



Mothers' experiences in stunting prevention efforts for children under five: A qualitative study

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ABSTRACT

Background: Stunting is a multidimensional public health problem, and its prevention requires family involvement, particularly from mothers as the primary caregivers of children. Various studies have identified maternal, nutritional, socioeconomic, cultural, and health service factors associated with stunting; however, mothers' experiences in translating health information into daily preventive practices still require in-depth understanding. This study aimed to explore mothers' experiences in undertaking stunting prevention efforts for children under five years. **Methods:** This study employed a qualitative design with a descriptive phenomenological approach. A total of 10 mothers with children aged 12–59 months were selected using purposive sampling. Data were collected through semi-structured in-depth interviews and field notes, then analyzed using Colaizzi's phenomenological method through the identification of significant statements, formulation of meanings, categorization of themes, and theme development. **Findings:** The analysis generated 5 main themes: mothers' understanding of stunting developed through interaction with health services; nutritional fulfillment served as the primary form of prevention; *Posyandu* (*Pos Layanan Terpadu*/Integrated Health Posts) and health workers served as sources of support; economic limitations, children's feeding difficulties, time constraints, and family habits constituted barriers to prevention; and family support strengthened preventive practices. The findings indicate that mothers' experiences in preventing stunting represent a multidimensional process shaped by the interaction between knowledge, caregiving practices, family resources, sociocultural context, and health services. **Conclusion:** Stunting prevention cannot rely solely on improving maternal knowledge but requires a contextual, family-centered community nursing approach. Strengthening health education, involving husbands and families, providing mentorship from cadres and health workers, and optimizing *Posyandu* services are needed to help mothers overcome the various barriers to implementing stunting prevention in their daily lives. **Novelty/Originality of this article:** This study contributes a novel, family- and community-centered perspective on stunting prevention by highlighting the role of *Posyandu* cadres as a local support system embedded in Indonesian rural culture.

KEYWORDS: community nursing; mothers' experiences; phenomenology; stunting prevention; toddlers.

1. Introduction

Stunting among children under five remains an important public health problem because it is associated with child growth and development and with the quality of human resources in the future (Akbar et al., 2023; Jalaludin et al., 2025). Stunting reflects a linear

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growth disorder that develops through a complex process and is not solely related to food adequacy, but is also influenced by maternal and child health conditions, caregiving practices, infectious diseases, socioeconomic conditions, environment, and access to health services. In Indonesia, efforts to reduce stunting have become a public health priority and have shown positive progress. Nevertheless, the continued presence of stunting cases across various regions indicates that prevention efforts still require attention, particularly at the family and community level. Research on stunting reduction strategies in Indonesia shows that maternal nutritional knowledge and government program support are important components in efforts to address stunting among children under five (Putri et al., 2024; Samta, 2025).

The family is the closest environment determining the fulfillment of children's health and nutritional needs, with mothers in many families serving as the primary caregivers responsible for meeting these needs (Fan et al., 2022; Rahmadiyah et al., 2024; Suhardin et al., 2024). The mother's role in stunting prevention takes place through various daily practices, ranging from breastfeeding, complementary feeding/*makanan pendamping air susu ibu* (MPASI), the selection and provision of nutritious food, maintaining child and environmental hygiene, preventing infectious diseases, ensuring immunization, to utilizing health services and monitoring child growth. Therefore, maternal behavior and decision-making in caregiving hold an important position in shaping an environment that supports optimal child growth. Picauly's (2024) study in a stunting locus area of East Nusa Tenggara found that maternal nutrition-related behavior, attitudes and practices in meeting nutritional needs, and children's eating culture were associated with the nutritional status of children under five. These findings indicate that stunting prevention needs to be situated within the context of daily caregiving behavior and the social environment in which mothers care for their children.

From a health behavior perspective, preventive practices are not formed by knowledge alone, but result from the interaction between perception, experience, resources, the social environment, and access to health services. Maternal knowledge regarding nutritional needs and stunting can shape the ability to recognize risk and determine preventive action, but adequate knowledge does not necessarily translate automatically into appropriate practice when mothers face economic limitations, food availability constraints, work demands, cultural influences, lack of family support, or barriers in accessing health services (Prasetyo et al., 2023; Rahmadani et al., 2025; Suryanegara, 2025; Wiliyanarti et al., 2022; Wirawati et al., 2024). This constitutes the conceptual basis for understanding mothers' experiences in stunting prevention as a multidimensional phenomenon that cannot be adequately understood through the quantitative measurement of knowledge or behavior alone.

Empirical evidence illustrates this complexity. Putri et al. (2024) found an association between maternal nutritional knowledge and stunting reduction efforts and emphasized the need for a multidisciplinary approach. Regarding caregiving practices, Picauly (2024) demonstrated the importance of maternal nutrition-related behavior and children's eating culture for the nutritional status of children under five. Earlier qualitative research has also shown that child feeding practices do not always correspond to growth needs. Pradnyawati et al. (2019), for instance, found that some mothers had provided exclusive breastfeeding and initiated complementary feeding at relatively appropriate times, yet limitations remained in attending to nutritional needs, feeding frequency, food type selection, and dietary variety for children. These findings indicate a gap between knowing or performing a health practice and the ability to sustain that practice optimally in daily life.

More recent studies further demonstrate that mothers' caregiving experiences are closely tied to family conditions and the social environment. Akmal et al. (2025), through qualitative research in North Jakarta, found suboptimal caregiving practices, including incomplete exclusive breastfeeding, unbalanced and monotonous complementary feeding, inadequate hygiene practices, and inconsistent utilization of health services. That study also showed that gaps in maternal knowledge, socioeconomic conditions, cultural beliefs, husband's support, and limited extended-family support jointly shaped child caregiving

practices. Stunting prevention behavior thus does not occur in isolation, but is formed through mothers' interactions with family, household conditions, culture, community, and the health service system (Soviyati et al., 2023; Yusriadi et al., 2024).

This perspective is further reinforced by phenomenological research exploring mothers' experiences contextually. Laila et al. (2025) and Saadah et al. (2024) showed that the experiences of low-income mothers in facing stunting risk were shaped by household food security, feeding strategies, time constraints, nutrition literacy, and engagement with primary health services such as the integrated health post/*pos pelayanan terpadu* (Posyandu). That study identified a gap between prevention approaches oriented toward technical nutritional indicators and mothers' needs, which are contextual, social, emotional, and cultural in nature. A participatory, trust-based service approach was reported to be more suited to supporting families. These findings show that mothers' subjective experiences are important to understand, because decisions regarding food, caregiving, hygiene, and the use of health services occur within the lived reality of family life, which cannot always be fully represented through quantitative indicators.

Based on these developments, the state of the art in stunting research has moved from identifying risk factors and associations between maternal knowledge or behavior and stunting toward a more contextual understanding of caregiving practices, feeding patterns, culture, socioeconomic conditions, and family interaction with health services. However, much prior research has still focused on mothers who already have children with stunting, seeking to explain the factors contributing to the occurrence of stunting or caregiving patterns after the condition has been identified (Pradnyawati et al., 2019; Akmal et al., 2025). Research on how mothers of children under five make sense of, carry out, negotiate, and sustain various preventive actions before or while facing stunting risk—as a complete lived experience—still requires further exploration.

This gap matters because stunting prevention efforts normatively recommended by health workers are not necessarily implemented by mothers in the same way in daily life. Each mother may hold different understandings, motivations, sources of information, economic capacity, family support, cultural values, barriers, and experiences of interacting with Posyandu and health facilities. Quantitative research can demonstrate associations between variables but has limitations in explaining the reasons behind mothers' decisions, how mothers interpret health information, how families influence those decisions, what barriers are genuinely experienced, and the strategies mothers use when facing limitations. A qualitative approach is needed to gain a deeper understanding of the meaning behind these preventive actions.

The novelty of this study lies in positioning mothers' experiences in the stunting prevention process as the primary focus, rather than merely measuring maternal knowledge, identifying stunting risk factors, or describing caregiving patterns among children who have already experienced stunting. This study views the experience of prevention as a process encompassing how mothers understand stunting, meet children's nutritional needs, provide breastfeeding and complementary feeding, maintain health and hygiene, monitor growth, utilize Posyandu and health services, obtain support from family and health workers, face barriers, and develop strategies to sustain their children's health and growth. This approach is expected to reveal dimensions of experience not yet fully explained through variable-measurement-based research and to offer a perspective more centered on mothers as the primary actors in child caregiving.

On this basis, this study aims to explore in depth mothers' experiences in undertaking stunting prevention efforts among children under five, covering mothers' understanding of stunting and its prevention, practices in meeting nutritional needs and maintaining child health, experiences utilizing health services, forms of support received, barriers encountered, and mothers' strategies for overcoming these barriers. The underlying assumption of this study is that mothers' experiences in stunting prevention are multidimensional, shaped by the interaction between knowledge, caregiving practices, socioeconomic conditions, sociocultural values, family support, and access to and experience with health services. An in-depth understanding of these experiences is

expected to serve as a foundation for developing health promotion, community nursing interventions, nutrition education, and stunting prevention programs that are more contextual, participatory, and responsive to the needs of mothers and families.

2. Methods

2.1 Study design

This study used a qualitative design with a descriptive phenomenological approach to explore in depth mothers' experiences in undertaking stunting prevention efforts among children under five. A phenomenological approach was chosen because the study focuses on mothers' lived experiences, including how mothers understand stunting risk, make sense of their role in prevention, meet their children's nutritional and health needs, utilize health services, obtain support, and face various barriers in daily life. A similar approach has been used in research on mothers' experiences caring for children with stunting and has enabled the identification of experiences related to breastfeeding, complementary feeding (MPASI), social support, feeding-related barriers, and other caregiving aspects (Ikasari et al., 2024; Novayelinda et al., 2024; Utario et al., 2024).

Ontologically, this study views the experience of stunting prevention as a reality experienced and interpreted by each mother based on her family, social, cultural, and economic conditions, as well as her interaction with health services. Epistemologically, knowledge of this experience is obtained through direct interaction between the researcher and participants via in-depth interviews. The researcher sought to understand experiences as narrated by participants while maintaining reflexivity so that the researcher's personal assumptions did not dominate the data interpretation process.

2.2 Study location and time

The study was conducted in the working area of the Embo Community Health Center/*Pusat Kesehatan Masyarakat* (Puskesmas), Jeneponto Regency, South Sulawesi Province, from May to July 2025. The study location was selected purposively, considering its relevance to stunting problems among children under five and the availability of a population of mothers with experience related to stunting prevention efforts through family and community-based health services. The selection of the Puskesmas Embo working area was supported by prior research showing that stunting among children under five in this area is associated with a number of maternal and early-life factors. A study by Syakur et al. (2023) involving 136 respondents in the Puskesmas Embo working area found that maternal education, birth weight, birth length, and exclusive breastfeeding were relevant risk factors for stunting. These findings indicate that maternal behavior and experience from the early period of a child's life hold an important position in stunting prevention efforts.

The selection of Jeneponto Regency was further supported by research showing that stunting prevention is related not only to individual maternal factors but also to family conditions and the health service system. Research conducted in Jeneponto and Barru Regencies demonstrated the relevance of maternal education, exclusive breastfeeding, sanitation, household asset conditions, and characteristics of Puskesmas services to stunting (Munir et al., 2025). In addition, qualitative research in Jeneponto Regency showed dynamics between local community understanding of stunting and the medical knowledge used in health programs (Nurlela et al., 2025). These conditions indicate that mothers' experiences in stunting prevention need to be understood not only in terms of nutritional behavior but also within the social, cultural, economic, and family context, and in relation to their interaction with health services.

Ontologically, the Puskesmas Embo working area is viewed as the social context in which the experience of stunting prevention is shaped through the interaction of mothers, children, families, Integrated Health Post (Posyandu) cadres, health workers, and the

community environment. Epistemologically, this experience is understood through mothers' direct narratives of how they make sense of stunting, implement preventive practices, face barriers, obtain support, and interact with health services. This location was therefore considered appropriate for the phenomenological approach used to gain an in-depth understanding of mothers' lived experiences in undertaking stunting prevention efforts among children under five.

2.3 Study participants

The target population for this study was mothers with children under five residing within the Puskesmas Embo area. Participants were selected using purposive sampling, that is, deliberate selection based on participants' ability to provide information that is rich and relevant to the study objectives. Purposive sampling has also been applied in previous phenomenological research on mothers' experiences caring for children with stunting-related problems (Utario et al., 2024). The inclusion criteria were, (1) mothers with children aged 12–59 months; (2) serving as the child's primary caregiver; (3) having resided in the study area for at least six months; (4) having participated in or received information regarding stunting prevention activities through Posyandu, Puskesmas, cadres, nurses, midwives, or other health workers; (5) able to communicate in Indonesian and/or a local language understood by the researcher; and (6) willing to participate and provide informed consent after receiving an explanation of the study.

Exclusion criteria comprised mothers who, at the time of data collection, experienced a physical or psychological condition preventing adequate participation in the interview, or who withdrew during the study process. The number of participants was not determined solely based on statistical calculation but on the sufficiency and depth of information obtained. Recruitment was conducted iteratively and was stopped once the data provided an adequate understanding of the phenomenon under study and additional interviews no longer yielded substantively new information. The final number of participants and the rationale for stopping recruitment will be reported transparently in the results manuscript.

2.4 Research focus and data sources

This qualitative study did not employ independent and dependent variables as used in quantitative research. The research focus was mothers' experiences in undertaking stunting prevention efforts among children under five. The phenomena explored included mothers' understanding of stunting; experiences with breastfeeding and complementary feeding (MPASI); fulfillment of nutritional needs; hygiene practices and disease prevention; growth and development monitoring; utilization of Posyandu and health services; support from husbands, family, cadres, and health workers; social, economic, and cultural barriers; and mothers' strategies for overcoming these barriers. Primary data were obtained directly from participants through in-depth interviews and field notes. Where available and with permission, supporting data could be drawn from relevant documents, such as Posyandu activity records or area profiles, solely to provide research context and not to replace participants' subjective experiences as the primary data source.

2.5 Research Instruments and data collection procedure

In qualitative research, the researcher serves as the primary instrument in the data collection and interpretation process. The researcher used a semi-structured interview guide, a voice recorder (with participant consent), a field notebook, a participant characteristics sheet, and informed consent documents. The interview guide was developed based on the study objectives and a review of the literature on mothers' experiences and practices in stunting prevention and management. Questions were formulated in an open-ended manner to allow participants to narrate their experiences freely and in depth. Data collection was conducted after obtaining research permits and ethical approval. Prospective

participants were identified according to the study criteria with assistance from the Puskesmas, Posyandu cadres, or local area officials, following standard procedure. These parties assisted only in identifying or connecting prospective participants; the decision to participate remained voluntary and free from pressure. The researcher explained the study objectives, interview procedures, benefits and potential discomforts, data confidentiality, the right to decline to answer questions, and the right to withdraw at any time without consequence. Participants who agreed then signed an informed consent form.

Interviews were conducted face-to-face in quiet, comfortable, and private settings agreed upon with participants, such as the participant's home or a designated room at the Puskesmas or Posyandu. Each interview lasted approximately 30–60 minutes, consistent with actual implementation. With participant consent, all interviews were recorded using a voice recorder. The researcher also took field notes on the interview setting, relevant nonverbal expressions, conversational context, and initial reflections. Interviews began with general questions about mothers' experiences, followed by probing questions based on participants' responses. The researcher avoided leading questions. Where information was unclear, the researcher sought clarification from the participant. After each interview, recordings were transcribed verbatim to preserve the meaning of participants' statements.

2.6 Data analysis

Data were analyzed using Colaizzi's phenomenological method. This method was chosen because it allows for systematic analysis of participants' descriptions of experience and has been used in qualitative research on mothers' experiences caring for children with stunting (Utario et al., 2024) as well as mothers' experiences with children who successfully recovered from stunting (Putri & Hati, 2025). Analysis was conducted in stages. First, the researcher read the entire interview transcripts repeatedly to gain a comprehensive understanding of participants' experiences. Second, significant statements related to the experience of stunting prevention were identified and coded. Third, the meaning of each significant statement was formulated while maintaining its connection to participants' original narratives. Fourth, meanings with shared characteristics were grouped into categories and theme clusters. Fifth, all themes were integrated into a comprehensive description of mothers' experiences in stunting prevention. Sixth, the fundamental structure of the phenomenon was formulated based on the relationships among themes. Seventh, interpretive results could be confirmed with participants through member checking to assess the consistency between the researcher's interpretation and participants' intended experiences.

The data condensation process involved identifying units of meaning from the transcripts, assigning codes, comparing codes across participants, and grouping them into categories and themes. Changes in codes, categories, and themes were documented in an audit trail. Data were displayed in a thematic matrix containing themes, subthemes/categories, codes, and representative participant quotations. This presentation was used to help the researcher compare patterns of experience across participants prior to drawing conclusions.

2.7 Data trustworthiness and data presentation

The trustworthiness of the findings was maintained through the principles of credibility, dependability, confirmability, and transferability. Credibility was established through in-depth interviews, probing, observation of context during interviews, and member checking of interpretations requiring confirmation. Where supporting sources or additional informants were used, triangulation was conducted transparently based on the data sources actually available. Dependability was maintained by documenting all stages of the research, from participant recruitment, the interview process, and transcription, to coding and theme development, within an audit trail. Confirmability was achieved through the retention of transcripts, field notes, reflexive notes, and analytic decisions, allowing the

relationship between raw data and interpreted findings to be traced. Transferability was supported by providing an adequate description of participant characteristics, social context, and the study location, enabling readers to assess the relevance of the findings to other contexts. The results of the analysis are presented narratively according to the themes and subthemes that emerged from participants' experiences. Each theme is supported by representative verbatim quotations. Participant identities were replaced with codes, such as P1, P2, P3, and so on, to maintain confidentiality. The quotations used do not include information that would allow direct identification of participants.

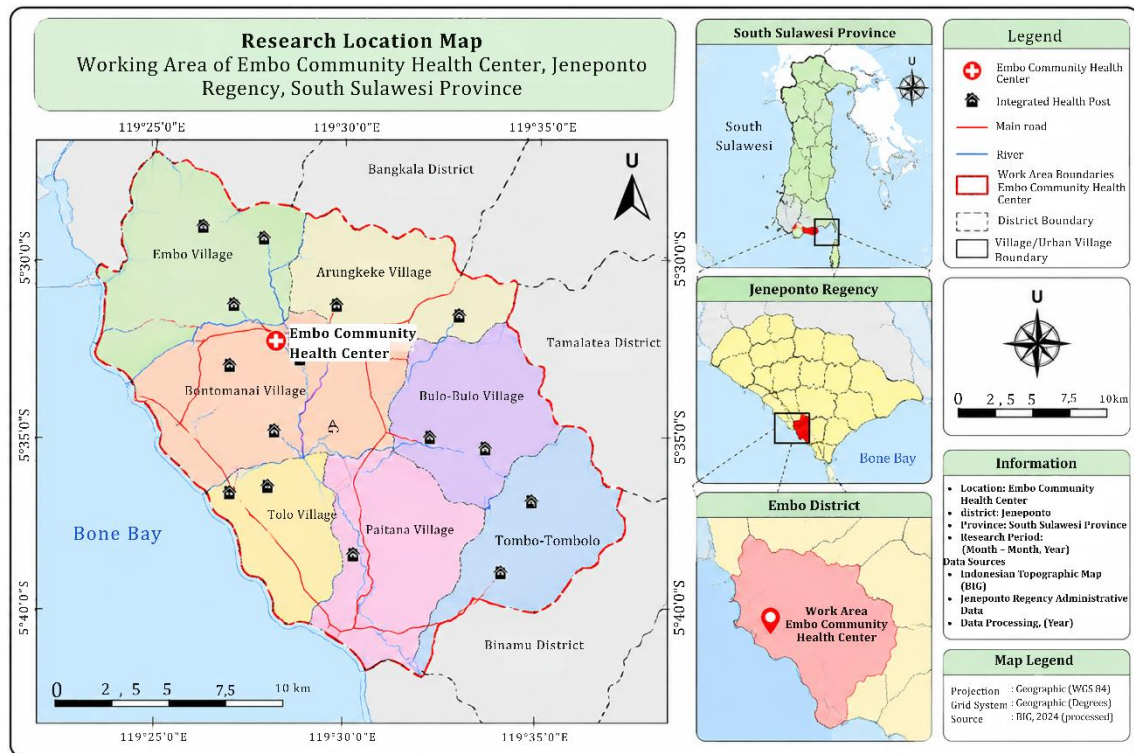


Fig. 1. Map of the study area

3. Results and Discussion

3.1 Research findings

This study involved 10 mothers with children under five in the working area of the Embo Community Health Center (Puskesmas), Jeneponto Regency, South Sulawesi Province. Participants were selected purposively based on their experience in caring for children under five and undertaking various actions related to stunting prevention. Based on the analysis of in-depth interviews, mothers' experiences illustrate that stunting prevention is understood not merely as meeting a child's food needs, but as an experience encompassing maternal knowledge, feeding practices, growth monitoring through the Integrated Health Post (Posyandu), support from family and health workers, and the ability to cope with economic limitations and family habits.

Table 1. Characteristics of research participants

Code	Age	Education	Occupation	Child's age (months)	Number of children	Posyandu Activity Level
P1	27	SHS	Housewife	24	2	Active
P2	32	JHS	Housewife	36	3	Active
P3	25	SHS	Housewife	18	1	Active
P4	35	ES	Housewife	48	4	Not on a regular basis
P5	29	JHS	Seller	30	2	Active

P6	24	SHS	Housewife	16	1	Active
P7	38	ES	Housewife	50	4	Not on a regular basis
P8	31	SHS	Seller	42	3	Active
P9	28	JHS	Housewife	27	2	Active
P10	33	SHS	Housewife	39	3	Active

Participants ranged in age from 24 to 38 years, with educational backgrounds ranging from elementary school to senior high school. Most were homemakers and had two to four children. Eight participants attended Posyandu regularly, while two did not attend regularly due to household responsibilities, work, and time constraints.

Table 2. Themes and sub-themes of mothers' experiences regarding stunting prevention efforts

No.	Theme	Subtheme
1	Mothers' understanding of stunting develops through health services	1. Stunting is understood as a growth disorder 2. information is obtained from Posyandu (community health posts) and healthcare workers 3. there is still an incomplete understanding of stunting.
2	Meeting nutritional needs serves as a primary form of prevention	1. Provision of breast milk (breastfeeding) and complementary foods (complementary feeding) 2. provision of a diverse diet 3. provision of animal-based protein sources 4. adaptation of food choices to the family's economic capacity.
3	Posyandu and health workers serve as sources of support	1. Weighing and measuring children's length/height 2. education on nutrition and stunting prevention 3. consultations on child growth and development.
4	Preventive obstacles arise in daily life	1. Family economic constraints 2. children experiencing difficulties with eating 3. mothers' limited time 4. family feeding practices.
5	Family support strengthens prevention practices.	1. Support from husbands 2. assistance from family members 3. family involvement in decisions regarding children's food 4. support in utilizing healthcare services.

3.1.1 Theme 1: Mothers' understanding of stunting developed through interaction with health services

The findings show that most mothers were already familiar with the term stunting, primarily through Posyandu cadres, midwives, nurses, and health education activities. Mothers generally understood stunting as a condition in which a child's height growth does not correspond to their age. However, understanding of the process by which stunting occurs and its risk factors still varied. Some mothers associated stunting prevention with providing nutritious food and monitoring child growth. Others still emphasized the physical condition of being a "short child" and had not yet fully understood that stunting is a process influenced by long-term health and nutritional conditions. These findings indicate that mothers' experience in preventing stunting began with a process of forming understanding, shaped by the interaction between existing family knowledge and information provided by health workers.

One participant stated:

"I know stunting means a child's growth doesn't match their age. At Posyandu, they usually explain that children need to be weighed often and their food needs to be watched." (P3)

Another participant described a shift in understanding after receiving education:

"I used to think that if a child was short, it might just take after the parents. After it was explained at Posyandu, I began to understand that a child's food and health also need attention." (P7)

3.1.2 Theme 2: Nutritional fulfillment and feeding practices as the primary form of prevention

Mothers interpreted meeting nutritional needs as the most concrete action in preventing stunting. These practices included breastfeeding, providing complementary feeding (MPASI) appropriate to age, preparing family food, offering eggs, fish, vegetables, and fruit when available, and efforts to increase the variety of children's food. Mothers attempted to make use of available and affordable food ingredients. However, dietary variety could not always be provided every day. Some mothers adjusted their children's menu to whatever food was available at home. Thus, the experience of stunting prevention at the family level constitutes a process of adaptation between health recommendations and available resources.

"If there's fish, I give fish, eggs too, often. I try to include vegetables. What matters is that the child is willing to eat, because sometimes I've already cooked something and he doesn't want it." (P2)

Another experience showed that knowledge of nutritious food could not always be applied ideally:

"The health worker already explained that meals should be complete, with side dishes, vegetables, and so on. But we also adjust based on what's available at home." (P5)

3.1.3 Theme 3: Posyandu and health workers as sources of preventive support

Posyandu emerged as an important part of mothers' experience in monitoring child growth. Mothers came to have their children's weight and height/length measured, to receive immunizations and vitamins, and to obtain information about child growth and feeding.

"I try to make it to Posyandu because I want to know if her weight has gone up or not. If something's lacking, the cadre or health worker usually tells me." (P1)

Interaction with cadres and health workers also helped mothers recognize their children's growth status.

"If there's a feeding problem, I usually ask. Sometimes they tell me to try making the food different so the child will eat." (P9)

Nevertheless, not all mothers were able to attend Posyandu regularly. Work responsibilities, domestic duties, the child's condition, and family schedules were among the reasons cited for non-attendance.

3.1.4 Theme 4: Economic conditions, children's feeding difficulties, and family habits as barriers

Mothers' experiences showed that carrying out stunting prevention was not always easy, even when they knew which actions were recommended. The most prominent

barriers in the data were family economic capacity, children's difficulty eating, time constraints, and family eating habits.

"What's hard is when the child doesn't want to eat. I've already made the food, but he only takes a few bites. So sometimes I don't know what else to make." (P6)

Economic limitations affected families' ability to provide the desired variety of food.

"Following everything that's recommended would actually be good, but it also depends on income. So we use food we can afford, as long as the child keeps eating." (P4)

These findings illustrate a gap between knowledge of prevention and the ability to implement it consistently.

3.1.5 Theme 5: Family support strengthens stunting prevention practices

Husbands and other family members played a role in mothers' experience of carrying out prevention. This support took the form of providing funds for food and health services, accompanying mothers and children to health facilities, helping to look after the child, and providing support when the child experienced health problems.

"My husband usually supports me. If the child needs to be taken for a check-up, he takes us when he's not working." (P8)

However, mothers' experiences also showed that caregiving decisions could be influenced by older family members.

"Sometimes the older generation says that children used to eat like that too and were healthy. I listen, but if the health worker gives a recommendation, I try to follow it." (P10)

This indicates that stunting prevention is not solely an individual maternal responsibility, but occurs within a family system and social environment.

3.2 Discussion

Overall, the findings depict the experience of stunting prevention as a multidimensional process. Mothers were not only confronted with the challenge of meeting food needs, but also with the process of understanding health information, making caregiving decisions, adapting health workers' recommendations to family economic capacity, managing children's eating behavior, utilizing Posyandu, and negotiating family habits and support. This position aligns with the developing literature that situates stunting as a problem shaped by individual, family, health service, socioeconomic, and environmental factors.

3.2.1 Maternal understanding and the local context of stunting prevention

The first theme shows that mothers' understanding of stunting was not formed by medical knowledge alone, but developed through interaction with cadres, health workers, caregiving experience, and understandings embedded within the family environment. Some mothers had come to understand stunting as a growth disorder, yet a belief persisted that short stature might primarily be attributable to heredity. This finding holds particular relevance to the context of Jeneponto Regency. Nurlela et al. (2025), through phenomenological research involving 15 informants in Jeneponto, found negotiation between local knowledge and medical knowledge in understanding stunting. Community members did not always interpret stunting in the same way as defined by the health service system. This finding indicates that stunting prevention education in Jeneponto needs to take

into account how the community understands child growth, rather than conveying medical information in a one-directional manner. Within the context of community nursing, these results indicate the need for family-centered health communication. Nurses and health workers need to first explore mothers' understanding of the causes of short stature, normal growth, food, and caregiving practices before providing education.

3.2.2 *Feeding practices as the primary preventive action, shaped by family capacity*

The second theme shows that mothers identified feeding as the primary action for maintaining child growth. This is consistent with empirical evidence from the same area. Syakur et al. (2023) conducted a case-control study of 136 respondents in the Puskesmas Embo working area, comprising 68 cases and 68 controls. That study reported maternal education (OR = 9.758), birth weight (OR = 5.590), birth length (OR = 8.065), and exclusive breastfeeding (OR=4.286) as risk factors examined in relation to stunting. This finding is important for interpreting the qualitative results. Prior quantitative data explain factors associated with risk, whereas the qualitative findings of the present study are intended to explain how mothers experience the process of implementing prevention. For instance, recommendations regarding breastfeeding or nutritious food are not merely individual decisions, but are shaped by maternal employment, food availability, income, children's responses to food, and family support.

Research by Darwis et al. (2021) in Majene, West Sulawesi, similarly found that mothers of children with stunting did not have a clear understanding of stunting, and that the complementary feeding (MPASI) provided did not always achieve a balance of carbohydrate, protein, and fat sources. This shared Sulawesi context suggests that the quality of feeding practices needs to be understood through family experience, rather than solely through the presence or absence of food.

3.2.3 *Institutional, economic, and sociocultural contexts shaping mothers' experiences*

The findings show that Posyandu was perceived as a place where mothers monitored growth and obtained health information. This finding is important because the experience of stunting prevention takes place within the relationship between mothers and the primary health service system. Concrete evidence from Jeneponto supports the importance of health service factors. Munir et al. (2025) analyzed data from 192 mothers, comprising 89 from Jeneponto and 103 from Barru. That study reported an association between stunting and basic education level (aOR = 3.26; 95% CI: 1.38–7.70) and lack of exclusive breastfeeding (aOR = 3.64; 95% CI: 1.25–10.6). At the service level, Puskesmas accreditation status was associated with lower odds of stunting (aOR = 0.32; 95% CI: 0.11–0.93) in that study's model (Munir et al., 2025). Accordingly, the quality of mothers' interaction with Puskesmas and Posyandu is an important area for further exploration. The availability of services does not necessarily guarantee optimal utilization when mothers face constraints of time, distance, work, communication, or perceive services as unnecessary when a child appears healthy.

The fourth theme reveals a possible gap between what mothers know and what families are able to do. Mothers may understand the need for varied food, but its implementation depends on the ability to obtain food ingredients and on household economic conditions. This is consistent with research by Munir et al. (2025), which showed the importance of family socioeconomic conditions in the context of stunting in Jeneponto and Barru. Interventions oriented solely toward improving maternal knowledge may therefore be inadequate if they do not also address families' capacity to implement recommendations (Cai et al., 2022; Jelle et al., 2023).

Findings from Azis et al. (2025) in South Sulawesi similarly showed that caregiving behavior in stunting prevention was associated with caregiving knowledge, nutritional knowledge, attitudes, motivation, culture, family planning, and knowledge of environmental sanitation. Culture even emerged as one important component in that study's model (Leal-

Rodríguez et al., 2023; Minkov & Kaasa, 2022). This finding reinforces the view that stunting prevention is a family practice shaped by social context, rather than merely a matter of individual maternal knowledge.

The fifth theme shows that husbands' support could help mothers provide for their children's needs and access health services. At the same time, advice from parents or extended family could influence mothers' decisions regarding feeding and caregiving. Darwis et al. (2021) found that husbands' support in addressing children's existing health problems was relatively good, but support for stunting prevention efforts remained lacking. This finding highlights the importance of distinguishing support once a child is already ill from family involvement in day-to-day preventive action. In the South Sulawesi context, Azis et al. (2025) also demonstrated an association between culture and caregiving behavior in stunting prevention. Prevention programs in the Puskesmas Embo working area should therefore not target mothers alone. Husbands, influential family members, Posyandu cadres, community leaders, and health workers can be engaged to build a family environment that supports preventive practices.

3.2.4 *Position and novelty of this study*

Compared with previous research, this study occupies a distinct position. Syakur et al. (2023) identified stunting risk factors quantitatively in the Puskesmas Embo working area, while Munir et al. (2025) analyzed individual, family, and Puskesmas service factors in Jeneponto and Barru. Meanwhile, Nurlela et al. (2025) explored social construction and community perceptions of stunting in Jeneponto. This study is directed toward filling the space between these findings by positioning mothers' experiences in carrying out day-to-day stunting prevention as the central phenomenon. Its novelty lies not in establishing that nutrition, breastfeeding, economics, culture, or health services matter, but in seeking to understand how these factors are simultaneously experienced by mothers within family life, and how mothers make decisions when health recommendations come into contact with economic limitations, children's eating behavior, family habits, and local understandings of stunting.

The implications of these findings relate primarily to community nursing and health promotion. Stunting prevention interventions in the Puskesmas Embo working area need to consider a family-centered approach, use communication aligned with local understanding, strengthen the involvement of husbands and family, improve the quality of feeding counseling, and position Posyandu as a consultation space that allows mothers to voice practical barriers, rather than solely as a site for weighing and growth measurement. Overall, mothers' experiences in preventing stunting can be understood as a process of adaptation between health knowledge and the realities of family life. The success of prevention depends not only on how much information mothers receive, but also on their ability to translate that information into caregiving practices, supported by family, economic resources, the sociocultural environment, and available health services.

4. Conclusions

This study shows that mothers' experiences in undertaking stunting prevention efforts among children under five constitute a multidimensional process shaped by the interaction between understanding of stunting, nutritional and caregiving practices, utilization of the Integrated Health Post (Posyandu) and health services, socioeconomic conditions, and family support. Mothers play a central role in translating health information into daily preventive practices; however, implementation is determined not only by knowledge but also by the family's ability to provide nutritious food, children's responses to food, family habits, time availability, and support from husbands and health workers. These findings affirm that stunting prevention in the working area of the Embo Community Health Center (Puskesmas), Jeneponto Regency, needs to be understood as a family-based health practice that occurs within the local social, economic, cultural, and health service context. The main

contribution of this study lies in the understanding that strengthening stunting prevention cannot be achieved through improving maternal knowledge alone, but requires a contextual, family-centered community nursing approach—one that strengthens the involvement of husbands and family, provides mentorship from cadres and health workers, promotes the utilization of Posyandu, and offers support in addressing the real barriers mothers experience in implementing stunting prevention practices.

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Author Contribution

A.I.S., conceptualization, methodology, investigation, data curation, formal analysis, writing – original draft preparation, visualization, project administration. S.H.R., methodology, investigation, validation, data analysis, writing – review & editing, supervision. A.A., conceptualization, validation, resources, writing – review & editing, supervision, project administration.

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The authors declare no conflict of interest.

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During the preparation of this work, the authors used Claude to assist in improving grammar, clarity, and academic tone of the manuscript. After using this tool, the authors reviewed and edited the content as needed and took full responsibility for the content of the publication.

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