

THE DOMINANCE OF MEDICAL DISCOURSE IN STUNTING MANAGEMENT: A FOUCAULDIAN SOCIOLOGICAL STUDY IN JENEPONTO REGENCY, INDONESIA

Sarifudin Andi Latif^{1*}, Andi Ihsan², Supriadi Torro³, A. Octamaya Tenri Awaru⁴

^{1,2,3,4}Universitas Negeri Makassar, South Sulawesi, Indonesia

*Corresponding author: nerssarif19@gmail.com

ABSTRACT

Stunting management in Indonesia is organised through biomedical indicators, growth monitoring, nutritional counselling, and behavioural correction. Although important, their dominance may reduce stunting to an individual clinical problem, obscure structural inequalities, and marginalise mothers' experiences and local knowledge. This study examined how medical discourse is produced, legitimised, and negotiated in stunting management in Jeneponto Regency using a Foucauldian sociological perspective. A qualitative case study was conducted from February to March 2026. Twenty purposive informants included one head of division at the Jeneponto District Health Office, four community health centre heads, and fifteen mothers of children identified as stunted. Data were generated through semi-structured interviews, observation, field notes, and document review. Braun and Clarke's thematic analysis was used, informed by Foucauldian concepts of power-knowledge, normalisation, surveillance, and subject formation. Credibility was strengthened through source triangulation, member checking, peer debriefing, and an audit trail. Four themes emerged: the biomedical construction of stunting as measurable abnormality; surveillance and normalisation of children's bodies; maternal responsabilisation through counselling and compliance expectations; and the negotiation of professional authority, material constraints, and local knowledge. Medical discourse enabled standardised detection and coordinated intervention, but it also narrowed causal explanations and placed disproportionate moral responsibility on mothers. Stunting policy should retain clinical assessment while incorporating poverty, food access, sanitation, gender relations, and community knowledge. A more participatory approach could redistribute responsibility and make interventions locally, contextually responsive and equitable.

Keywords: Biopolitics, Discourse Analysis, Social Determinants of Health, Stunting

INTRODUCTION

Stunting remains a critical public health and social development problem because it reflects not only impaired linear growth but also the cumulative effects of nutritional deprivation, recurrent infection, inadequate care, poverty, unequal access to healthcare, and unfavourable living conditions during the first 1,000 days of life (Mgomezulu et al., 2025). Its consequences extend beyond children's physical growth to cognitive development, educational achievement, productivity, and health risks in adulthood. Indonesia has made measurable progress, with the national prevalence of stunting declining from 21.5% in 2023 to 19.8% in 2024 (Prayitno et al., 2025). Nevertheless, approximately 4.4 million Indonesian children under five were still estimated to be affected in 2024, while substantial disparities persisted between regions and socioeconomic groups (Arief et al., 2025). Children from the poorest households experienced a markedly higher prevalence than those from affluent families, demonstrating that stunting is inseparable from structural inequality (Rahardiantoro et al., 2024). This problem is particularly significant in Jeneponto Regency, where stunting prevalence reached 39.8% in 2022, making it one of the districts with the highest burden in South Sulawesi (Syakur et al., 2023). The persistence of this high prevalence suggests that stunting cannot be adequately explained or addressed solely through nutritional and clinical variables (Fadmi et al., 2024).

The dominant literature generally conceptualises stunting through a biomedical and epidemiological framework. Research has extensively identified maternal nutrition, low birth weight, inadequate breastfeeding, inappropriate complementary feeding, infectious diseases, sanitation, food insecurity, and limited healthcare access as major determinants (Aswi et al., 2025). This body of evidence is essential for designing specific and nutrition-sensitive interventions. However, its predominant focus on measurable risk factors tends to position the child's body as an object of diagnosis, classification, monitoring, and correction. Height-for-age standards, nutritional surveillance, anthropometric measurement, growth charts, risk categories, and intervention targets produce an authoritative language through which children are defined as normal, short, or stunted (Rahmaniah et al., 2025). Consequently, biomedical knowledge is frequently treated as the most legitimate form of truth, while parents and communities are positioned as recipients who must comply with expert recommendations.

Michel Foucault's concepts of discourse, power knowledge, the medical gaze, normalisation, governmentality, and biopolitics provide a critical framework for examining this process. From a Foucauldian perspective, medical discourse does not merely describe the biological reality of stunting, it also constructs categories of normality and abnormality, determines whose knowledge is legitimate, and shapes how families understand and govern children's bodies (Callaghan, 2022). Through growth-monitoring programmes, nutritional counselling, household visits, health records, and performance indicators, mothers and children become subjects of continuous observation. Such practices may improve early detection and service delivery, but they can simultaneously create disciplinary relations in which mothers are blamed for inappropriate feeding, children are reduced to anthropometric indicators, and local explanations are dismissed as ignorance or resistance (Suijker, 2023).

Previous critical scholarship has shown that Indonesian stunting discourse may operate as a form of biopower by regulating children, parents, and educators while directing attention toward individual behaviour rather than broader socioeconomic structures. Adrian and Tesar argue that the dominant discourse constructs children and families as objects of surveillance and may overlook poverty, inequality, and other structural conditions (Leroy & Frongillo, 2019). Other studies have demonstrated that stunting is influenced by intersecting social and environmental determinants, including maternal education, household welfare, access to sanitation, and geographical inequality (Mrema et al., 2023). These findings challenge interventions that treat inadequate knowledge or parental noncompliance as the principal causes of stunting (Asefa et al., 2024). Nevertheless, existing programmes continue to privilege technical indicators, standardised messages, and expert-led interventions, often without adequately examining how local communities interpret, negotiate, accept, or resist them.

An explicit research gap therefore exists. Most studies in Jenepono have concentrated on prevalence, individual risk factors, feeding practices, health-service performance, or programme effectiveness. Limited research has investigated how medical discourse acquires dominance in local stunting governance, how power circulates among government officials, health professionals, community health volunteers, traditional actors, and families, or how local knowledge is marginalised, negotiated, and potentially integrated into intervention practices. Moreover, few studies have critically explored how statistical targets and biomedical standards shape the identities of mothers and children and influence everyday encounters between healthcare institutions and the community.

The novelty of this study lies in conceptualising stunting management in Jeneponto as a discursive arena rather than exclusively as a biomedical intervention. It applies a Foucauldian sociological perspective to reveal how regimes of truth, medical authority, surveillance, normalisation, and biopolitical governance operate within local stunting programmes. At the same time, the study examines community agency and the possibility of dialogue between medical and local knowledge without denying the scientific importance of nutritional interventions.

Accordingly, this study aims to analyse the dominance of medical discourse in stunting management in Jeneponto Regency by examining the production of biomedical truth, the power relations among relevant actors, the disciplinary and biopolitical practices directed at mothers and children, and the ways local communities negotiate or resist dominant health knowledge.

METHODS

This study employed a qualitative approach using a bounded case-study design (Yosep et al., 2026). This design was selected because the study examined the dominance of medical discourse as a context-dependent social phenomenon within stunting-management practices in Jeneponto Regency. Rather than focusing exclusively on individual experiences, the case study enabled an examination of interactions among health authorities, primary healthcare leaders, and mothers of children with stunting. The analysis was theoretically informed by Foucault's concepts of power-knowledge, normalisation, surveillance, the medical gaze, and biopolitics.

The study was conducted in Jeneponto Regency, South Sulawesi, Indonesia, from February to March 2026. Jeneponto was purposively selected because of its persistent stunting burden and the intensive implementation of government-led nutritional surveillance and intervention programmes. This setting provided a relevant context for examining how biomedical knowledge was produced, communicated, and negotiated within local health governance and everyday maternal practices

Twenty informants were recruited through criterion-based purposive sampling. They comprised five policymakers and health-service leaders one head of the relevant division at the Jeneponto District Health Office and four heads of community health centres and 15 mothers of children diagnosed with stunting. Inclusion criteria for officials were direct involvement in planning or implementing stunting programmes and at least one year of relevant experience. Mothers were eligible if they resided in Jeneponto, had a child identified as stunted through health-service measurements, and were willing to discuss their experiences. Individuals unable to participate in an interview or provide informed consent were excluded. Sample adequacy was determined by informational richness and data saturation rather than statistical calculation.

The researcher served as the primary instrument in data collection, interpretation, and reflexive analysis. Supporting instruments included a semi-structured interview guide, audio recorder, field notes, observation sheets, and relevant programme documentation. The interview guide was developed from the research objectives and Foucauldian concepts, assessed for clarity and content relevance, and refined following a pilot interview with a nonparticipant.

Participants were contacted through health-service and community networks, provided with study information, and asked to give written informed consent. Individual in-depth interviews were conducted in private locations agreed upon by participants and lasted approximately 45-60 minutes. Interviews were audio-recorded with permission and supplemented by field notes, contextual observations, and document review. Data collection continued until no substantively new information emerged.

Data were analysed using Braun and Clarke's reflexive thematic analysis, informed by Foucauldian discourse analysis. Recordings were transcribed verbatim, anonymised, and read repeatedly. Meaningful segments were coded, compared, and organised into categories and preliminary themes. Themes were reviewed, refined, defined, and interpreted in relation to power-knowledge, normalisation, surveillance, and resistance. Analysis was conducted manually.

Credibility was strengthened through source triangulation, document comparison, member checking, and peer debriefing. Dependability and confirmability were supported by an audit trail and reflexive notes. Transferability was enhanced through detailed descriptions of the research setting, participants, and sociocultural context.

RESULTS

Informant Characteristics

The study involved 20 informants comprising five health policymakers or service leaders and 15 mothers of children identified as stunted. The inclusion of informants from institutional and community groups enabled comparison between official medical discourse and mothers' everyday interpretations of stunting.

Table 1. Distribution and Codes of Informants

Informant code	Informant category	Involvement in stunting management	Number
DHO-01	Head of Division, Jeneponto District Health Office	Policy coordination, programme planning, monitoring, and evaluation	1
PHC-01	Head of Community Health Centre 1	Implementation and supervision of primary-level interventions	1
PHC-02	Head of Community Health Centre 2	Implementation and supervision of primary-level interventions	1
PHC-03	Head of Community Health Centre 3	Implementation and supervision of primary-level interventions	1
PHC-04	Head of Community Health Centre 4	Implementation and supervision of primary-level interventions	1
M-01–M-15	Mothers of children identified as stunted	Recipients and everyday implementers of nutritional recommendations	15
Total			20

The thematic analysis identified five interrelated themes describing the dominance of medical discourse in stunting management in Jeneponto Regency. These themes revealed how biomedical knowledge established authoritative definitions, regulated children's bodies, shaped maternal responsibility, marginalised local knowledge, and was negotiated within everyday family practices.

Table 2. Themes and Substantive Findings

No	Theme	Substantive findings
1	Medical knowledge as the dominant regime of truth	Anthropometric measurements, growth standards, health protocols, and professional interpretations were treated as the most legitimate basis for defining and managing stunting.
2	Surveillance and normalisation of children's bodies	Routine measurements, Posyandu attendance, health records, and household visits functioned as mechanisms for monitoring, classifying, and normalising children's growth.
3	Mothers as responsible subjects	Mothers were positioned as the principal actors responsible for children's nutrition, care practices, programme compliance, and improvement in growth status.
4	Marginalisation of local knowledge and structural conditions	Local feeding knowledge, cultural practices, poverty, food availability, and unequal household resources received less recognition than biomedical recommendations.
5	Negotiation, adaptation, and resistance	Mothers selectively accepted, modified, or resisted medical recommendations by adjusting them to household resources, cultural knowledge, and everyday realities.

Theme 1: Medical Knowledge as the Dominant Regime of Truth

Medical discourse emerged as the principal framework through which stunting was defined, measured, and interpreted. Health officials consistently used anthropometric indicators, standardised growth charts, programme targets, and nutritional protocols to establish the truth about children's growth. One community health centre leader explained:

"We determine the child's condition from standardised measurements. Without accurate height and age data, we cannot establish whether the child is stunted." (PHC-02)

This statement demonstrates that biomedical instruments did not merely record children's physical conditions but also legitimised professional authority to classify their bodies. Mothers generally accepted these classifications, although some did not fully understand the measurement process:

"I only knew that my child was considered stunted after the health worker explained the measurement results. Before that, I thought my child was simply smaller than other children." (M-03)

Medical personnel therefore occupied the position of authoritative interpreters, while mothers were largely positioned as recipients of expert knowledge.

Theme 2: Surveillance and Normalisation of Children's Bodies

Routine growth monitoring operated as both a preventive service and a mechanism of surveillance. Children's height, weight, age, nutritional intake, and attendance at Posyandu

were regularly recorded and compared with standard growth categories. A mother described this continuous monitoring:

“Every month, I have to bring my child for measurement. If I do not attend, the cadre contacts me or comes to ask why my child was not taken to the Posyandu.” (M-04)

Health officials considered such monitoring necessary to prevent children from being lost to follow-up:

“Children identified as being at risk must be monitored regularly. We need to know whether their condition improves after the intervention.” (DHO-01)

From a Foucauldian perspective, these practices transformed children’s bodies into measurable and administratively governable objects. Surveillance extended beyond health facilities into households, encouraging mothers to discipline their conduct according to institutional expectations.

Theme 3: Mothers as Responsible Subjects

The findings indicated that mothers were constructed as the primary subjects responsible for preventing and correcting stunting. Counselling emphasised breastfeeding, complementary feeding, hygiene, Posyandu attendance, and adherence to nutritional recommendations. One health-centre leader stated:

“The mother’s understanding and commitment are very important because she is the person who prepares food and cares for the child every day.” (PHC-03)

Although such messages sought to strengthen maternal capacity, they sometimes generated feelings of blame and inadequacy:

“They often ask what food I give my child. Sometimes I feel that people think my child is short because I do not care for or feed the child properly.” (M-09)

The emphasis on maternal behaviour tended to obscure paternal responsibility, household decision-making, poverty, and unequal access to nutritious food. Mothers consequently became both the targets of intervention and the subjects expected to regulate themselves.

Theme 4: Marginalisation of Local Knowledge and Structural Conditions

Biomedical recommendations were not always compatible with household economic and cultural realities. Mothers recognised the value of nutritious food but reported difficulties implementing standardised advice:

“We are advised to provide eggs, fish, vegetables, and milk regularly. The advice is good, but our income is uncertain, so we cannot always provide everything.” (M-12)

Local feeding practices and knowledge inherited from older family members were sometimes viewed as inappropriate:

“My parents said that certain traditional foods were good for children, but the health worker advised me to follow the recommended menu.” (M-07)

These accounts demonstrate an epistemic hierarchy in which professional knowledge was considered scientific and legitimate, while local knowledge was positioned as secondary. Apparent noncompliance was therefore not necessarily caused by ignorance but could reflect poverty, food availability, cultural meaning, and household authority.

Theme 5: Negotiation, Adaptation, and Resistance

Mothers were not entirely passive recipients of medical discourse. They actively interpreted recommendations and adjusted them to available resources. One mother explained:

“I follow the health worker’s advice, but I also use foods recommended by my parents because those foods are available and familiar to our family.” (M-15)

Another participant described selective compliance:

“I understand what they recommend, but I choose what I can afford. I do not always explain this during counselling because I am afraid of being considered disobedient.” (M-11)

Resistance was generally subtle and did not take the form of direct confrontation. It appeared through silence, partial compliance, substitution of recommended foods, and the continuation of family-based practices. Thus, although medical discourse remained dominant, its implementation was continuously negotiated within everyday family life.

Data Saturation

Data saturation was assessed through the recurrence of codes, completeness of thematic categories, and representation of both institutional and maternal perspectives. No substantively new codes were identified after the eighteenth interview. The final two interviews reinforced the five existing themes and clarified the relationships between medical authority, maternal responsibility, structural constraints, and community negotiation. All 20 interviews were retained to strengthen source triangulation and contextual interpretation.

DISCUSSION

This study shows that stunting management in Jenepono is not merely a collection of nutritional and clinical interventions but also a social process through which particular forms of knowledge become authoritative. Anthropometric measurements, growth standards, nutritional protocols, and programme indicators established biomedical knowledge as the dominant regime of truth. These instruments are scientifically valuable for identifying growth faltering and directing early intervention. However, from a Foucauldian perspective, they are not entirely neutral because they also determine who has the authority to define children’s conditions, establish standards of normality, and prescribe appropriate family conduct. Medical discourse therefore operates simultaneously as a mechanism of care and a technology of governance.

A central conceptual contribution of the study is the identification of a shift from the *medical gaze* to an *administrative gaze*. The child’s body was not only examined clinically but also translated into measurements, nutritional categories, attendance records, household reports, and programme-achievement indicators (Asefa et al., 2024). Through these processes, children became visible to the health system as measurable subjects. This visibility can facilitate intervention, yet it can also reduce complex childhood conditions to standardised

classifications. The meaning of stunting may consequently become detached from the social environments in which children grow, including poverty, food insecurity, insecure livelihoods, inadequate sanitation, gendered household relations, and unequal access to public services (Soofi et al., 2024).

Routine Posyandu measurements, home visits, counselling, and follow-up records illustrate Foucault's concept of disciplinary power. Such practices do not depend primarily on coercion; they operate by encouraging families to observe, evaluate, and regulate themselves according to institutional expectations. Mothers learn to compare their children's bodies with standard growth curves and to assess their caregiving against prescribed feeding practices. Surveillance thus becomes internalised through maternal self-monitoring. This does not mean that growth monitoring should be abandoned (Deshpande & Ramachandran, 2025). Rather, the finding demonstrates that its ethical and social effects depend on how it is communicated and implemented. Monitoring conducted through dialogue can support families, whereas monitoring framed around compliance may produce shame, anxiety, or fear of institutional judgement.

The construction of mothers as the principal subjects responsible for stunting prevention represents another important finding. Mothers were expected to control feeding, hygiene, breastfeeding, attendance at health services, and compliance with nutritional recommendations (Soofi et al., 2024). In Foucauldian terms, this process may be understood as *responsibilisation*: a public and structural problem is partially transferred to individuals, who are expected to govern their own conduct (Keat & Adugna, 2024). Although maternal participation is essential, excessive emphasis on mothers can obscure the roles of fathers, extended families, employers, markets, local government, and wider welfare systems. It may also transform counselling into a moral evaluation of motherhood, especially when a child's growth does not improve despite maternal effort.

Stunting policy therefore contains a paradox. The programme seeks to protect children through expanded monitoring and professional intervention, but its operational language can unintentionally individualise responsibility. When success is primarily assessed through changes in anthropometric indicators and maternal compliance, structural constraints may be treated as secondary (Nguyen et al., 2025). A mother who cannot provide a prescribed menu because of unstable household income may be categorised as inadequately informed or insufficiently compliant, even when she understands the recommendation. The systemic implication is that knowledge-oriented interventions alone are insufficient when families lack the material capacity to act on that knowledge.

The findings concerning local knowledge further demonstrate that medical dominance does not completely eliminate alternative understandings. Mothers selectively adopted health advice, substituted recommended foods with affordable local products, and continued practices inherited from parents or older relatives. Such actions should not automatically be interpreted as rejection of science (Balza et al., 2025). They may represent pragmatic negotiation between medical recommendations, economic limitations, cultural familiarity, and household authority. Resistance was generally subtle, appearing as silence during counselling, partial compliance, or the continuation of family practices outside professional observation. Power, therefore, was productive and relational rather than absolute: medical discourse shaped maternal conduct, but mothers also interpreted and modified it.

This interpretation supports a pluralistic approach without romanticising all local practices. Local knowledge may contain valuable understandings of food availability, caregiving, family solidarity, and seasonal conditions, but some practices may also restrict nutritional diversity or delay professional treatment (Darmawati et al., 2026). The relevant policy question is therefore not whether medical or local knowledge should prevail absolutely. Instead, the issue is how different forms of knowledge can be critically evaluated and brought into dialogue while maintaining child safety and scientific standards.

The findings extend the analysis of Adriany and Tesar, who argued that Indonesian stunting discourse functions as a form of biopower by regulating children, parents, and educators and producing them as objects of surveillance. Their study also warned that an emphasis on individual nutrition and behaviour may conceal broader social problems (Salloum et al., 2024). The present study supports this argument but locates the process within district-level health governance. It demonstrates how national biomedical categories are operationalised through primary healthcare leadership, Posyandu monitoring, counselling, household visits, and maternal self-regulation. It therefore connects abstract policy discourse with everyday institutional encounters.

The concentration of responsibility on mothers is also consistent with a qualitative case study in Sambas Regency, which found that stunting interventions tended to overburden mothers while giving insufficient attention to paternal participation, community agency, and local social conditions. That study recommended replacing top-down technical interventions with participatory and gender-responsive strategies (Gulestø et al., 2025). The Jeneponto findings add that maternal burden is not created only by explicit programme instructions. It is also produced through routine questions, measurement practices, attendance expectations, and moral assumptions about competent motherhood.

At the same time, the findings should not be read as contradicting epidemiological evidence. A case-control study in Jeneponto found that maternal height and low birth weight were significant risk factors for stunting, whereas food taboos were not statistically associated with stunting in the examined population (Ataullahjan et al., 2025). That evidence demonstrates the importance of biological and early-life determinants. The current study contributes a different analytical level by asking how such determinants are interpreted, communicated, and converted into institutional practices. Biomedical and sociological explanations are therefore complementary: one identifies associations and clinical risks, while the other examines how knowledge about those risks organises relationships, responsibilities, and policy responses.

National research has similarly established that stunting is associated with interacting household, maternal, environmental, and healthcare factors rather than a single behavioural cause. Studies using Indonesian population data have highlighted the relevance of maternal characteristics, sanitation, household wealth, geographical inequalities, and access to health services (Sentika et al., 2024). These studies support the present argument that interventions centred predominantly on maternal education risk overlooking the conditions that determine whether recommendations are practically achievable.

The study also adds nuance to literature that portrays communities as resistant to health programmes. What appears institutionally as resistance may instead be negotiated compliance. Mothers may accept the medical definition of stunting while adapting the proposed solution to available food, income, and family expectations. This finding challenges binary categories such

as compliant noncompliant or modern traditional (Rahmaniah et al., 2025). It suggests that programme implementation occurs within a hybrid space where medical authority remains influential but is continuously reinterpreted through local realities.

Systemically, stunting governance should therefore move from a predominantly instructional model toward a co-produced model. Nutritional counselling should begin by examining what food is available, who controls household resources, who participates in childcare, and what constraints prevent recommended practices. Programme indicators should extend beyond children's measurements and mothers' attendance to include food security, sanitation, paternal involvement, continuity of social assistance, quality of counselling, and community participation. Such an approach would retain the benefits of biomedical monitoring while reducing its potential to stigmatise families.

Several limitations require careful consideration. First, the study involved 20 purposively selected informants in one regency; therefore, its purpose was interpretive depth rather than statistical representation. The findings may illuminate similar settings, but they should not be generalised automatically to all families, health centres, or Indonesian districts. Second, the institutional group consisted of one district health official and four community health-centre leaders. The perspectives of frontline nutritionists, midwives, Posyandu cadres, village authorities, fathers, grandparents, traditional practitioners, and children were not directly represented.

Third, interviews concerning government programmes and maternal practices are vulnerable to social-desirability bias. Officials may emphasise formal procedures, while mothers may conceal disagreement because of unequal power relationships or fear of being judged. Observations and documents strengthened contextual interpretation, but they could not fully remove this limitation. Fourth, thematic interpretation was informed by Foucauldian concepts. This lens was productive for identifying surveillance, normalisation, and power-knowledge relations, but it may have foregrounded domination more strongly than cooperation, compassion, or professional commitment.

The concept of medical dominance must also be applied cautiously. Biomedical measurement is not inherently oppressive, and professional authority remains necessary for accurate diagnosis and safe intervention. The concern is not the existence of medical expertise but the possibility that it becomes exclusive, decontextualised, or morally punitive. Finally, data saturation indicates that no substantially new themes emerged within this sample; it does not prove that all possible experiences or discourses were captured.

Future studies should include a broader range of actors, particularly fathers, grandparents, nutritionists, midwives, cadres, village leaders, social-service officials, agricultural stakeholders, and traditional practitioners. Comparative research across health-centre areas could examine how different leadership styles, socioeconomic contexts, and counselling practices shape medical authority and community participation. Longitudinal ethnographic studies are also needed to observe how surveillance, negotiation, and resistance develop over time rather than relying primarily on retrospective interviews.

Participatory action research could test interventions in which families and health workers jointly design culturally acceptable and economically feasible nutritional strategies. Future evaluations should measure not only anthropometric outcomes but also maternal stigma, family participation, food affordability, trust in health services, and the responsiveness of social

protection. Research should additionally examine whether paternal-engagement initiatives redistribute caregiving responsibility or merely create new forms of monitoring.

The principal implication is that sustainable stunting reduction requires more than correcting individual behaviour. It requires an integrated system capable of combining biomedical evidence, social protection, gender equity, local knowledge, and meaningful community participation. Medical discourse can remain scientifically authoritative without becoming socially exclusive when it is practised through dialogue, contextual sensitivity, and shared responsibility.

CONCLUSION

This study concludes that stunting management in Jeneponto Regency is dominated by medical discourse that defines children's growth through anthropometric standards, professional authority, nutritional protocols, and continuous surveillance. Although these mechanisms are essential for early detection and intervention, they also position children as measurable objects and mothers as the primary subjects responsible for preventing and correcting stunting. This individualisation of responsibility risks obscuring structural determinants, including poverty, food insecurity, gender inequality, limited resources, and unequal access to essential services. Mothers did not passively accept medical authority; they negotiated, adapted, and occasionally resisted health recommendations according to their economic capacity, cultural knowledge, and household realities. Therefore, apparent noncompliance should not automatically be interpreted as ignorance or unwillingness. Stunting interventions in Jeneponto must move beyond a top-down biomedical approach toward participatory, culturally responsive, and structurally informed governance. Biomedical evidence should remain central, but it must be integrated with local knowledge, shared family responsibility, social protection, and meaningful community participation. Sustainable stunting reduction will depend not only on changing maternal behaviour but also on transforming the social and institutional conditions that shape children's nutritional health.

RECOMMENDATIONS

1. Strengthen multisectoral interventions by integrating nutritional programmes with poverty reduction, food security, sanitation, clean-water access, education, and social protection.
2. Maintain evidence-based growth monitoring while ensuring that anthropometric measurements are communicated clearly, respectfully, and without stigmatising children or their families.
3. Implement participatory nutritional counselling that positions mothers as partners in decision-making rather than passive recipients of medical instructions.
4. Adapt nutritional recommendations to local conditions, including household income, locally available food, seasonal resources, and sociocultural feeding practices.
5. Expand family responsibility by actively involving fathers, grandparents, and other family members in childcare, food provision, and stunting-prevention activities.
6. Integrate local and biomedical knowledge by critically evaluating community practices and incorporating safe, nutritionally appropriate local foods into intervention programmes.

7. Strengthen community participation by involving Posyandu cadres, village authorities, religious leaders, traditional actors, and community organisations in programme planning and evaluation.
8. Avoid blaming mothers by training health workers to provide empathetic, non-judgemental, culturally sensitive, and context-responsive counselling.
9. Develop broader programme indicators that include household food security, paternal involvement, social-protection coverage, counselling quality, community trust, and service accessibility.
10. Conduct further research involving fathers, nutritionists, midwives, Posyandu cadres, village leaders, social-service officials, and traditional practitioners through longitudinal, comparative, or participatory designs.

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