatan masyarakat yang kompleks di Kabupaten Jeneponto, Sulawesi Selatan, yang memiliki prevalensi tertinggi di provinsi tersebut. Berbeda dengan perspektif medis yang mendefinisikan stunting sebagai gangguan pertumbuhan akibat kekurangan gizi kronis, masyarakat setempat memandang tubuh pendek sebagai kondisi wajar yang dipengaruhi faktor keturunan. Perbedaan ini menimbulkan kesenjangan antara definisi medis pemerintah dan pengetahuan lokal yang terbentuk dalam pengalaman sehari-hari. Penelitian ini menganalisis bagaimana masyarakat membangun pemahaman tentang stunting melalui negosiasi antara pengetahuan lokal dan wacana medis. Penelitian menggunakan pendekatan kualitatif fenomenologis di empat desa yang mewakili wilayah pesisir dan pegunungan. Sebanyak 15 informan dipilih secara purposif, terdiri atas orang tua balita, tenaga kesehatan, kader posyandu, tokoh masyarakat, dan aparat pemerintah. Data dikumpulkan melalui wawancara mendalam, observasi partisipatif, dan dokumentasi, kemudian dianalisis secara induktif. Temuan menunjukkan bahwa label stunting tidak dipandang sebagai masalah kesehatan, melainkan sebagai strategi sosial untuk memperoleh bantuan gizi dan dukungan pemerintah. Negosiasi antara pengetahuan medis dan lokal menghasilkan pemaknaan hibrida yang mengakomodasi logika kesehatan formal tanpa meniadakan keyakinan masyarakat. Hasil ini menegaskan bahwa intervensi stunting harus diselaraskan dengan rasionalitas lokal agar lebih efektif, mudah diterima, dan berkelanjutan.

Kata Kunci: Stunting; Pengetahuan Lokal; Pengetahuan Medis; Konstruksi Sosial; Strategi Sosial

ABSTRACT
Stunting is a complex public health issue in Jeneponto Regency, South Sulawesi, which has the highest prevalence in the province. Unlike the medical perspective that defines stunting as a growth disorder caused by chronic malnutrition, the local community perceives short stature as a normal condition influenced by hereditary factors. This difference creates a gap between the government's medical definition and local knowledge embedded in everyday experience. This study analyzes how the community constructs an understanding of stunting through negotiations between local knowledge and medical discourse. The research employed a qualitative phenomenological approach in four villages representing coastal and highland areas. Fifteen informants were purposively selected, consisting of parents of children under five, health workers, posyandu cadres, community leaders, and government officials. Data were collected through in-depth interviews, participant observation, and documentation, and analyzed inductively. The findings reveal that the stunting label is not viewed as a health problem but as a social strategy to access nutritional assistance and government support. The negotiation between medical and local knowledge produces a hybrid meaning that accommodates formal health logic while maintaining community beliefs. These results underscore the need for stunting interventions aligned with local rationalities to ensure effectiveness, acceptance, and sustainability.

Keywords: *Stunting; Local Knowledge; Medical Knowledge; Social Construction; Social Strategy*

INTRODUCTION

Stunting remains one of the most persistent and multidimensional public health challenges in Indonesia, particularly as it affects not only physical growth but also cognitive development, productivity, and long-term human capital formation. Although generally framed as a nutritional issue, stunting has increasingly been recognized as a phenomenon shaped by broader socio-economic and cultural contexts. In many regions, the meaning of stunting is not solely associated with medical explanations of growth failure, but is intertwined with societal values, local interpretations of child health, and social practices embedded in everyday community life (Geertz, 2008; Helman, 2007; Pelto & Armar-Klemesu, 2011). Such complexity explains why stunting continues to be a global concern and is included in the Sustainable Development Goals (SDGs), particularly Goal 2 and Goal 3, which emphasize eliminating all forms of malnutrition and ensuring healthy lives for children (De Onis & Branca, 2016; Organization, 2019). Thus, stunting reduction is not merely a technical intervention, but also part of a global commitment to sustainable human development (Black et al., 2013).

At the national level, the Indonesian government has positioned stunting reduction as a priority agenda through Presidential Regulation No. 72 of 2021. This policy aims to integrate nutrition improvement, sanitation, and behavioral change interventions into a single framework for accelerating stunting prevention. Despite various efforts, recent data indicate that the prevalence of stunting remains uneven across regions, particularly in eastern Indonesia, where socio-economic disparities and access to health services contribute to persistent challenges (Juniarti et al., 2025; Laksono et al., 2022). These regional variations suggest that technical solutions alone are insufficient. Instead, policy implementation requires an approach that is more contextual, culturally informed, and aligned with local perceptions of child health (Swidari et al., 2020).

One of the regions that crucially reflects this complexity is Jeneponto Regency in South Sulawesi, which recorded a stunting prevalence of 37 percent according to the Indonesian Nutrition Status Survey (Kustanto et al., 2024). As the district with the highest stunting prevalence in the province, Jeneponto becomes not only a site of policy intervention but also a social space where the definitions of health, nutrition, and childhood are constantly negotiated. The high prevalence of stunting in this area raises important questions: How do local communities understand the term "stunting"? What meanings do they attach to the condition, and how does this influence their participation in government programs? These questions indicate that stunting cannot be understood solely as a biological phenomenon but must also be examined as a socially constructed concept, shaped by cultural interpretations and social interactions (P. L. Berger & Luckmann, 1966; Conrad & Barker, 2010).

Previous research has generally focused on stunting from biomedical perspectives, emphasizing insufficient nutrition, recurrent infections, and poor sanitation as its key determinants (Mahmudiono et al., 2018; Permatasari et al., 2023; Torlesse et al., 2016). While these studies provide valuable insights, they tend to overlook how communities interpret health through local knowledge systems, everyday life experiences, and cultural norms. For many families, a healthy child is not necessarily measured by height-for-age indicators, but by observable qualities such as cheerfulness, appetite, and physical activity. This divergence reflects a fundamental epistemic gap between medical knowledge constructed through statistical indicators and local knowledge shaped by social experiences and cultural meanings (Hennink et

al., 2020; Pelto & Armar-Klemesu, 2011). Consequently, medical interpretations of stunting do not always resonate with local lived realities.

This gap reveals a research problem that remains insufficiently addressed: the mismatch between biomedical categorizations of stunting and the social meanings constructed by local communities. While existing literature recognizes cultural influences on health behavior, few studies specifically explore how stunting is redefined, negotiated, and operationalized by communities within the framework of state-led interventions. Moreover, the label "stunting" does not merely classify a biomedical condition but also carries administrative and material implications. In areas like Jeneponto, families may actively participate in stunting programs not because they view stunting as a health risk, but because the label grants access to nutritional assistance and social support provided by the state. This dynamic positions stunting as a social strategy rather than a strictly medical problem, suggesting the presence of a deeper sociological process that merits investigation.

Based on this research gap, the present study aims to analyze how communities in Jeneponto construct meanings around stunting through negotiations between local knowledge and medical knowledge. Specifically, this study explores how health workers' explanations intersect with community interpretations of child health, and how these interactions produce new meanings that shape public responses to government programs. By uncovering these negotiations, the study not only seeks to understand the conceptualization of stunting at the local level but also to explain how such conceptualizations influence the acceptance, rejection, or adaptation of state interventions.

The contribution of this study is primarily empirical. Rather than merely identifying patterns of malnutrition, this research demonstrates how stunting becomes embedded in social practice, functioning as a symbolic and practical resource within community life. This finding challenges the assumption that health programs automatically align with local perceptions and reveals the sociocultural dimensions of policy implementation. By presenting evidence from Jeneponto, the study enriches sociological perspectives on health in Indonesia and highlights the importance of incorporating local knowledge into stunting reduction strategies. Ultimately, this research offers insights for policymakers to design interventions that go beyond standardized biomedical indicators and genuinely engage with community rationalities, thus enabling more sustainable and culturally attuned public health policies.

METHOD

This study employed a qualitative approach with a phenomenological design to understand how communities construct the meaning of stunting through their lived experiences, social practices, and interactions with health institutions. A phenomenological approach was chosen because it enables researchers to explore subjective meanings that individuals attach to social phenomena based on their cultural and experiential contexts, rather than relying on predetermined biomedical categories (Creswell & Creswell, 2018; Schutz, 1967).

The research was conducted in four villages in Jeneponto Regency, South Sulawesi, Indonesia, which were purposively selected to represent two highland villages and two coastal villages. The highland villages are characterized by dispersed settlements, limited access to formal health services, and

livelihoods dominated by dryland farming. Conversely, the coastal villages have greater social mobility, closer connections to markets, and child-rearing practices shaped by maritime economic activities. These geographical and social differences influence how communities interpret children's bodies, health conditions, and the category of *stunting*. Therefore, the selection of these villages was intended to capture variations in meaning-making processes related to stunting that arise from different environmental, economic, and cultural settings.

Data collection took place over three months, from May to July 2025, involving a total of 126 hours of participatory observation conducted at community health posts (posyandu), informants' homes, and public village spaces. Observations focused on how parents responded to anthropometric measurements, interacted with health workers, and discussed their children's growth in everyday conversations. In addition to observation, data were collected through in-depth semi-structured interviews and a review of relevant program documents. Semi-structured interviews were employed because they provide flexibility to explore participants' narratives in depth while maintaining consistency across informants (Hennink et al., 2020).

A total of fifteen informants were selected purposively based on their involvement and knowledge of stunting-related issues. They included parents of children under five, posyandu cadres, health workers, community leaders, and local government officials. Interviews were conducted in Indonesian and the Makassarese language, depending on the informants' preferences, to ensure that meanings were conveyed accurately. To enhance methodological transparency, several sample interview questions used in this study are presented below:

"How do you define a healthy child in your family and community?"
"What does the term stunting mean to you?"
"How did you first learn about the term stunting, and from whom?"
"What changes occurred after your child was identified as stunted?"
"Do you perceive benefits or disadvantages from participating in the stunting program?"

These questions allowed participants to share their personal experiences and provided insights into how stunting is understood and socially negotiated as a category with practical implications in daily life.

Data were analyzed inductively through a manual coding process guided by the qualitative analysis procedures of data condensation, data display, and conclusion drawing (Ridder, 2014). The phenomenological orientation ensured that analytical categories emerged from participants' lived experiences rather than from predefined theoretical constructs, allowing the findings to remain grounded in the community's social realities. To ensure research credibility, triangulation, member checking, and peer debriefing were employed. Member checking involved returning preliminary interpretations to selected informants to verify the accuracy of the researcher's understanding of their perspectives (Creswell & Creswell, 2018). Peer debriefing was conducted by engaging qualitative research experts to review analytical decisions, while triangulation was achieved by comparing interview data, field observations, and supporting documents to strengthen interpretive rigor and confirm emerging patterns. These verification strategies enhanced the trustworthiness of the findings and ensured that interpretations aligned with empirical realities in the field.

RESULTS AND DISCUSSION

Local Perceptions of Child Health and Stunting

The results of the study show that people in Jeneponto Regency have a different perception of the concept of stunting compared to the medical understanding adopted by the government. For most families, the measure of a child's health is not determined by height as per medical standards, but by daily activities, cheerfulness, and appetite. In their view, children who appear agile and do not get sick often are considered healthy, regardless of their height. This perception is born from empirical experience and local knowledge systems that have been socially inherited in their communities.

> "My child is small, but healthy, active, and rarely sick. If you say stunting, I'm not sure, because our family has always been small." (Interview results June 12, 2025)

The statement clearly describes how the people of Jeneponto assess health through social measures rather than medical standards. From the perspective of the sociology of knowledge, society constructs the meaning of the body and health based on daily experiences, not scientific indicators. As explained by P. L. Berger and Luckmann (1966), social reality is formed through a process of externalization, objectification, and internalization, in which daily life experiences become the basis for the formation of collective knowledge. In this context, a "healthy child" is not the result of medical measurement, but the outcome of social agreements built through local interactions and values.

Field findings also show that the people of Jeneponto do not consider stunting as a health threat. Instead, they consider it to be part of the natural variation of humans. A childcare grandmother explains:

> "My children have always been like that, when they were babies, but now they are all grown. So it's not because of pain, it's just congenital." (Interview results June 15, 2025)

This view shows that society subtly rejects the concept of stunting as a "disease." They attribute short bodies to hereditary factors, not nutritional deficiencies. This is in line with previous findings in South Sulawesi, which show that public perception of stunting often comes from local beliefs that frame health through family experiences rather than medical measurements (Yuliana & Suryani, 2022).

In addition, the term stunting introduced by health workers is often understood differently by the public. A posyandu cadre said:

> "We were told that short children are stunted, but parents say that it is not sick, just derivatives. Sometimes they are even happy because they get additional food from the program." (Interview results June 18, 2025)

This quote shows how medical knowledge experiences a negotiation of meaning when dealing with social contexts. In social construction theory, this process is referred to as *the redefinition of reality*, in which people reinterpret scientific knowledge to fit the logic of their lives (Conrad & Barker, 2010). Medical information about stunting is not rejected, but adapted to local values that are more easily accepted. The community views the stunting program not as a treatment for disease, but as a form of government attention that can help the needs of families.

This phenomenon shows that the concept of health for the people of Jeneponto is relational and contextual. As explained by Swidari et al. (2020), in rural Indonesian societies, the perception of health is often linked to social function and family well-being, not solely to individual biological conditions. People consider it healthy when a person can play a social role and carry out daily activities without interruption. Thus, the body is not seen in isolation from social relations, but becomes part of the balance of life in the community.

To clarify the fundamental differences between medical and local perspectives on child health, here is a summary of the field results formulated in Table I.

Table I. Difference in Perception between Medical Knowledge and Local Knowledge

Assessment Aspects	Medical Knowledge (Ministry of Health of the Republic of Indonesia, 2024)	Local Knowledge (Jeneponto Community)
Health benchmarks	Height by age (WHO Z-score)	Activity, cheerfulness, and appetite
Causes of short body	Chronic malnutrition (*stunting*)	Hereditary factors and natural conditions
Body conception	Objective measurement results	Part of family identity
Perception of conditions	Health problems that must be intervened in	Fair condition, harmless
Response to the program	Focus on improving nutrition	Accepted for bringing social benefits

Source: *Field data processed by researchers, 2025*

The table clearly shows the fundamental difference between medical knowledge and local knowledge in understanding children's health. When medical knowledge emphasizes objectivity and intervention, local knowledge emphasizes empirical experience and social value. These two systems of knowledge do not negate each other, but interact with each other and negotiate meaning.

Thus, the perception of the Jeneponto people towards stunting cannot be understood as a form of ignorance of science, but as the result of a social construction rooted in local rationality. They live in two worlds of knowledge: the medical one and the social one, and both are negotiated adaptively to maintain a balance of life. These findings confirm that local understanding must be an important part of public health communication strategies so that stunting interventions are more contextual and accepted by the community.

These findings indicate that local communities do not view height as a primary indicator of health. Instead, health is socially interpreted through daily function, appetite, and a child's ability to participate in communal life. This perspective forms the basis upon which formal health labels, including stunting, are understood and evaluated in the local context.

The Social Meaning of the Stunting Label

The results of the study show that *the stunting* label in Jeneponto Regency has a different social meaning than intended by the national health policy. People do not always interpret it as a sign of disease or malnutrition, but as a form of government attention that brings economic and social benefits. These findings show that the term *stunting* has undergone a transformation in meaning when it enters the context of rural people's lives.

The stunting reduction acceleration program in Jeneponto basically targets children aged 0–2 years. Children who are recorded in the data collection as *stunted* are entitled to receive nutritious food assistance, vitamins, and routine health visits from the posyandu. This condition makes *stunting* data collection not only a medical activity, but also a social process that determines who is entitled to assistance. Therefore, many families try to ensure their child is registered in the beneficiary category before the age of two.

> "If the child is not two years old and is included in the stunting data, every week we get additional food. But if two years have passed, you can't get it anymore." (Interview results June 3, 2025)

This statement describes how the administrative limitations of the program indirectly shape people's adaptive behavior. *Stunting* in this context is no longer just a medical diagnosis, but a social category that has practical consequences. This strengthens the view that the people of Jeneponto do not see *stunting* as a problem, but as a social opportunity to improve family welfare. In the terminology of the sociology of knowledge, this is a form of *redefinition of meaning*, which is when formal concepts are reinterpreted to fit local social realities (P. L. Berger & Luckmann, 1966).

> "Now if there is data collection, parents even ask for their children to be included. He said that he could get food from the posyandu." (Interview results June 8, 2025)

This phenomenon shows how society adjusts to policies through rational social logic. They did not reject the program, but reinterpreted the function of *stunting* within the framework of family needs. A similar thing was found by Mahmudiono et al. (2018) in East Java, where households with limited economic conditions make child nutrition programs part of welfare strategies. In Jeneponto, this adaptation is clear: *stunting* data collection is a means of securing access to nutritious food assistance.

> "My son entered the stunting program when he was one year old, so every week he gets porridge, eggs, and fruit. Now it's been two years, it's no longer possible." (Interview results June 10, 2025)

This quote shows how the community understands the program system based on direct experience. When the assistance is only valid until the age of two, people try to ensure their children are included in the data collection before crossing that limit. In the framework of social phenomenology, these actions demonstrate practical rationality, that is, the ability of societies to adapt their actions to the existing policy structure (Schutz, 1967).

Field findings show that social interpretations of stunting labels are not only individual, but also collective. In some villages, the community shared information about the data collection schedule and the criteria for receiving assistance. This social solidarity makes the health program a new arena of social interaction, where residents actively participate and help each other so as not to be left behind from the benefits of the program. In other words, *stunting* has become a collective symbol of the state's concern for small communities.

The following table illustrates how the social meaning *of stunting* is formed through the interaction between formal policies and people's daily lives.

Table II. Social Dynamics and the Meaning of Stunting Labels in Jeneponto

Aspects	Field Findings	Formed Social Meaning
Age of beneficiaries	The program is for children 0–2 years old only	The community adjusts data collection before the age limit
Family motivation	Access nutritious food assistance	*Stunting* is interpreted as a social opportunity
Attitudes towards medical labels	Not considered a disease	Medical knowledge adapted in a local context
Social impact	Increasing participation in posyandu	The program becomes an arena for solidarity and social interaction
Relations with the state	Based on administrative data	Data becomes a bridge between society and policy

Source: *Field data processed by researchers, 2025*

From the table, it appears that medically designed nutrition policies have been lived by the community in a more social and contextual form. The age limit of 0–2 years creates a new logic in domestic life, where health data collection is part of the adaptation strategy to the formal assistance structure. The community does not oppose medical authorities, but negotiates them to be relevant to local needs.

This phenomenon illustrates how the concept of *stunting* in Jeneponto has become an active social reality, not a passive category. It serves as a bridge between state policies and people's lives. Thus, understanding *stunting* needs to go beyond the nutrition approach alone but also understand the inherent social meaning behind it, so that *stunting* reduction programs are truly based on local realities and accepted sustainably by the community.

The reinterpretation of stunting as a social opportunity rather than a health condition demonstrates that policy interventions do not operate in isolation. Instead, they interact with pre-existing social logics that shape how families engage with health programs and position themselves within state-administered classifications.

These social meanings become the foundation for an ongoing negotiation between local knowledge and medical discourse, which will be elaborated in the following section.

Negotiating Local and Medical Knowledge

The results of the study show that there is a complex negotiation process between the local knowledge of the Jeneponto community and the medical knowledge introduced through government programs. On the one hand, health workers assess *stunting* through objective indicators such as height by age, according to WHO standards. On the other hand, people assess children's health based on daily social experiences, such as appetite, activity, and cheerfulness. This paradigm difference does not cause direct rejection, but results in a form of compromise and social adaptation on the ground.

> "The officer said that my child was stunted because his body was small, but I said this child was healthy. He never gets sick and eats a lot. So maybe it's just a small amount, not because of malnutrition." (Interview results June 12, 2025)

The citation shows that people do not reject the authority of health workers, but reinterpret the results of medical measurements according to the context of their life experiences. Within the framework of social construction, this phenomenon shows the existence of a dialectic between objective reality (medical data) and subjective reality (social experience) as described by P. L. Berger and Luckmann (1966). The process of negotiating this meaning takes place subtly, through daily interaction between posyandu officers and the community.

Health workers have a position as bearers of formal knowledge, while the community plays the role of recipients and interpreters. However, in practice, people do not just accept, but actively reconstruct the meaning of medical information according to their social language. A posyandu cadre explained:

> "We explained to the residents that stunting was due to malnutrition, but they answered that it could be a descendant of their parents. So we leave it at that, the important thing is that they want to participate in the program." (Interview results June 9, 2025)

These findings suggest that health communication at the local level is often asymmetrical bidirectional. Medical information is delivered in technical language, but the public receives it through the framework of everyday knowledge. In this case, *local knowledge* serves as a filter that selects and interprets health messages. As explained by Geertz (2008), people always try to give meaning to new concepts through symbols and cultural experiences that they already understand.

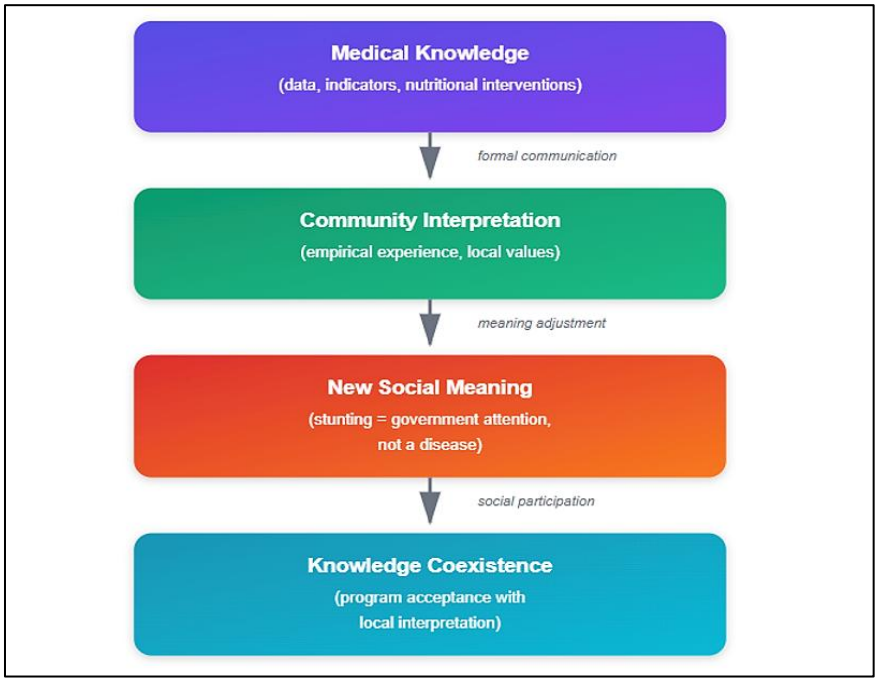
The results of observations also show that the meeting between these two knowledge systems does not always cause conflict, but rather forms a pattern of coexistence. People are willing to participate in health programs, such as taking children to posyandu or receiving additional food, but still maintain the belief that their child's condition is not entirely determined by nutrition. Health workers also understand this reality and choose a persuasive approach rather than a confrontational one.

> "If it is explained using medical language, they are confused. So we use subtle methods, such as saying 'nutritious food so that children are smarter', not because of stunting." (Interview results June 14, 2025)

This approach shows a form of inter-subjectivity as described by Schutz (1967), in which meaning is built together between the officer and the community in a continuous process of communication. In such a situation, neither side is completely dominant; What happens is that they adjust language, symbols, and perspectives so that messages can be accepted socially.

To illustrate this dynamic, here is Figure I, which shows the process of negotiating meaning between local and medical knowledge in the life of the people of Jeneponto.

Figure I. The Flow Mechanism of Local and Medical Knowledge Negotiation Related to Stunting in Jeneponto



Source: *Researcher's processing based on the results of interviews and field observations, 2025*

The figure illustrates that the interaction between health workers and the community produces a new social meaning that lies between the two knowledge systems. Medical knowledge brings an objective approach through data and measurement standards, while society interprets it through social experiences and cultural values. The result is not rejection, but a form of reciprocal adaptation that enriches the understanding of health at the local level.

This phenomenon also confirms that the implementation of health policies does not only depend on the transfer of medical information, but also on the ability to manage the social meaning that lives in society. As stated by Swidari et al. (2020), the success of health communication depends on the suitability of the message with the structure of local meaning. Therefore, the understanding of stunting in Jeneponto cannot be separated from the way people negotiate the meaning of health through their own language and experience.

From the perspective of social phenomenology, this negotiation shows how knowledge is not singular, but is formed through relations between subjects. The people of Jeneponto are not passive recipients of policies, but social actors who actively adapt medical concepts to local rationality. Thus, the reality of stunting at the local level is the result of a dialogue between the scientific world and the social world, between data and experience, between policy and daily life.

The interactions between health workers and families do not eliminate local perspectives, nor do they fully impose medical reasoning. Rather, a hybrid space emerges where both knowledge systems coexist and continually influence each other.

To integrate these empirical findings into broader sociological theory, the next section synthesizes how these negotiated meanings reflect the dialectical relationship between structure, agency, and lived experience in the construction of stunting as a social reality.

Theoretical Synthesis

The findings of this study show that the phenomenon *of stunting* in Jeneponto Regency can not only be understood as a medical or nutritional problem, but also as a social reality formed from the interaction between the community, public policy, and knowledge systems. The people of Jeneponto construct the meaning of *stunting* through their daily life experiences, local values, and social relations with the government. This process results in a different form of understanding than the formal medical view. *Stunting* is not understood as a disease, but as part of a normal life, even in some contexts it is considered a sign of the government's attention to the welfare of the community.

Within the framework of the theory of social construction put forward by P. Berger and Luckmann (2016), social reality is born from a dialectical process involving externalization, objectification, and internalization. The government, through health policies and programs to accelerate *stunting* reduction, expresses medical knowledge (externalization) into the form of measurable policies through nutrition indicators and anthropometric data. At the community level, the policy is objectified in the form of data collection and posyandu practices. However, people then reinterpret the meaning of *stunting* according to their experiences and social values. Through the process of internalization, the new meaning is accepted as part of the collective consciousness where the label *of stunting* is not just a medical term, but a social symbol that contains pragmatic and emotional value.

This phenomenon shows the existence of a dialectic between structure and agency. The structure of health policy provides a formal category to reference for health workers, while communities adjust and use it as part of their social strategy. In the phenomenological view of Schutz (1967), the actions of the Jeneponto people represent a form of practical rationality rooted in the world of life. People understand policy not from technical logic, but from meanings born from social interactions, life experiences, and efforts to maintain family welfare. Thus, community participation in *stunting* programs can be seen as a meaningful social action, not just a form of ignorance of modern health concepts.

The process of adaptation of this meaning can also be explained through the concept *of medicalization* introduced by Conrad (2010). In many contexts, the term medical extends its realm into social life. However, in the case of Jeneponto, the process is exactly the opposite: people *re-socialize* the medical term stunting by associating it with the social and economic aspects of their lives. Government programs designed to address nutrition problems turned into a mechanism for distributing social attention from the state to citizens. In the process, medical knowledge is transformed into a social category that lives in people's practices and conversations.

From the perspective of the sociology of knowledge, this shows that medical knowledge and local knowledge are not in a position of contradiction with each other, but rather interact dynamically. Medical knowledge provides an objective framework for understanding health, while local knowledge adds a social and cultural context that makes it relevant to everyday life. When these two knowledge systems interact with each other, a new form of social reality is born that bridges the scientific world and the world of society. This reality shows that health is not solely related to the body, but also to meaning, social relationships, and the policy structures that surround it.

This synthesis emphasizes that effective health policies depend not only on the appropriateness of medical interventions, but also on the ability of governments to understand how people interpret those policies. In the context of Jeneponto, the success of the *stunting* reduction program is greatly influenced by the community's acceptance of the social meaning behind the program. The community is not just a recipient of policies, but also social actors who actively construct new meanings for the policies received. Therefore, *stunting management* needs to be understood as a social process that involves a dialogue between medical knowledge and local knowledge.

Through the perspective of social phenomenology, this study shows that the reality of *stunting* in Jeneponto is formed through negotiations between policy structures and the world of people's lives. In the negotiations, a unique form of social adaptation was born, in which medical terms were lived, reinterpreted, and made part of a legitimate social strategy in people's lives. By understanding these social dimensions, health policies can be developed in a more contextual manner, respect local knowledge, and potentially generate more sustainable social change.

CONCLUSION

This study concludes that stunting in Jeneponto Regency is not merely understood as a biomedical condition linked to chronic malnutrition, but as a social category embedded in local knowledge, lived experience, and community interaction with state health programs. For the community, a healthy child is defined not by anthropometric standards, but by social indicators such as activity, appetite, and the ability to participate in daily life. As a result, the stunting label is reinterpreted not as a sign of disease, but as an opportunity to access government assistance. The negotiation between medical discourse and local rationality produces a hybrid understanding of stunting that accommodates formal health messages while maintaining local beliefs about hereditary traits and bodily norms. These findings confirm that stunting is not solely a nutritional problem, but a socially constructed reality shaped by meaning-making processes, institutional practices, and everyday experiences.

To optimize stunting reduction efforts in Jeneponto, several strategic improvements are recommended. Local governments should develop communication approaches that connect medical explanations with meanings understood by the community. Rather than focusing on height measurements, messages need to emphasize outcomes valued by families, such as children’s readiness for school, cognitive development, and active participation in social activities. Aligning policy narratives with local perspectives will increase acceptance and reduce misunderstandings.

Health workers and posyandu cadres are encouraged to use simple language and culturally familiar expressions when explaining stunting. Demonstrations of nutritious food preparation should rely on ingredients commonly available in households, making nutritional guidance more practical and relevant to everyday life.

Program designers should also review the current mechanism of nutritional assistance. Support that is limited strictly by age may encourage families to register children only to obtain aid. More flexible criteria would ensure that assistance reflects actual needs and motivates sustained changes in feeding practices.

Finally, community leaders should be involved in facilitating discussions that connect medical information with local experiences. Their participation can increase trust, correct misconceptions about hereditary causes of short stature, and encourage wider community participation. Implemented together, these recommendations can strengthen policy relevance, enhance public understanding, and promote more sustainable improvements in child health.

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SHORT PROFILE

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