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Negotiating Stunting Stigma among Families and Health Workers in Kalukubula Village, Central Sulawesi

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A B S T R A C T

This article examines how families and health workers in Kalukubula Village, Central Sulawesi, respond to the social stigma associated with stunting. While public health approaches generally view stunting solely as a nutritional indicator, this ethnographic study reveals that, at the local level, the condition is perceived as a moral judgment regarding a mother's role and family honor. Through observations and interviews with ten informants, consisting of mothers, health volunteers, village midwives, and community leaders. It was found that a stunting diagnosis from the local community health center (Puskesmas) often triggers varied reactions. Some families withdraw from public spaces, such as the integrated health post (Posyandu), to avoid public scrutiny, while others respond to social pressure by providing intensive home-based care to restore their reputation. These differing reactions stem from the gap between clinical definitions and local perspectives on stunting. The social stigma surrounding stunting in Kalukubula Village is not merely shaped by clinical labels but is negotiated through interactions among families, health workers, and the community as they interpret children's growth conditions. This negotiation process shapes how families respond to a stunting diagnosis, which in turn influences their decisions to accept, reject, or avoid health services.

A. INTRODUCTION

Stunting is a condition characterized by growth failure in children under five years of age due to chronic malnutrition, resulting in children who are too short for their age, defined by a height-for-age z-score of less than -2 standard deviations (-2 SD) for stunted and less than -3 SD for severely stunted (Suryaningsi et al., 2024). Data from Indonesia's Nutritional Status in Figures 2025 indicates a severe stunting prevalence of 4.2% and a total stunting rate of 15.6%. In Central Sulawesi, these figures are even more alarming, with severe stunting at 5.9% and total stunting reaching 20.2% (RI, 2025).

These statistics demand urgent attention, as children represent the next generation whose development dictates the future quality of human capital. Crucially, this issue cannot be framed through a strictly clinical lens; it requires a multidimensional perspective, particularly one that accounts for Indonesia's diverse multicultural landscape. Stunting transcends mere biological growth failure in infants and toddlers; it is a manifestation of chronic malnutrition intertwined with complex socio-cultural conditions that unfold from gestation through the first two years of life (Rima Indirwa, 2023). In Indonesia, stunting remains a pressing public health concern.

In the specific context of Kalukubula Village, where social solidarity remains deeply rooted, stunting is viewed not only through formal institutional frameworks, such as Posyandu (integrated health posts), Puskesmas (community health centers), and hospitals, but also within the private realm of the household. Given that children culturally fall within the parental sphere, the family serves as the focal point for efforts to address stunting. However, interactions between parents (particularly mothers) and the healthcare system often inadvertently trigger negative stigma. Consequently, stunting is understood as an intersectional phenomenon shaped by

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biological, psychological, socioeconomic, and cultural factors (Hayati, 2026). Taking these regional variations into account, stunting intervention strategies aim not merely to reduce prevalence rates but to integrate the lived, everyday experiences of local families.

Within the households of Kalukubula Village, a child holds a position that extends far beyond mere lineage; children embody the family's self-esteem, honor, and social standing. Consequently, a stunted child is often perceived as a sign of parental negligence or failure in childrearing. This leads families to frequently conceal the condition, meaning a child officially diagnosed as stunted by the community health center (Puskesmas) is not necessarily acknowledged as such within the family's own perception. In Kalukubula Village, where kinship networks and communal moral appraisals continue to exert strong social control, the clinical diagnosis of stunting is not merely interpreted as a medical issue; rather, it is internalized as a social 'claim' regarding parental caregiving competence. Consequently, families frequently choose to conceal the condition to preserve household honor, thereby creating a 'gap' between formal clinical categories and the emic recognition operating within the domestic sphere.

In Kalukubula Village, parents exercise heightened caution in childrearing by embedding childcare and supervision within both the nuclear and extended family. They deliberately avoid relying on non-kin caregivers, believing that the kinship network provides a safer, more reassuring environment for the child. This is done with the understanding that close kin share an intrinsic bond with the child, offering essential protection and affection when maternal oversight is absent. This familial involvement is deeply rooted in a primordial kinship system.

Furthermore, family collective decisions play a pivotal role in child care and upbringing, encompassing prenatal care, infant and toddler care, nutrition, health, education, and household economics. When children fall ill or experience health issues, families often turn to traditional therapeutic methods, such as generational massage techniques (pengurutan), inherited food preparation traditions, or local healers (dukun/orang pintar). Nevertheless, they continue to utilize modern medical institutions for comprehensive healthcare and treatment.

The spirit of solidarity within Kalukubula Village serves as a vital catalyst for reducing the prevalence of stunting. Cross-sectoral collaboration, ranging from Posyandu implementation and Puskesmas involvement to the participation of local government officials, community leaders, and religious figures in the 'Rembug Stunting' (stunting alleviation forum), supports these mitigation efforts. Furthermore, the active participation of mothers in Posyandu, combined with the dedicated efforts of health cadres and midwives conducting door-to-door visits, ensures that healthcare services reach even the most remote households. The community's deep-rooted respect for the moral authority and guidance of central figures also plays a crucial role in driving the success of stunting-reduction initiatives.

This complex research must continue to evolve. This realization stems from a growing of literature on stunting that moves beyond deceptively neutral biomedical categories to increasingly encompass socio-cultural negotiations, the moral economy of the household, social stratification systems, kinship structures, and social stigma.

Studies examining the social dimensions of health policies demonstrate that diagnostic labels, such as 'stunting' frequently transcend clinical boundaries to become powerful markers of social judgment, shifting the burden of accountability onto maternal competence (Putri et al., 2025). Building on this critical discourse, recent inquiries into localized responses to child health in Central Sulawesi emphasize that families do not merely passively receive health interventions. Instead, they actively navigate, resist, or domesticate external medical categories to protect their social standing within tight-knit communities. However, despite extensive research on the structural and nutritional determinants of stunting, limited ethnographic attention has been paid to how mothers and their kinship networks negotiate the everyday psychological weight and social stigma attached to the stunting label at the local village.

While previous studies have predominantly emphasized the biomedical and nutritional dimensions that While previous studies have predominantly examined stunting through a biomedical lens, attributing its onset during the golden age to factors such as maternal anemia, gestational complications, childhood infections, nutritional deficiencies, and environmental sanitation (Pribadi, 2024), others point to parental nutritional literacy, caregiving and feeding practices, household socioeconomic status, and delayed detection (Fauziah et al., 2024). Furthermore, socio-cultural inquiries highlight that dietary habits, food taboos and prescriptions for both mothers and children, and intergenerational cultural traditions also shape the condition (Nikmah et al., 2024). Additional research notes that household cigarette smoke exposure, infant honey consumption, traditional pregnancy and birth beliefs, breastfeeding taboos, complementary feeding practices, and social support networks are critical contributing elements (Oktafiani et al., 2024), alongside children's eating behaviors, parental work demands, and a lack of awareness regarding balanced nutrition (Widiawati et al., 2025).

Departing from these existing works, this study investigates the social stigma surrounding stunted families within the community, which emerges from diverging understandings of stunting between healthcare professionals and mothers. This stigma generates dual psychological and behavioral consequences: negatively, it

drives parents to shun Posyandu activities and avoid formal health facilities like Puskesmas or hospitals; conversely, it can positively motivate mothers to intensify childrearing efforts to ensure their children catch up to standard developmental milestones.

B. METHOD

This study applied a qualitative approach utilizing observation and in-depth interviews to capture data depth and variation (Denzin & Lincoln, 1994). An ethnographic approach within the framework of medical anthropology was applied to examine and analyze the negotiation and construction of stunting stigma among affected children and their families in Kalukubula Village, Central Sulawesi. The ethnographic method is used for in-depth analysis (Spradley, 1997).

Data collection was conducted over a period of six months. Field observations, during Posyandu activities and everyday social interactions. In-depth interviews were carried out with eleven informants selected through purposive sampling, comprising five mothers of stunted children, two Posyandu health cadres, two healthcare workers involved in stunting alleviation programs, one community figure who participated in Rembug Stunting, and one family member actively engaged in childcare. All data presented were obtained with the informants' explicit consent, without masking their identities.

C. RESULTS AND DISCUSSION

In anthropological studies, stigma is perceived as a socio-cultural phenomenon reflecting how society attributes meaning to differences and deviations from prevailing group norms (Shuttleworth, 2004). Communities possess a set of values, symbols, and moral systems that delineate who is considered 'normal' and who is deemed 'deviant' (Laraenim et al., 2024). Consequently, stigma is not merely an individual issue but a product of social and cultural processes that mark individuals or groups with a specific identity, often negative based on dominant cultural constructions. Stigma illuminates the intricate relationship between culture, power, and identity (Goffman, 1963). In this context, how stigma is constructed, maintained, and negotiated in everyday life, such as stigma toward disease, poverty, or marginalized groups emerges not only from factual differences but also from symbolic and social structures that dictate the distribution of social prestige (Brandao & Silva, 2021).

This study reveals the hidden social mechanisms underlying practices of exclusion, discrimination, or negative labeling that may appear natural within a society. Furthermore, it highlights how labeled individuals and groups respond to and negotiate their identities, demonstrating that stigma serves not only as a tool for labeling but also as a space for resistance and social transformation. Thus, this research provides a broader understanding of the diversity of human experiences and the ways in which culture shapes the concept of stunting stigma through social relations, the boundaries of identity between the stunted and non-stunted, and the creation of meaning over these differences.

1. Stunting and Childcare

In the society of Kalukubula Village, childcare is primarily shouldered by the household, encompassing both nuclear and extended family networks. The nuclear family serves as the primary sphere where everyday health practices are shaped and executed, ranging from decisions regarding breastfeeding, the selection and preparation of complementary feeding (MP-ASI), and dietary management, to the choice of therapeutic institutions. In this contexs, childcare involves fathers, mothers, and siblings. However, because fathers predominantly work outside the home, their direct involvement in caregiving is minimal. In contrast, mothers spend more time at home, acting as primary caregivers and figures closest to the child. Yet, when maternal obligations require mothers to leave the home for various domestic or economic reasons, childcare responsibilities are temporarily shifted to siblings or members of the extended kinship network.

Fathers are entrusted with the primary role of household breadwinners, whereas mothers and working-age children may assist in generating supplementary income. Consequently, direct childcare responsibilities are seldom placed on the father. Meanwhile, mothers act as primary caregivers, assisted by older siblings who help tend to younger children when the mother is away or occupied with domestic chores. The extended family is further integrated into this framework when both the mother and older siblings must leave the home for school, work, or other duties. The involvement of extended family members, such as aunts or grandmothers facilitated by close kinship ties, is deemed capable of providing proper supervision and appropriate childcare while the mother

fulfills her roles outside the domestic sphere. As expressed by the mothers:

> *"...I just stay at home. But usually I go to the market or there's an invitation from the family, I will go out. But when I remember that I have a child at home, so it doesn't take long time. Sometimes an older sibling looks after, but when he goes to school, so after school he can look after his younger sibling. His father, never because of work". (Frida, September 2025)*

> *"Usually, his older sibling looks after him. But that's only on vacation, Saturdays or Sundays, because of school. When I'm going to the market or for other business, just for a moment. But for the wedding's family, I bring him with me. He's not fussy, either. His dad? No... he's working." (Afifah Nur, September 2025)*

Families residing with extended family members can entrust their children to other household members when leaving the home or attending to domestic chores. Some leave their children with sisters, others with their parents, and some with cousins living outside the immediate household. Extended family members, such as grandmothers or aunts, play a vital role in infant and toddler care. They are more trusted as close kin, ensuring that young children remain secure and protected. Some willingly visit the household to look after the infant or toddler, while others bring the child to their own homes, effectively entrusting them to ensure proper supervision. Similarly, mothers who engage in wage labor often rely on extended family members living under the same roof for daily childcare. As several mothers recounted during the interviews:

> *"Oh... if I have to go far awhile and there's no one at home, I usually leave my child with my older sister, his aunt. She lives in Palu. But I don't go there, she comes here. I think my child will save wth my family. With someone else, I don't think so. I'm afraid something will be happened to him, such as he might falls and no one tell us..." (Afifah Nur, September 2025)*

> *"Sametimes with her grandmother. My mother lives in Kalukubula also. It's near from here. If there's no one at home, her father's working, her older sister is at school. I took her there. When I went home, I pick her up before. My mother told me to take her there. She didn't want her granddaughter to be looked after by someone else. Maybe she's worried about it. I pick her up, before I go." (Frida, September 2025)*

As bearers of this role, mothers are assigned full responsibility for the child's well-being and health. If a child falls ill, the mother is often 'blamed,' deemed a failure, or perceived as lacking attentiveness even when she has provided maximum care and attention. This dynamic is particularly evident when a child experiences stunting; mothers frequently face negative commentary, such as being accused of negligence in feeding, laziness in childcare, or a lack of proper parenting knowledge. Mothers frequently experience social burdens and stigma when their children suffer from stunting, as the community routinely links the condition to a lack of parental, specifically maternal attention or care. As illustrated in the following interviews with mothers:

> *"Yes, because it's normal. If we find that our child is stunted. The other could say that, so why? We've taking good care of our child. Don't continue to cheat them. Even we've taken good care of our child, just resign the situation." (Frida, September 2025)*

> *"Oh that's right. They say…Be good in feeding your child! If he doesn't want to eat, bribe him. If he doesn't like it, make food he likes." (Zaitun, September 2025)*

This indicates that the social construction of caregiving positions mothers as the primary party held accountable; consequently, when a child experiences growth faltering, mothers are frequently subjected to blame despite having exerted maximum effort in child-rearing (Yakin et al., 2026). This attitude reflects the presence of a moral dimension within healthcare practices, wherein a child's health serves as a benchmark for the quality of mothering (Lukitasari et al., 2025).

Basically, mothers in Kalukubula Village are fully aware of the vital importance of children's health. They acquire this knowledge from health workers and learn from their experiences with previous cases of stunting. Below are excerpts from interviews with the mothers:

> *"I heard from the midwife, when I took my child ceck up. She said that do not neglect a child suffering from stunting." (Haryati, September 2025)*

> *"Well, She already been stunting, so I already know how to anticipate it." (Frida, September 2025)*

This indicates that a mother's capacity for childcare is inextricably linked to the role of village midwives (bidan desa), who actively provide education and counseling on stunting. Nevertheless, mothers' absorption of this knowledge varies, largely depending on their individual educational backgrounds. Ultimately, this variation influences the quality of caregiving and shapes the likelihood of a child developing stunting (Rahmah et al., 2023). As illustrated in the following interviews with midwives:

> *"It's like you. It's really good to understanding. It's not like someone else. It's really helpful to tell…" (Elen, Januari 2025)*

"Yes, it is a bit difficult to explain to someone with limited education. But if we explain it repeatedly, again and again. They will understand it, finally." (Mariska, Januari 2025)

Even when mothers have dedicated exceptional attention and care to their children, outsiders frequently perceive them as neglectful of their caregiving responsibilities when a child experiences stunting. Below are interview excerpts with community members and a midwife:

"Children should be cared for by their parents. But for now, it is becoming rare for parents to personally look after their children. The child was left in someone else's care, so they ended up being neglected." (Rauf, Januari 2025)

"In my opinion, cases of stunting nowadays are more frequently observed in children who are cared by the others. It might be, because the way a mother cares for her children, different from others. Even within the same family, but their approaches are different." (Elen, November 2025)

This assumption highlights the immense burden placed on mothers in child-rearing. However, in fulfilling their domestic and economic roles, mothers cannot constantly remain by their children's side; they must occasionally leave the home for various necessities, requiring others to temporarily step into the caregiving role. When surrogate caregivers take over, the quality of care may decline or fall short of maternal standards, potentially increasing the child's vulnerability to illness or, if such conditions persist contributing to growth faltering and stunting.

Parents' attitudes and health-seeking decisions when a child falls ill are frequently perceived as a contributing factor that worsens an illness (Gomez et al., 2024) or in severe cases, leads to mortality. A notable case in Kalukubula Village involved a child initially labeled as stunted by health workers. Reluctant to accept this diagnostic label, the parents chose to avoid Posyandu and Puskesmas visits. When the child later suffered a very high fever, the family opted for traditional healing rather than clinical treatment. As the condition rapidly deteriorated beyond recovery, the child tragically passed away, a fatality widely attributed to delayed medical intervention. The family subsequently left the village, reportedly due to the ensuing social pressure and stigma. Below are interview excerpts with a health cadre, a midwife involved in managing the case at the time, and a local mother:

"There was one case, involving a child who had a fever for approximately three days. The child was identified as stunted, so an intervention was carried out, providing food, milk, and eggs. While the aid was accepted, the parents were reluctant to seek medical treatment. They wanted their child to be healed through traditional rituals instead. However, as the ritual was delayed and the child's condition likely worsened, *the child ultimately passed away." (Wildan, September 2025)*

"Yes, there was one case. An infant, roughly six months old, passed away. The baby had a fever. The infant was stunted and underweight. The fever had lasted for three days. Intervention was offered, but the family refused traditional treatment. They said they wanted to handle it through traditional customs instead. However, that didn't happen, and the baby ultimately died due to the delay in treatment." (Elen, November 2025)

Other mothers who received a stunting classification for their children from the Posyandu initially felt a sense of shame regarding the condition. However, over time, this label had to be accepted as an inherent consequence of bearing primary childcare responsibilities. For them, such a condition could not simply be ignored, as inaction would only worsen the child's health status. As reflected in the following interview excerpts with the mothers:

"At first, I felt ashamed and afraid, wondering why my child had become stunted, especially since I had taken good care of him. Well... what else could I do? I simply made sure to take care of him for medical treatment regularly, so that the condition wouldn't worsen." (Frida, September 2025)

"It's not really a matter of shame. But what can I do when things turn out this way? Well... I just have to accept it. Whatever happens, I have to accept, so that the children can become healthier." (Zaitun, September 2025)

Children classified as stunted are still brought to the Posyandu for routine weighing and health monitoring at the auxiliary community health center (Pustu). Rather than withdrawing from public health services, mothers continue to accept interventions and actively engage in stunting alleviation programs. Below are interview excerpts illustrating this:

"…No… Because if left unchecked, the condition will actually worsen. Health workers also advise that to prevent stunting, you need to take the child for weighing. And if the child is sick, take them to a midwife for treatment." (Frida, September 2025)

"There is no need to worry about it. Whatever people say, just ignore it. We are responsible for our own children. What matters most is that the children continue to receive care and that efforts are made to ensure they no longer suffer from stunting." (Afifah Nur, September 2025)

A mother's knowledge regarding the characteristics of stunting influences her childcare practices. Although this impact may not always be direct, it nonetheless shapes the pathways that can lead to a child developing stunting.

For many mothers, having a short child is considered a normal variation in child growth, as children in general often display proportional differences in body size. This perception is especially strong if the parents are also short, as they view a child's physical stature as a direct result of genetic inheritance from the parents. Below are interview excerpts with the mothers:

> *"After all, being short is perfectly normal. I myself am short and small-statured. My child also has many friends at school who are small. So, why does this become an issue and get labeled as stunting?" (Afifah Nur, September 2025)*

> *"Yes, that's normal for small children. Indonesians are small-statured people, aren't they? What do you think? We're all on the smaller side, right? At the last, there was no such thing as "stunting." So why is it being made into an issue now...?" (Zaitun, September 2025)*

Regarding nutritional fulfillment for stunting prevention, mothers feel they have provided nutritious meals for their children. However, these foods often fail to match the child's preferences, leading mothers to serve whatever is available or whatever satisfies the child's appetite, even if it falls short of health standards. Yet, for these mothers, ensuring the child eats and receives food intake remains the primary concern. Below are interview excerpts with the mothers:

> *"I was once told that when feeding children, I should serve nutrient-rich foods, such as spinach, pumpkin, and carrots. So, yes, I do give them those vegetables." (Afifah Nur, September 2025)*

> *"I often get criticized by older people for giving my child Somay. But why? She likes it. So, I just give it to her. The most important thing is that she actually wants to eat. That's better than forcing him to eat vegetables—which he dislikes. What's wrong if he threw up and then refused to eat anything at all time? That would be worse than letting her go with an empty stomach, which could actually make her sick. Of course, she takes vitamins, but she simply doesn't like vegetables." (Dewi, September 2025)*

Consequently, childcare is not viewed solely as the exclusive responsibility of the mother, but rather as a shared duty among all household and family members (Seran et al., 2023). This is especially true given that contemporary maternal roles extend far beyond the domestic sphere into the public domain. When a child experiences stunting, mothers receive support not only from the broader kinship network but also from medical institutions and the wider community. Medical institutions, in particular, play a crucial role in enhancing mothers' accurate understanding of stunting, preventing them from relying solely on personal, subjective experiences, which can otherwise influence both the likelihood of stunting and the mother's behavioral responses in managing it.

2. Formation of the Paradigm and Stigma of Stunting in Kalukubula Village

The formal classification of a child as stunted originates within the Posyandu (integrated healthcare post), where the child's growth metrics are monitored and recorded by healthcare professionals and community volunteers. This data is subsequently channeled to the Pustu (auxiliary health center) or Puskesmas (primary health center) before being reported to the District Health Office.

The identification of stunting begins with recording body weight and height or length measurements at the Posyandu. These measurements are compared against WHO standards using the height-for-age or length-for-age indicator (HAZ/LAZ). A child is classified as stunted when the z-score falls below -2 standard deviations (SD), and severely stunted if it is below -3 SD (Kementerian Kesehatan RI, 2023). The z-score calculation is processed through an application, generating results once the required data are completely entered. This data entry for children is conducted directly at either the Posyandu or the auxiliary community health center (Pustu).

Through this systematic record-keeping, children exhibiting growth patterns that deviate from established standards are identified at an early stage, and their distribution is spatially mapped within a specific region. Once a child is categorized as stunted, two forms of intervention are implemented: specific nutrition interventions and sensitive nutrition interventions. Specific nutrition interventions focus on clinical measures, including supplementary feeding, iron supplementation, vitamin distribution, or infection therapy when necessary (Samsuddin et al., 2023). Conversely, sensitive nutrition interventions encompass broader systemic improvements, such as enhanced sanitation, access to clean water, family empowerment, and the elevation of parental education (Liza Munira, 2023). Following these interventions, all developmental data are recorded periodically to monitor the efficacy of the implemented strategies.

Given the transparent and communal nature of the Posyandu, where interactions among mothers, volunteers, and midwives occur openly, information regarding a child's stunting status disseminates rapidly. Observations conducted at the Melati 1 and Mawar 2 Posyandu in Kalukubula Village indicate that activities are highly intensive and communicative. Volunteers and midwives frequently provide counseling and guidance on nutrition

and childcare to prevent stunting. For children already identified as stunted, interventions become more focused, often involving direct advice and warnings to mothers to prioritize recovery through intensive care. This social phenomenon positions the stunted child and their mother as the 'center of attention.' This process is further amplified by the communal culture of rural areas or local communities characterized by high-intensity social interactions. In these settings, information concerning a child's health condition spreads swiftly through informal discourses among mothers, volunteers, families, and other community members.

Consequently, this heightened visibility transforms the Posyandu into a social arena where stunting-related stigma inadvertently originates and propagates, despite its primary objective as a health monitoring facility. This stigma emerges through the mechanism of social comparison. Posyandu facilitates a collective moment where a child's physical growth is directly compared to that of their peers. This comparative environment often subjects parents to social scrutiny based on their child's measurements. The following is an interview excerpt from a Posyandu worker (kader):

> *"Yes, at the Posyandu, we record weight, height, and upper arm circumference the child. Then, the information is reported to the Pustu. Based on it, the determinance that the child is stunted become, because the measurement fall below the red line." (Wildan, September 2025).*

Children identified as potentially stunted are informed to the mothers or family members who bring them to the Posyandu on that day. Due to the open, public nature of Posyandu activities, this information easily circulates from one individual to another. Below is an image illustrating the open interaction among mothers during a Posyandu session:

Figure 1. Mothers' Interactions During Health Check-ups at The Posyandu Melati 1



When a child is formally identified as stunted at the Posyandu, it often triggers deep emotional distress for parents, forcing them to internalize societal judgment regarding their child's condition. Field data indicates that mothers of stunted children frequently face negative commentary; they are commonly perceived as neglectful in feeding, indifferent in child-rearing, or lacking the requisite knowledge for proper care. These mothers frequently endure a heavy social burden and stigma when their children are diagnosed with stunting. Community discourse routinely links stunting to a lack of parental attention or care, specifically directing blame toward the mother. This phenomenon demonstrates that the social construction of parenting places a disproportionate level of accountability on mothers. Consequently, when a child experiences growth impairments, this burden falls heavily upon the mother, rendering her the primary target of social scrutiny despite her utmost efforts to provide adequate care. This is reflected in the following account from mother informants:

> *"That thought crossed my mind. Why did the midwife said that? Claimed that our child was stunted, without knowing how hard we struggle and take care of them." (Afifah Nur, September 2025).*

> *"At first, I felt ashamed and afraid, wondering... Why is this happening to my child? After all, I had taken good care of her. Well... what else could I do? So... I made sure to take her for regular medical treatment so He could recover from stunting." (Frida, September 2025)*

This issue indicates that regardless of the extent of a mother's efforts in child-rearing, the others continue to perceive her as incompetent while completely disregarding her lived experiences. She also experiences a sense of shame and guilt resulting from this treatment,

even though she has provided what she believes to be the best possible care.

Stigma arises when public understanding of stunting remains limited, particularly when a child's health status is treated as the absolute benchmark for the quality of a mother's care. Common indicators—such as frequent illness or a lack of appetite are viewed by the public as primary signs of stunting. This perspective is reflected in an interview with mothers:

> *"Well… it was said that a stunted child is the condition is not adjusted to their age. Their height and weight. They are not cheerful. They're often gloomy, unplaying enough. And they're weak and easy to get sick." (Frida, September 2025)*

> *"Yes, it was said that childreen must be cheerful and happy. Especially if it was a boy. Jumping and climbing. If he was just quiet, he would be stunted. Then he easy to get sick. If the child was small, he would be stunted." (Afifah Nur, September 2025)*

In this context, the mother's role is perceived as paramount; mothers are expected to ensure dietary compliance, often by forcing the child to eat or strictly adhering to the child's preferences. Such practices reflect a reductionist understanding that dietary intake is the sole factor in stunting prevention (Tjiali & Adam, 2024). This perception fuels the narrative that stunting is merely a 'maternal failure,' despite scientific evidence showing that stunting results from a complex interaction of nutrition, health, environment, and socioeconomic structures. In reality, a mother's capacity to meet her child's nutritional and health needs is heavily constrained by household economic conditions (Sebayang et al., 2025). High economic burdens limit family access to nutritious food, healthcare, and a healthy living environment. Furthermore, maternal employment status cannot be viewed simplistically as either a risk or a protective factor for stunting (Rakinaung et al., 2026). On one hand, working mothers face time constraints in childcare but simultaneously enhance the family's financial resources. On the other hand, non-working mothers have greater opportunities to accompany their children, yet they do not always possess the financial capacity required to afford adequate nutritional and healthcare needs.

Stigma further proliferates within specific social spaces characterized by intensive information exchange and social interaction, with the Posyandu serving as a primary example. Consequently, the Posyandu operates in institutional ambivalence; while its public and comparative nature inadvertently generates spatial stigmatization, it simultaneously functions as a critical arena for midwives and cadres to deconstruct that very stigma through empathetic counseling. In this context, the roles of midwives and volunteers are crucial in shifting the perspective from viewing stunting as an individual maternal failure to understanding it as a complex health issue influenced by multifaceted factors. The case in Kalukubula Village demonstrates the active engagement of midwives and volunteers in preventing the Posyandu from becoming a breeding ground for stunting stigma. Through frequent counseling and guidance, they discourage mutual disparagement among mothers, instead fostering a culture of mutual reinforcement. Their involvement, characterized by solidarity and kinship, exemplified through home visits and supportive guidance, facilitates a paradigm shift in community perceptions. Ultimately, this shifts the social narrative away from 'maternal failure,' ensuring that mothers feel supported rather than marginalized. In this capacity, midwives and volunteers function not merely as technical health workers, but as social agents who alleviate the moral burden on mothers by fostering grassroots solidarity and mobilizing the immediate family support network.

Beyond the Posyandu, the Puskesmas (Community Health Center) serves as a pivotal medium for deconstructing stunting stigma. This role is essential, as the Puskesmas functions as a primary healthcare hub invested with the mandate, authority, and legitimacy to shape health narratives within the community (Pratiwi & Dewi, 2026). In this capacity, the Puskesmas acts simultaneously as a medical institution and an agent of social change (Indra P. et al., 2024). Puskesmas professionals play a significant role in destigmatizing stunting, shifting the public narrative from a moralistic maternal failure into a systemic health issue requiring collective action. Consequently, the Puskesmas provides a structural framework to rectify erroneous public perspectives regarding health, particularly concerning stunting. This institutional intervention also addresses the psychological barriers faced by mothers, such as the reluctance to acknowledge their child's stunting status due to the associated shame. Although mothers may initially exhibit resistance, the social interventions conducted by the Puskesmas through counseling and health education effectively reframe the community's flawed paradigms. By doing so, the institution facilitates a broader cognitive

shift, replacing social stigma with a more comprehensive understanding of the condition.

In the socio-cultural landscape of Kalukubula Village, child-rearing and health are frequently framed through a religious lens where children are perceived as a divine trust (amanah) that must be nurtured with care. Field observations indicate that local understandings of childcare are deeply intertwined with religious values, wherein mitigating stunting is often articulated by community members not merely as a medical obligation, but as a shared moral and spiritual responsibility. However, interviews with mothers and health cadres reveal that while institutional actors and community discourses actively promote this religious framing, its practical internalization varies at the household level, often intersecting with daily economic pressures and localized stigmas.

Furthermore, institutional programs and community forums such as Rembug Stunting frequently incorporate religious idioms and moral appeals, leveraging local gatherings to disseminate the narrative that families with stunted children should be supported rather than blamed. Field observations and accounts from health cadres indicate that religious and community values are often mobilized during these multi-sectoral forums to align public health messaging with local beliefs, effectively reaching the grassroots level.

3. Implications of Stunting Stigma in the Kalukubula Village Community

Stunting stigma significantly contributes to feelings of shame and a perceived loss of social standing among mothers. When a child's physical growth is categorized as stunted or failing to meet age-appropriate developmental milestones, it is frequently concluded to be the result of failed parenting, primarily targeting the mother. This categorization creates a clear distinction between stunted children and those with 'normal' growth, leading mothers to experience profound guilt and a sense of futility regarding their caregiving efforts. Such dynamics exacerbate the psychological burden on parents, often resulting in a reluctance to seek assistance or to engage in open dialogue about their circumstances. This is evident in an interview with a mother:

"Firstly, I felt ashamed and embarrassed when another said that my child is stunting. I even refused to take the child for a check-up. But the health volunteer told me, If you stay like *that, how your child even be healthy?" (Frida, September 2025).*

Therefore, it is imperative to shift the societal paradigm that evaluates parental competence based solely on a child's physical attributes. Raising holistic awareness regarding the multifarious causes of stunting is essential to encourage parents to seek support and solutions without the fear of being stigmatized as 'failed parents'.

A notable case in Kalukubula Village illustrates the profound tension between formal biomedical protocols and local health-seeking behaviors. A family chose to relocate from the village following the tragic death of their child, who had previously been identified as stunted by the local health center (Puskesmas). While healthcare providers attributed the fatality to delayed clinical intervention and a reliance on traditional healing methods rather than biomedical treatment, community discourses frequently cast the event through the lens of parental negligence and the social stigma attached to rejecting institutional health advice. The following interview excerpt with a health cadre (kader) details how this incident unfolded and was perceived at the grassroots level:

" Yes, the child had been diagnosed with stunting and was intervened. They were told to seek treatment at the auxiliary community health center but they refused. It seemed they preferred to traditional customs instead. However, because treatment was delayed, the child finally... passed away." (Wildan, September 2025)

This tragic event has actually sparked a variety of conflicting social narratives within the community. On one hand, healthcare workers attribute the worsening condition to delayed medical intervention and a reliance on traditional treatment methods; on the other, villagers often reduce the issue to a debate over parental responsibility and the fundamental tension between formal medical institutions and local healing practices.

These occurrences suggest that stunting prevention must be addressed more rigorously by accounting for the presence of traditional healing institutions, which are frequently preferred by the community as alternative care. A segment of the population maintains greater trust in indigenous healing mechanisms over formal medical services, even when a child's condition is clinically categorized as stunting and requires immediate health intervention. This attitude reflects deep-seated cultural beliefs in the efficacy of traditional rituals, while simultaneously highlighting the stigma and resistance toward medical labels such as 'stunting,' which are often perceived as carrying negative or shameful connotations

for the family. Ultimately, this underscores a significant divergence between community perspectives on health and the biomedical frameworks employed by healthcare professionals.

'Rembuk Stunting' held every August in Kalukubula Village effectively serves as a platform that bridges structural and traditional approaches within the community. By engaging various sectors—ranging from medical professionals and community health workers (kader) to customary leaders, community figures, religious leaders, and the general public—this forum synthesizes diverse ideas into integrated recommendations. This initiative reinforces the recognition of local knowledge and indigenous cultural values, aiming for a modern healthcare orientation that remains inclusive of traditional healing practices.

Conversely, some community members adopt a more empathetic perspective, viewing stunting as a multifaceted health issue rather than a mere parental failure. These individuals are more receptive to medical information and health education, acknowledging that stunting arises from various determinants, including environmental factors such as poor sanitation, recurrent infections, and limited access to nutritious food. In this context, parents of stunted children are not perceived as having 'failed'; instead, they are seen as individuals constrained by challenging socioeconomic conditions who require support to improve their child's well-being. Such a viewpoint serves to dismantle the cycle of stigma surrounding stunting by fostering broader communal understanding. This is reflected in the following interview with a community informant:

4. The Impact of Stigma on Families with Stunting Children

Fundamentally, when families particularly mothers whose children are diagnosed as stunted by the Puskesmas, encounter such clinical claims, their responses are rarely uniform. While biomedical diagnoses carry institutional authority that often compels public acquiescence, parental reactions to these labels vary significantly. Rather than representing a uniform act of resistance or 'hidden agency,' a mother's assertion of having provided adequate care may signal multiple psychological and social positions: it can serve as a defensive stance against external scrutiny, an expression of uncertainty or fatalistic resignation, or a complex negotiation between her intimate, lived caregiving experiences and biomedical metrics. Therefore, understanding a mother's attitude or disagreement requires sensitivity to this emotional and cognitive spectrum, ensuring that every instance of divergence is not automatically equated with active resistance. This tension between clinical diagnosis and maternal intuition is illustrated in the following interview with a mothers:

> *"We took such good care of the child, but what can we do when they get sick?." (Frida, September 2025).*

> *"Well... I suppose... The children have been given good food and well cared. So, if it's like that, what can we do..." (Kalsum, September 2025)*

This statement reflects a complex emotional response rather than a direct rejection of stunting diagnostics. It may signal a mother's defensive positioning against external judgments, an expression of fatalistic resignation in the face of illness, or an underlying negotiation between her lived caregiving efforts and biomedical authority.

The stigma arising from the perception of parental failure in childrearing triggers feelings of shame, guilt, and even a sense of being undervalued. Stigmatized parents often become isolated and encounter difficulties in seeking support from both their families and the wider community. Excessive shame further obstructs their access to healthcare services or medical consultations, driven by the fear of being judged or perceived as incompetent caregivers. This heightened stress, in turn, adversely affects the quality of parenting provided to the child. Conversely, such negative perceptions can, in some instances, provoke a constructive response among parents. While the stigma initially causes distress, if reinterpreted as a 'hard lesson,' it can empower parents to overcome their shame and guilt. They may then transcend the problem, actively seeking solutions and mobilization of support to address their challenges. This resilience is illustrated in the following interview with a mother informant:

> *"... whatever people say, just skip it. We know our own children. The most important is just take care of them, so they are no longer stunted anymore." (Afifah Nur, September 2025).*

On the other hand, interventions such as supplementary food assistance and home visits are not automatically perceived as sources of stigma; instead, they generate diverse and contradictory meanings within the community. While some mothers and families view this assistance as a form of moral and material support that eases daily caregiving burdens, others experience targeted interventions as intrusive surveillance, evoking anxiety over neighbors' scrutiny and heightening the visibility of domestic vulnerability within the public sphere of the village. These layered meanings demonstrate that parental responses to stunting alleviation programs do not stem

from simple despair, but rather emerge from a psychosocial negotiation between the necessity of material aid and anxieties regarding social judgment.

Conversely, this situation can also be perceived as a catalyst for positive change. For some, the stunting claim serves as a prompt for more intensive involvement in medical services and childcare. Field data demonstrate how informants negotiate their identities amidst stigmatization; they no longer passively accept the label of 'mother of a stunted child' but instead articulate adaptive and resistive strategies to maintain their dignity and social standing. Furthermore, the intensive interactions between the community, health volunteers (kader), and mothers become pivotal in the social construction of health and healing. Their continued participation in growth monitoring and treatment signifies that, despite the presence of stigma, they remain resilient against social pressure, while simultaneously reconstructing the definition of a 'good mother' based on their own contexts and experiences. This is further illustrated in the following interview with a mother informant:

> *" The most important is listen to midwife. Believe that our child will be better. After all, they are the ones who know most." (Frida, 5 September 2025).*

Families with stunted children receive specialized treatment from integrated health posts (Posyandu) and sub-district health clinics (Pustu). This takes the form of targeted interventions, such as the provision of specialized food assistance not afforded to non-stunted children. Furthermore, for those who avoid these health institutions following a stunting diagnosis, midwives and community health workers (kader) conduct 'door-to-door' visits to ensure the aid reaches its target. However, such treatment inherently distinguishes the 'stunted' from the 'normal.' The provision of food aid inadvertently showcases the family's perceived inability to fulfill nutritional needs. Consequently, without a nuanced cultural approach, this specialized treatment may reinforce social stigma and symbolic exclusion of these families. The 'stunting' label, which should remain a technical medical term, transforms into a negative social identity, creating a rift between the family and the community, as well as between the public and healthcare providers. When specialized treatment is administered without respecting the family's dignity, interventions intended to assist can instead trigger resistance. Intensive home visits and food aid further solidify the image of the 'stunted' group as helpless and dependent. Therefore, stunting management strategies should be inclusive, participatory, and non-labeling, emphasizing family empowerment and community solidarity so that assistance is perceived as a form of collective care rather than social judgment.

Conversely, specialized treatment for families with stunted children can also yield positive outcomes, particularly when implemented through an approach that is sensitive, inclusive, and respectful of the community's socio-cultural values. Such targeted care enables families to receive more intensive attention from healthcare professionals, including routine growth monitoring, the provision of nutritious supplementary feeding, and comprehensive education on parenting and sanitation practices. When delivered appropriately, these interventions foster a supportive environment that enhances the family's capacity to address nutritional challenges. This constructive impact is reflected in the following interview with a midwife informant:

> *"For those who are living far away, they brought the aid to them directly. Especially if they are do not come to the Posyandu, we visit them by person. Together with the community health volunteers, we go to their home. We also doing weight and height measurement directly overthere." (Elen, November 2025).*

Through such specialized support, families develop a heightened awareness regarding the significance of nutrition, hygiene, and healthy lifestyles. Ultimately, this increased consciousness can accelerate the recovery of the child's nutritional status and enhance the holistic well-being of the entire family unit.

In the community of Kalukubula Village, communal solidarity and the tradition of mutual cooperation (gotong-royong) are fundamental to stunting mitigation efforts. The proactive engagement of community members, health kader (kader kesehatan), and local leaders in reporting stunting cases is critical for initiating immediate interventions to address nutritional deficiencies. This collaborative synergy ensures that stunting is treated as a shared communal concern, enabling rapid response and localized problem-solving. This dynamic is further elucidated in the following interview with a community leader informant:

> *" Rembug stunting is held every August, once a year. It is organized by the Village Government. It involves all segments of the community, including representatives from the Community Health Center (Puskesmas), village officials, health volunteers, mothers, and general residents. The objective is to identify obstacles in the implementation of stunting programs and to gather proposals, suggestions, and input from the community." (Ihzan, Mei 2025).*

Consequently, whether community-based reporting and local monitoring function to mitigate or exacerbate stigma remains a contested process. On the one hand, collective oversight is often practiced and framed through the values of gotong royong (mutual cooperation), where reporting or identifying a vulnerable child is interpreted by residents as an act of communal care and shared responsibility. On the other hand, this same mechanism can be experienced by families as an intrusive form of social control and exposure, highlighting the fine line between supportive solidarity and institutionalized surveillance in the community life. This phenomenon demonstrates that the social meaning of stunting does not inherently lead to negative stigma; instead, it depends on how the community constructs its understanding of specific health conditions. When stunting is framed as a communal challenge requiring collective action, a transformation of social meaning occurs—shifting from a potential negative label into a space for solidarity and social agency. Furthermore, the roles of community leaders and institutional frameworks such as the 'Stunting Deliberation' (Rembug Stunting) are pivotal in shifting the public paradigm: Through structural frameworks like 'Rembuk Stunting', the community shifts the discourse from maternal culpability to a localized, multi-sectoral accountability.

D. CONCLUSIONS

Stunting-related stigma operates through cultural narratives of 'the healthy child,' 'the ideal mother,' and 'the responsible family,' which are reproduced in daily interactions, including within primary healthcare settings such as Posyandu and Puskesmas. Rather than fostering constructive behavioral change, stigma often triggers negotiation strategies and 'hidden resistance' among families, such as healthcare avoidance, inaccurate reporting of child health conditions, or the rejection of nutritional interventions—ultimately undermining the effectiveness of stunting reduction programs. Conversely, these healthcare services can also serve as platforms for support, encouraging families to transcend stigma through active participation in health initiatives. Furthermore, broader community involvement contributes to shifting stunting from an individual failure to a collective challenge that can be resolved through social synergy.

Consequently, this article emphasizes the vital role of Medical Anthropology in understanding and responding to stunting as a multidimensional issue. Efforts to accelerate stunting reduction must transcend purely technocratic and indicator-based interventions. Instead, they must integrate cultural sensitivity, stigma reduction, and the cultivation of empathetic social relationships between healthcare providers and the community. The dissemination of stunting stigma should be mitigated by engaging healthcare professionals—particularly midwives and community health workers (kader)—alongside central community figures to shift the public paradigm that blames maternal negligence for stunting. By doing so, mothers can regain the confidence to actively participate in medical treatments and proactively seek solutions to improve their child's health.

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