BETWEEN LOVE AND LIMITED KNOWLEDGE: A QUALITATIVE STUDY OF MOTHERS' EXPERIENCES CARING FOR TODDLERS WITH STUNTING IN RURAL COMMUNITIES

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Abstract

Purpose: This study aims to explore the lived experiences, perceptions, and challenges mothers face in caring for toddlers with stunting in a rural community setting in the service area of Puskesmas Sukarame, Palembang, South Sumatra, Indonesia.
Methodology: A qualitative descriptive design was used, involving fifteen mothers of stunted toddlers selected through purposive sampling. Data were collected through in-depth, semi-structured interviews lasting 45 to 60 minutes and analyzed using the six-step thematic analysis approach. Ethical approval was obtained from Universitas Padjadjaran (Approval No. 1265/UN6.KEP/EC/2024), and all participants provided informed consent before data collection.
Findings: Five major themes emerged: (1) mothers' incomplete and often inaccurate understanding of the causes of stunting, (2) economic and access barriers to nutritious food, (3) socio-cultural beliefs shaping child feeding practices, (4) emotional burden and social stigma experienced by mothers of stunted children, and (5) mothers' reliance on and trust in posyandu cadres and midwives for guidance.
Practical/Social Implications: The findings highlight the need for nutrition education that is culturally sensitive, economically feasible, and delivered by health workers already trusted by the community, rather than through generic, top-down messaging.
Originality/Value: This study offers an emic, mother-centred perspective that is largely absent from quantitative stunting surveillance data, revealing the psychosocial dimensions of caregiving that accompany the biomedical definition of stunting.

Keywords: Maternal Experience, Nutritional Care, Rural Health, Stunting

1. INTRODUCTION

Stunting continues to be framed predominantly through anthropometric indicators and epidemiological trends, yet behind every height-for-age measurement below the World Health Organization standard is a mother navigating daily decisions about how to feed, care for, and protect her child.(1) National surveys such as the Indonesian Nutritional Status Survey provide valuable prevalence data, but they offer limited insight into how mothers themselves understand, experience, and respond to their child's condition.(2) This gap is particularly important because maternal knowledge, beliefs, and emotional wellbeing are known to strongly influence child feeding practices and health-seeking behavior.

In rural communities, where access to nutritious food, clean water, and specialized health services is often constrained, mothers frequently bear the primary responsibility for child nutrition while facing economic, cultural, and informational barriers that are rarely captured by structured survey instruments. Understanding stunting from the mother's point of view is therefore essential to designing nutrition interventions that are not only clinically sound but also acceptable, feasible, and sustainable within the realities of everyday family life.(3)

Although previous qualitative studies have explored mothers' perceptions of stunting and the experiences of families caring for children with stunting, less is known about how mothers in rural communities navigate the interconnected challenges of limited knowledge, economic constraints, socio-cultural beliefs, emotional burden, and access to trusted sources of health information in their everyday caregiving practices.(4) Existing studies have provided important insights into mothers' perceptions and family resilience; however, the ways in which these factors interact within the daily caregiving experiences of mothers living in rural settings remain insufficiently understood.(5) This gap is particularly important because rural mothers may face contextual barriers related to food affordability, access to health services, family influences, and culturally embedded beliefs that may shape how stunting prevention recommendations are understood and implemented.(6)

Therefore, this study aimed to explore the lived experiences, perceptions, barriers, and emotional challenges of mothers caring for toddlers with stunting in a rural community. By focusing on mothers' own perspectives, this study contributes an emic understanding of how knowledge, socioeconomic and socio-cultural constraints, emotional experiences, and trust in community health workers shape caregiving practices and may inform more contextually grounded and family-centred strategies for stunting prevention.

2. METHODOLOGY

Participants and Recruitment

This study employed a qualitative descriptive design. Fifteen mothers of toddlers aged 24–59 months who had been confirmed as stunted based on length-for-age or height-for-age measurements recorded at the local Integrated Health Service Post (Posyandu) were recruited using purposive sampling. Participants were selected to obtain information-rich accounts relevant to the study objectives. The inclusion criteria were: (1) mothers or primary caregivers of toddlers aged 24–59 months; (2) having a child confirmed as stunted based on the recorded length-for-age or height-for-age measurement at the local Posyandu; (3) having experience caring for the child during the period of stunting; (4) being able to communicate in Indonesian; and (5) being willing to participate and provide informed consent. Mothers who were unable to participate in the interview because of a severe health condition, cognitive or communication difficulties, or who withdrew their consent during the study were excluded.

Potential participants were identified with the assistance of [Posyandu/community health workers] based on the eligibility criteria. Eligible mothers were approached and provided with an explanation of the study objectives, procedures, potential risks and benefits, voluntary nature of participation, confidentiality, and their right to withdraw at any time without consequences. Participation was not based solely on availability; eligibility was first determined according to the predefined inclusion and exclusion criteria, after which participants were invited to participate. Written informed consent was obtained from each participant before data collection. To minimize potential selection bias, recruitment was conducted across Posyandu Sukabangun II and continued until sufficient information relevant to the research questions had been obtained.

Ethical approval was obtained from Universitas Padjadjaran (Approval No. 1265/UN6.KEP/EC/2024). The study was conducted in accordance with applicable ethical principles for research involving human participants. All participants provided written informed consent before the interviews. Participants' identities were protected by assigning unique codes, and identifiable information was removed from the transcripts and reporting.

Sample Size and Data Saturation

The sample size was determined using an information-rich purposive sampling approach rather than a predetermined statistical sample-size calculation. Recruitment and data collection proceeded iteratively, with the adequacy of the sample assessed based on information saturation and the relevance and depth of the information obtained from participants. After the [13th/14th] interview, no substantially new concepts or themes emerged from the data. The subsequent [14th and 15th] interviews were conducted to confirm the consistency and completeness of the emerging findings. Data

collection was therefore concluded after 15 participants when the research team judged that additional interviews were unlikely to generate substantively new information relevant to the study objectives.

Researcher Reflexivity

Researcher reflexivity was maintained throughout data collection, analysis, and interpretation. The research team consisted of researchers with backgrounds in [midwifery/public health/nutrition/other relevant backgrounds]. The researchers' professional backgrounds and prior knowledge of maternal and child health may have influenced the formulation of interview questions, interactions with participants, and interpretation of the data. Where applicable, the researchers' relationship with the participants was limited to the context of the research, and the researchers did not have a direct clinical or supervisory relationship with the participants. During the research process, the researchers maintained reflexive notes to identify their assumptions, expectations, and potential influence on participants' responses and interpretation of the findings. These reflections were discussed within the research team during the analysis process to reduce the influence of individual preconceptions.

Data Analysis and Qualitative Rigor

Qualitative data were analyzed using a systematic thematic analysis process. Interviews were transcribed verbatim and reviewed against the original audio recordings to ensure accuracy. The researchers repeatedly read the transcripts to become familiar with the data and identify meaningful statements relevant to the research questions. Initial codes were generated inductively from the participants' accounts. Similar codes were compared, grouped, and organized into categories. The research team then examined relationships among categories and developed preliminary themes. Themes were reviewed against the coded extracts and the complete dataset to assess their internal coherence, distinctiveness, and relevance to the study objectives. The final themes were developed through iterative discussion and consensus among the researchers.

To establish qualitative rigor, several strategies were applied. First, investigator triangulation was used by involving [two or more] researchers in reviewing transcripts, coding, and interpretation. Differences in coding or interpretation were discussed until consensus was reached. Second, member checking was conducted by [returning a summary of the findings/key interpretations to selected participants and asking them to confirm whether the interpretation reflected their experiences]. Third, an audit trail was maintained throughout the research process, including records of recruitment, interview procedures, coding decisions, development of categories, and revisions of themes. Fourth, reflexive notes were maintained to document researchers' assumptions and potential influences on the analytical process. Finally, the research team reviewed the final themes against the original transcripts to ensure that the findings remained grounded in participants' accounts..

Table 1. *Characteristics of informants (n = 15)*

Characteristic	Category	n (of 15)
Mother's age	20-29 years	8
	30-38 years	7
Mother's education	Elementary school	3
	Junior high school	6
	Senior high school	5
	Diploma/Bachelor	1
Occupation	Housewife	11
	Farm laborer/small trader	4
Child's age (stunted)	24-59 months	15
Number of children	1-2 children	9
	3-4 children	6

Note: Informants are identified in the Results section using anonymized codes M1 to M15.

Data were collected through in-depth, semi-structured interviews, each lasting approximately 45 to 60 minutes, conducted in the informants' homes to allow for a relaxed and naturalistic conversation. Interview guides covered informants' understanding of stunting, daily feeding practices, perceived barriers, sources of support, and emotional responses to their child's condition. All interviews were audio-recorded with consent, transcribed verbatim, and analyzed using the six-step thematic analysis approach, comprising familiarization with the data, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the final analysis. Trustworthiness was established through member checking, investigator triangulation, and an audit trail of the coding process.

3. RESULTS

Thematic analysis of the 15 interviews identified 5 major themes reflecting mothers' perceptions, experiences, and challenges in caring for children with stunting. The analysis progressed from initial codes to focused codes, subthemes, and overarching themes by identifying recurring patterns across the interview transcripts. The five themes were supported by representative quotations illustrating the informants' experiences and perspectives.

Theme 1: Incomplete and Misconceived Understanding of Stunting

The first theme concerned mothers' incomplete understanding and misconceptions about stunting. This theme comprised three subthemes: stunting perceived primarily as short stature, stunting perceived as hereditary, and limited awareness of its long-term consequences. Most informants associated stunting mainly with a child being shorter than other children of the same age and had limited understanding of its broader implications for growth and development. Some mothers considered short stature to be a familial characteristic and therefore perceived it as normal rather than as a condition requiring further attention. Awareness of the potential long-term effects of stunting, including impaired cognitive development and other aspects of child development, was also limited. One mother explained, "I thought my child was just short because I am also short. I did not know it was called stunting until the cadre measured him at the Posyandu" (M4).

Theme 2: Economic and Access Barriers to Nutritious Food

The second theme highlighted economic and access-related barriers to providing nutritious food. Three subthemes emerged: limited household income, limited access to protein-rich foods, and prioritization of staple foods. Mothers frequently described household income as an important determinant of food choices, particularly the ability to provide animal-source foods such as eggs, fish, and meat on a regular basis. Although some mothers recognized the nutritional value of these foods, their relatively high cost made regular consumption difficult. Consequently, mothers often prioritized staple foods and less expensive vegetables to ensure sufficient food for the entire household. As one informant stated, "I know eggs and fish are good for him, but if I buy them every day, there will not be enough money left for the rest of the week" (M9).

Theme 3: Socio-Cultural Beliefs Shaping Feeding Practices

The third theme reflected the influence of socio-cultural beliefs on child-feeding practices. This theme consisted of traditional beliefs about food, the influence of older family members, and conflicts between traditional beliefs and health professionals' recommendations. Several mothers reported food-related beliefs and restrictions, including perceptions that certain foods were unsuitable or "too heavy" for young children. Advice from older family members, particularly mothers-in-law and other senior relatives, also influenced mothers' decisions regarding complementary feeding. In some cases, these beliefs conflicted with recommendations from midwives or other health professionals and contributed

to delayed introduction of nutrient-dense foods. One mother reported, “My mother-in-law told me not to give fish too early because it would make him have worms, so I waited longer than the midwife suggested” (M12).

Theme 4: Emotional Burden and Social Stigma

The fourth theme concerned the emotional burden and perceived social stigma associated with having a child identified as stunted. Three subthemes were identified: maternal guilt and self-blame, anxiety and sadness, and social comparison and stigma. Several mothers described feelings of guilt, sadness, worry, and self-blame after becoming aware of their child’s growth condition. These emotional responses were intensified when mothers perceived negative comments or comparisons from neighbors and relatives. Some mothers also reported feeling uncomfortable attending Posyandu when their child’s growth was compared with that of other children, which in some cases resulted in temporary avoidance of Posyandu visits. One mother expressed this experience by stating, *“When people say my child looks smaller than others his age, I feel like it is my fault as a mother, even though I try my best”* (M2).

Theme 5: Reliance on and Trust in Cadres and Midwives

The fifth theme described mothers’ reliance on and trust in village midwives and Posyandu cadres as sources of information and support. This theme included three subthemes: trust in health workers, preference for personalized communication, and health workers as the primary source of information. Despite the economic, socio-cultural, and emotional challenges they experienced, mothers consistently described midwives and Posyandu cadres as accessible and credible sources of information about child growth, nutrition, and stunting. Mothers particularly valued face-to-face communication and individualized advice because they perceived health workers as being familiar with their child’s condition. Personalized guidance was considered more meaningful and trustworthy than general information obtained from posters, printed materials, or broader health campaigns. As one informant explained, *“I listen more to what the midwife says directly to me than to the posters at the health center, because she knows my child personally”* (M7).

Overall, the five themes illustrate that mothers’ experiences of caring for children with stunting were shaped by interconnected informational, economic, socio-cultural, emotional, and health-service factors. While limited knowledge, financial constraints, traditional beliefs, and social stigma created challenges in implementing optimal feeding and care practices, trusted relationships with midwives and Posyandu cadres represented an important source of support and potentially provided an avenue for strengthening mothers’ understanding and engagement in stunting prevention and management.

(M7)

4. DISCUSSION

The findings of the present study indicate that mothers’ understanding of stunting was incomplete and, in some cases, shaped by misconceptions. In this study, mothers primarily associated stunting with short stature, while some interpreted their child’s short stature as a hereditary characteristic. Mothers also demonstrated limited awareness of the broader and long-term consequences of stunting for child development. These findings represent the perspectives emerging directly from the present participants and should be distinguished from interpretations derived from previous research. The findings are broadly consistent with previous qualitative research in Indonesia showing that mothers’ perceptions of stunting and its risk factors vary according to personal experiences, educational background, socioeconomic conditions, and exposure to health information. (7) Similarly, Rahmadiyah et al. (2024) reported that some families perceived stunting as hereditary or believed that children who were short would eventually achieve normal growth. Thus, the present findings are consistent with previous evidence rather than representing a substantially different pattern. (8)

However, the present study adds a contextual perspective by demonstrating how these misconceptions were expressed in mothers’ everyday interpretations of their own children’s growth. Rather than simply lacking factual knowledge, some mothers appeared to incorporate short stature into an existing family explanation, particularly when they themselves or other family members were also

short. This may help explain why technical explanations of stunting are not necessarily sufficient to change perceptions. Although previous studies have emphasized the influence of education and socioeconomic conditions on maternal understanding. (7) The present findings suggest that health education should also address how families interpret growth within their own social and family contexts. Therefore, education on stunting should move beyond technical definitions, prevalence data, and lists of risk factors and instead connect information with mothers' experiences of growth monitoring, breastfeeding, complementary feeding, childhood illness, sanitation, and hygiene.

The present study also identified economic and access barriers that affected mothers' ability to provide diverse and nutrient-dense foods. Mothers described difficulty purchasing protein-rich foods such as eggs, fish, and meat on a regular basis and reported prioritizing staple foods and less expensive alternatives when household resources were limited. This finding is consistent with previous research indicating that socioeconomic conditions may constrain dietary diversity even when mothers possess awareness of appropriate child nutrition. (7) Similarly, research in Banten identified maternal knowledge, exclusive breastfeeding, complementary feeding history, health-worker support, and socioeconomic status as factors associated with stunting. (9) At the broader structural level, Siswati et al. (2022) demonstrated that poverty reduction, education, food access, sanitation, hygiene, and improvements in knowledge and perceptions collectively contribute to stunting reduction.(10)

No finding in the present study clearly contradicted these previous studies or the broader theoretical expectation that stunting is influenced by multiple and interacting determinants. Rather, the findings reinforce the understanding that maternal knowledge is only one component of the problem. Importantly, the present findings illustrate how structural constraints may limit the translation of knowledge into action. Mothers may understand that eggs, fish, or other nutrient-dense foods are beneficial but remain unable to provide them consistently because of competing household needs. This distinction is important because it indicates that improving knowledge alone may not result in sustained changes in feeding practices when families face substantial economic constraints. The present findings further demonstrate that feeding practices were influenced by socio-cultural beliefs and family decision-making. Some mothers reported food-related beliefs and advice from older family members that conflicted with recommendations from health professionals. Previous research has similarly demonstrated that dietary practices, food accessibility, family support, and information constraints are interconnected within women's health experiences. (11)

More recent research has identified social and cultural norms as factors influencing the acceptance and effectiveness of stunting prevention interventions.(12) The present study is therefore broadly consistent with this literature; however, it provides a more specific illustration of how intergenerational advice may directly influence decisions about complementary feeding. This finding suggests that mothers should not be regarded as the sole decision-makers in child feeding. Health education may be more effective when it also engages husbands, grandparents, mothers-in-law, and other family members who influence childcare and feeding decisions.

The economic and socio-cultural findings have direct implications for health counseling. In the present study, mothers' difficulties were not limited to knowing what should be done; they also involved whether recommended practices were affordable, culturally acceptable, and supported by other family members. Consequently, counseling that provides recommendations without considering these contextual factors may create a gap between professional advice and families' capacity to implement it. A problem-solving approach may therefore be more appropriate, whereby health professionals assist families in identifying feasible dietary and caregiving strategies based on available resources. Previous research has emphasized the importance of communication with mothers as well as husbands and other family members in stunting prevention and has highlighted the need to strengthen cadres' knowledge and communication skills. (13) . The present findings support this direction by showing that family context needs to be considered when translating health recommendations into everyday practices.

Another finding of the present study was the emotional burden and perceived social stigma experienced by some mothers. Mothers described guilt, sadness, anxiety, and self-blame, particularly when their children were compared with other children or when comments from neighbors and relatives were perceived as judgmental. This psychosocial dimension was evident in the present interviews and should not be interpreted solely as an extension of previous nutritional research. Previous qualitative research has shown that mothers' experiences of caring for children with stunting are embedded within

broader family and social contexts. (5) However, the present findings specifically highlight how perceptions of social comparison and maternal responsibility may influence mothers' emotional experiences and, in some cases, their willingness to attend Posyandu.

This finding has an important implication for the way stunting is communicated. Although previous studies have emphasized the importance of maternal knowledge and caregiving practices, communication that focuses excessively on maternal responsibility may unintentionally reinforce guilt or stigma. This interpretation extends the previous literature by suggesting that the effectiveness of health education should be considered not only in terms of knowledge acquisition but also in terms of how messages are emotionally experienced by mothers. Health professionals should therefore use empathetic and non-judgmental communication and position mothers as partners in problem-solving rather than as individuals who need to be blamed or corrected. In practical terms, counseling should address not only "what should be done" but also "what can realistically be done within the family's circumstances."

A further finding was the strong trust that mothers placed in midwives and Posyandu cadres. In the present study, mothers described these health workers as accessible and credible sources of information and particularly valued face-to-face guidance because they believed that health workers understood their child's individual condition. This finding is consistent with research demonstrating the important role of cadres in communicating with mothers, husbands, and families in stunting prevention. (13) Research has also identified gaps in cadres' knowledge and anthropometric measurement skills, emphasizing the need for structured training and competency development (Widiasih et al., 2025). Training approaches incorporating demonstrations and role-play have further been shown to improve cadres' knowledge, attitudes, and self-efficacy in their health-education roles. (14)

Nevertheless, the present study adds an important perspective by showing that trust in health workers was not simply related to their role as information providers, but also to the perceived personal relationship between the health worker and the child. Mothers considered individualized, face-to-face advice more meaningful than general information provided through posters or broader health campaigns. This finding was not inconsistent with previous research; rather, it provides a contextual explanation of why interpersonal communication may be particularly important in community-based stunting prevention. Midwives and cadres may therefore function not only as disseminators of health information but also as trusted intermediaries who translate technical recommendations into practical and context-sensitive guidance.

Overall, the findings of the present study largely support previous research and theoretical expectations that stunting is a multidimensional problem influenced by nutritional, socioeconomic, cultural, familial, and health-service factors. No major finding clearly contradicted the existing literature. However, the present study contributes additional contextual insights into how these factors are experienced by mothers in everyday life, particularly the interaction between misconceptions about hereditary short stature, household economic constraints, intergenerational beliefs, emotional burden, and trust in community health workers. These findings suggest that effective stunting prevention should not rely solely on transferring knowledge. Instead, health education should be contextualized, family-centered, culturally sensitive, responsive to socioeconomic realities, and delivered through trusted health professionals and community cadres. Such an approach may help bridge the gap between what mothers know, what they believe, and what they are realistically able to implement in their daily lives.

5. CONCLUSIONS

This qualitative study reveals that mothers of stunted toddlers in a rural community navigate a complex interplay of limited knowledge, economic constraints, socio-cultural beliefs, and emotional burden in their daily caregiving. Stunting prevention efforts that rely solely on biomedical messaging are unlikely to be effective unless they also address the lived economic and social realities described by mothers, and unless they build upon the trust that mothers already place in local midwives and health cadres. Future stunting interventions are encouraged to adopt a mother-centred, family-inclusive approach that combines nutrition education with emotional support and culturally appropriate communication strategies

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