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Governing Stunting through Power, Discourse, and Local Resistance in Indonesia

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ABSTRACT

The issue of stunting has largely been treated as a biomedical problem to be solved through technical intervention without considering the politics of the problem. This paper seeks to analyze how the governance of stunting occurs within the power/knowledge complex and how communities interact with such interventions in the Indonesian case. In a qualitative study carried out using case study methodology within Ngusikan village, data was gathered using interview, focus group discussion, observation and documentation methods involving twenty-two respondents. Using the Foucault-inspired theoretical perspective, the study identifies three key dynamics of how stunting governance happens: (1) the processes of governance involve surveillance and normalization through the posyandu and growth monitoring systems; (2) medical discourse represents the dominant regime of truth, which continually competes with the local knowledge; and (3) communities, especially mothers, creatively respond to such interventions.

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1. Introduction

Stunting has been viewed essentially from a biomedical perspective where the problem is tackled using nutrition-specific strategies and health programs. Several research works have focused on the significance of nutrition-related issues, maternal-child health, and interventions during the critical first 1,000 days in determining stunting (Ardianti & Sumarmi, 2023; Elisaria et al., 2021; Vaivada et al., 2020). Nevertheless, stunting does not affect children only physically but also poses serious risks for cognitive development, economic productivity, and quality of the country's human resource base. Stunted children tend to show poor cognitive performance and

immune response and run a risk of lower productivity when they become adults. In such a way, the cycle of poverty continues being transferred from one generation to another. It means that the stunting phenomenon should not be treated as a medical issue, but rather be seen as a development problem at the national level.

Worldwide, stunting remains a complicated issue since the phenomenon is characterized by interplay between several social, economic, cultural, and political aspects. According to cross-national researches, determinants of stunting remain very contextual. For example, high prevalence of stunting in Ethiopia may be attributed to poor living standards and maternal illiteracy (Mesfin et al., 2015). Differences in social determinants of health between rural and urban populations of Vietnam and inequalities in food distribution may influence stunting rate negatively in Vietnam (Minh Do et al., 2018). Stunting rate is closely related to food insecurity and household social determinants in South Africa (Harper et al., 2023). Child marriage practiced in Nepal contributes to nutritional problems of children in the country (Bhandari, 2019). However, structural inequality is the determinant of stunting in Latin America (Flores-Quispe et al., 2019). The provided information demonstrates that the issue requires a tailored response that will depend on local social context.

Such a global paradigm can also be seen in many other developing nations like Indonesia, where stunting still is being dealt with using biomedical and programmatic frameworks. Indeed, in the case of Indonesia, stunting is a big issue when it comes to health development and human capital development. Official records show that stunting prevalence in Indonesia was as high as 24.4% back in 2021, despite the country's target being just 14% by the year 2024 according to national policies. As such, a massive effort is needed to ensure that a certain percentage is reduced annually to meet the 14% target, necessitating extensive cross-sector coordination. The convergence framework adopted by the national government includes the use of specific interventions and sensitive interventions to address stunting. These include nutrition, maternal and child health; sanitation, education, and social protection.

Moreover, success in addressing the problem of stunting in Indonesia varies greatly among regions. While some regions have been able to make constant improvements in their efforts to reduce stunting, there are also regions which have either experienced stagnation or even deterioration. Such a situation reveals that a top-down approach is often not enough, especially if different communities face different social realities. Social and cultural factors become essential in the process of implementing policies within each particular community, showing once again that policies are not implemented in isolation of social reality.

The use of biomedical and technocratic methods in the policies regarding stunting results in the oversimplification of the whole problem, reducing it to the technical issue which is to be solved by rational means, based on the principles of health science. This view neglects other important aspects of the problem such as the social, cultural and political context which influences the problem. According to

several research findings, the role of social and cultural constructs is important for the success of any stunting intervention measures (Bella et al., 2019; Hidayah & Sadewo, 2022; Loya & Nuryanto, 2017). Moreover, sometimes stunting is perceived as a normal state in certain cultural context and is not regarded as a problem connected with children's health.

Moreover, the disparity between medical intervention and social practices also poses questions in terms of governance of stunting interventions. The technocratic and scientific nature of such policies is not always well received in societies due to their contradiction with the indigenous knowledge system practiced there. In most instances, the community also has its own perception of what constitutes child health which is not necessarily equivalent to that of the medical definition. For instance, an active and less fussy child is generally viewed as a healthy child despite being high-risk according to medical definition.

Within the academic body of work, current efforts that aim at understanding determinants of stunting are often still focused on nutritional status, parenting styles, and socio-economic conditions. Even though this kind of effort provides valuable insight into factors affecting stunting, it is insufficient to explain how stunting-related knowledge was constructed, distributed, and institutionalized in a policy context. In addition, efforts to examine the role of local knowledge about stunting have yet to be theoretically driven, especially regarding its dynamic with medical discourses in the context of larger power dynamics. Moreover, the use of critical theories is rather rare.

In Foucaultian terms, knowledge is anything but neutral as it always depends on the power relation and shapes how individuals or society perceive their world. The idea of the power/knowledge illustrates that medical knowledge operates not only as scientific knowledge, but also as means by which the definitions of normativity and social conduct are set. With regard to stunting, the established standards of child development worldwide become the starting point at which interventions of states occur through different health programs aimed at monitoring children's bodies.

In addition, by using the notion of biopolitics, the modern state practices its power by controlling the lives of the citizens by means of regulation of their health, reproduction, and welfare. Stunting interventions can be viewed as a tool of biopolitical power which seeks to enhance the quality of human resource by regulating the bodies of children and mothers. Weighing and nutrition interventions for instance, are some of the tools used in controlling and optimizing the population.

Nevertheless, it must be noted that the power dynamic does not go only one way. The community has the power to interpret and negotiate the dominant medical discourse and even resist it. Local culture and local knowledge continue playing an important role in how communities practice their health care activities. This means that the interplay of both discourses becomes critical for the evaluation of stunting policies.

From the above discussion, there seems to be a clear gap in the existing body of literature because it has failed to study stunting as a practice which has something

to do with power and the way knowledge and discourse are constructed. As such, what needs to be done at this point is for one to look at stunting as both health and power practice.

The intention of this study is to make an attempt to critically explore how stunting governance constitutes itself as power/knowledge in Indonesia. Specifically, it would be important to critically reflect on how stunting governance functions via policies, health surveillance systems, and medical discourses. Further, another focus of this study will be to investigate how stunting intervention policies are understood, negotiated, and possibly resisted by the people in their everyday experiences. In this regard, using Foucault's theory on power/knowledge would enable the present study to contribute to the existing body of knowledge in that it makes a case for understanding stunting as not only a public health problem but also as an issue of power/knowledge.

The present research draws from the theory of Michel Foucault in order to explain stunting not only as a matter of health but also as a power mechanism that operates through certain policies, discourses, and social control mechanisms. In other words, the Foucauldian theory allows for the examination of how-governance-is exercised.

Power/knowledge theory suggests that power and knowledge cannot be seen as separate entities; rather, they are interrelated in that they construct and define each other. The case of stunting shows that state-produced knowledge on the matter acts not only as scientific knowledge but also as a way to define the norm of child development through the definition of the height norms. Those children who do not meet the criteria are termed abnormal and become subjects to the state intervention. Hence, knowledge itself becomes political in terms of defining what is healthy and what is not.

Discourse is the term utilized for explaining how this kind of knowledge is spread in the society and its validation. Discourse on stunting is constructed by policies, health campaigns, health facilities in communities, and education campaigns that mold people's views about their children's bodies and their ways of raising children. This discourse, however, does not occur alone because the communities also have discourses based on traditions, experiences, and cultural values. This results to an area where discourses come into conflict and affect the ways in which policies are implemented socially.

Additionally, the theory of normalization helps in explaining the use of medical standards in regulating societal behavior through their use as reference points. This is true in the case of stunting, where globally accepted standards of childhood growth are used to monitor activities such as weighing and keeping records in Health Development Cards (KMS). The above practices are not just for technical purposes but also aim at regulating societal behavior so as to match with health standards as laid down by the state.

In addition, the notion of biopolitics describes how the state controls the life of its citizens through health policy. In case of stunting, such measures as nutrition

programs, maternal and child health programs, and growth monitoring all belong to the set of measures that aim to enhance human capital in the state. Children's and mothers' bodies are thus the object of regulation, monitoring, and optimization under various health programs. Hence, stunting is not only a question of health of a person but also concerns the management of population in general.

Yet, power is relative. In the context of Foucault's theory, any exercise of power is invariably accompanied by the potentiality of resisting such exercise. Not all society remains passive in accepting medical discourse, and there could be interpretation, negotiation, or refusal of certain interventions as not consistent with local culture. Hence, an examination of stunting must take into consideration how power operates in relation to society as a dynamic phenomenon.

Based on this theoretical framework, this study will aim at exploring the workings of stunting policies based on the power/knowledge, discourse, normalization, and biopower processes, as well as exploring the reactions of local communities towards these policies within their respective social contexts. This framework would also allow us to critically understand why, despite being technologically sound, certain health policies fail to deliver the intended results in practice. Through emphasizing the relationship between discourse, power, and practical knowledge, the Foucault perspective helps us understand that the effectiveness of any policy is conditioned by its reception, interpretation, and implementation within particular social contexts.

2. Methods

This study employed a qualitative research design within a critical-interpretive paradigm to examine stunting governance as a social and political process shaped by power relations, policy practices, and local discourse. An instrumental single-case study was conducted in Ngusikan Village, Jombang Regency, East Java, Indonesia. The site was purposively selected because of its successful reduction in stunting prevalence and its integration of formal public health interventions with local knowledge, providing an information-rich case for examining everyday governance practices.

Participants were selected using purposive sampling to include actors directly involved in stunting prevention. Twenty-two participants were recruited, comprising mothers of toddlers (n = 10), health workers (n = 4), midwives (n = 2), nutritionists (n = 2), village heads (n = 2), and community leaders (n = 2). Data were collected between November 2024 and April 2025 through semi-structured interviews, focus group discussions, participant observation during Posyandu activities, and document analysis of policy documents, programme reports, and child growth monitoring records (KMS).

Data were analysed using thematic analysis involving open, axial, and selective coding. The interpretation was guided by Foucauldian concepts of power/knowledge, discourse, normalization, and biopower to examine how stunting governance operates through public health practices and how local communities negotiate these interventions.

To enhance trustworthiness, the study employed triangulation of data sources and methods, maintained an audit trail throughout the research process, and used thick

description to support transferability. Ethical approval was granted by the Social Science Research Ethics Committee of Darul Ulum University (Approval No. 021/F-UDR/ETIK/IX/2024). Written informed consent was obtained from all participants prior to data collection, and confidentiality and anonymity were maintained throughout the study.

3. Results and Discussion

The findings of this study can be categorized into three related themes, which demonstrate the process of governance for stunting management at the community level. The themes encompass the interaction between policy instruments, knowledge production, and social practice within the community context. Rather than treating stunting as an entirely biomedical matter, the results show that governance in stunting management involves the processes of surveillance, discourse, and negotiation as a result of the interrelationship between institutional action and social context.

3.1 Results

3.1.1 Governing Through Policy and Surveillance

Research findings show that the process of governing stunting in Ngusikan Village occurs by way of processes of surveillance that are systematic, organized, and repeated, which are institutionalized in posyandu practice as the main setting for health practices. Posyandu practice is not merely an act of delivering healthcare services but also a site where the body of children is systematically scrutinized.

In effect, all posyandu programs occur through a highly systematic process, indicative of a health surveillance system operating on a regular basis in the community setting. Each month, mothers bring their kids to engage in various activities including registration, weighing, record-keeping, health services and health education. According to the village midwife: “It goes through the same routine every time: Registration, weighing, record-keeping, health services, and health education… should a toddler fall within the ‘yellow’ or ‘red’ category, it would immediately be recognized, and I follow it up”. (Midwife). The above procedure clearly shows that child growth monitoring is not arbitrary but rather a systematic practice. Using such a mechanism, a child’s growth is categorized depending on its state into various categories including “normal,” “yellow zone” and “red zone.” The categorization determines the kind of intervention to be conducted on the child’s body.

The function of the cadres in the posyandu is critical in building a good surveillance system. The cadres do not only collect information, but they also play a vital role in maintaining continuity and follow-up of this surveillance process in their respective homes. According to an interview, “Without posyandu we would never know about the weight of the children each month. That way we could tell whether the kid was malnourished or not” (Village Health Worker 1). In addition to collecting data, the cadres also conduct home visitations for the at-risk children who have stagnating weights or are in the red-line category. This example shows that surveillance takes place not only in the posyandu setting but also in their respective

homes. Community involvement is one of the factors that make this surveillance system sustainable. The fact that the mothers attend the posyandu each week shows that health surveillance is part of their social life.

However, such involvement is not just motivated by health awareness but also by other social and particular reasons. As a health worker puts it, “Because if we can offer them food like green bean porridge, eggs, and biscuits, then both the mothers and children will be very pleased; then the children will also be more willing to participate.” (Community Health Worker 2). Hence, it is evident that health intervention methods are based not only on purely medical reasons but are also socially oriented in order to motivate the target community. Moreover, this health surveillance is conducted according to an integrated health data registration system using the Health Progress Card (KMS), followed by reporting to the respective community health centers (puskesmas) as well as to local governments. The collected child development data not only serves for community-level purposes but also becomes a part of the national-level health surveillance process.

Monitoring mechanism is also included in follow-up intervention programs such as Nutrition Recovery Center (TPG). Children who have been detected with problems of malnutrition are collected and provided with concentrated interventions during a specific period of time. In the words of a community health worker, “children are collected and given nutritious meals for twelve days while their mothers get lessons about cooking. (Community Health Worker 3). This example shows how monitoring process is not only about problem detection but also includes a step of normalization through organized interventions. At the same time, it is clear from the findings that not everything about monitoring process can be smooth and problem-free. Sometimes, communities may have various perceptions about health problems of their children. “Many people still believe that stunting means the child is short but it’s not like that.” (Community Health Worker 4).

This difference in perception shows that even though the surveillance system is effective, perceptions of measurement outcomes will still be affected by local perceptions. Furthermore, surveillance processes are supported by the active participation of institutional actors including the village government and field extension officers. Collaboration across sectors is vital in increasing effectiveness in policy implementation within the community. As stated by a family planning field extension officer: "The success of this project depended on everybody being involved. From the chief of the sub district down to the midwives, the cadres, all the way up to schools and community leaders." (PLKB). The participation of these different players shows that stunting governance goes beyond the health sector alone.

3.1.2 Producing Truth: Medical Discourse vs. Local Knowledge

It turns out that the knowledge related to stunting in Ngusikan Village is not simply singular but is, in fact, the product of a dynamic relationship between medical discourse introduced by health professionals and indigenous knowledge residing in daily practice of people in the village. This means that the truth relating to children’s

health is not just a medical construct but also an experience-based reality.

The initial notion about stunting for most of the mothers is that it is a condition when the kid is short or skinny due to his genetics or inherited from the parents. Clearly, it demonstrates the prevalence of locally established knowledge acquired through practical experience and tradition. Nevertheless, such attitude changes once the mothers got familiar with the concepts related to child's health through the posyandu. Thus, one of the mothers expressed her opinion on that matter: "I thought stunting is something that a kid is born. But thanks to the posyandu, I found out that it is actually a result of prolonged malnutrition which influences kids' intelligence." (Mother 2). Moreover, similar conclusion about the nature of stunting can be drawn based on the testimony of yet another woman whose opinion changed during her attendance at the posyandu: "I used to think that it just meant that the kid is short but not, that it is associated with the kid's intelligence and his future." (Mother 3).

In practical terms, it is a difficult choice that mothers need to make between heeding the advice of healthcare professionals or adhering to tradition. The resulting space of negotiation in decision-making on raising children is: "Sometimes I'm confused the midwife said fish protein was good, but my parents said little kids shouldn't eat fish or they'll vomit." (Mother 2). Another example of a mother's struggle between healthcare professionals' and extended family's advice can be found in the sphere of food and care: "Where health is concerned, I listen to the midwife; where traditions and prayers are concerned, I listen to the family." (Mother 2). This proves that mothers neither follow one regime of knowledge alone nor are they indifferent to knowledge.

From the point of view of the health providers, there are clear strategies to create and share knowledge in the form of medical information as the most important criteria for the rearing up of children. The process of education is achieved through health education activities, consultations, and technological services. As mentioned by a nutritionist, "Mothers are asking many questions nowadays even late at night using WhatsApp so, we have developed Poskozio so that consultations can be more specific." (Nutritionist). The above quote shows that creation of medical information is not limited to only formal settings such as health posts.

However, the propagation of medical knowledge does not necessarily involve coercion. The health practitioners are well aware that a too normative approach might result in resistance from the locals. Hence, adaptation and communication are necessary in order to propagate the knowledge of medicine. "If you immediately tell him it's wrong, he gets offended… so it has to relate back to his values." (Nutritionist). The posyandu workers are important mediators between the language of medicine and the local context. In addition to propagating the information, they translate medical jargon into terms that are understandable by the community. "If we talk in soft voices, they mothers will listen if the voices sound like accusations, they'll just shut themselves." (Posyandu Worker 2). Nonetheless, the local knowledge cannot be overlooked in influencing parenting styles. There are various beliefs concerning

health, nutrition, and maternal behavior that exist locally. “There are still some that believe you should not give fish to small children although it’s healthy for them.” (Cadre 3)

Moreover, there is also another approach to define health based on empirical experience, when a child is said to be healthy if he or she is active and not fussy despite falling under high-risk category from medical point of view. “The most important thing is that the child is active and not fussy although they are small, it doesn’t matter.” (Mother 3). As one can see, the results show that the criteria of health in this community sometimes do not correspond to medical norms, but rather to subjective experience of raising children. On the contrary, there are cases when mothers started taking a reflective approach to their practices by selectively choosing between medical and traditional approaches. They don’t give up traditions altogether, but select what should be used based on experience and reasonableness. “Previously, I followed everything but now I pick those which seem reasonable to me, but keep practicing good ones.” (Mother 5).

Moreover, non-medical actors like religious leaders also participate in health discourse in the community. Health discourses within religious study groups are generally presented from both moral and religious perspectives. "A mother is a family manager ”The child’s health is the mother’s duty." (Religious Leader) Therefore, we understand that the creation of health discourse is not only done by the medical community but also by other social institutions as well.

3.1.3 Negotiating and Resisting Health Interventions in Everyday Practices

As it has been found out from the research, however, health interventions in case of dealing with stunting can sometimes not be fully accepted but negotiated and even resisted. The role of mothers, who are key players in the process of raising the child, is important in terms of the extent to which recommendations are observed, changed or completely disregarded. For instance, in case of feeding the child, mothers do not always follow the advice of doctors, relying on experience, emotions and, finally, social pressure at home. One of the mothers said, for example, "One time, while my baby was still not six months old, I was feeling so sorry for my baby crying all the time and so I fed him mashed banana – just so that he would not go hungry." (Mother 1). It means that sometimes deviation from doctors' advice occurs not due to ignorance but as a reaction to the actual life situations.

Also, there have been similar cases in which some of the interviewed mothers faced constraints in breastfeeding and had to incorporate other measures for the sake of meeting their child’s nutritional requirements, such as “My breast milk supply was low, therefore he cried most times, at first it was hard for me to give formula until eventually I had to add formula and even banana so that he could remain full” (Mother 2). This clearly shows that in many cases, parenting does not strictly conform to the recommended practices.

Moreover, the economic state and societal pressure can shape decisions related to parenting practices. Women often lack resources and thus fail to provide

for optimal nutrition as recommended. This is evident through statements like, "When I was pregnant, I had a lot of stress financially it was not easy, my husband was ill. I attempted eating well, but, well I could not always." (Mother 5). The example shows that following health guidelines depends on other factors such as socioeconomic status, family structure, and women's workload.

In certain situations, parental behavior can be dictated by societal pressure and interactions within the larger family network. The mothers frequently find themselves in such a situation where they have to be adaptive towards the advice provided by their parents or relatives even though it is not consistent with the medical advice provided. "Well, I used to listen to what my parents had to say… now what I do is pick up what makes sense even though I follow traditions." (Mother 6). From this statement, it is evident that opposition is not only outright disobedience.

Furthermore, the complex health state of the child determines the response of the mother towards health intervention programs. Sometimes the mother has to cope with the other diseases complicating the condition of the child. "My child has to take medicines all the time sometimes his appetite changes. I have to think of how to ensure that he keeps eating". (Mother 4). This example shows that the process of caregiving depends not only on the level of knowledge, but also on medical and emotional aspects experienced by the family. Resistance can be expressed in maintaining the traditions that people believe valuable. Traditions are not always left behind but re-negotiated so that they could fit the present situations. "I maintain my traditions, but I give up on those that do not make sense anymore" (Mother 6). This quote shows that resistance does not mean opposition. It is, in its turn, adaptational and selective. As for mothers, posyandu cadres are also confronted with resistance in terms of health education activities. In their effort to persuade the women to adopt healthier practices, they understand that the more prescriptive they are, the more likely the women are to reject any advice. "We shouldn't speak too harshly to the mothers; then they'll simply retreat. We should speak slowly, patiently, to make them agree to do things differently" (Worker 3). In other words, it would appear that behavioral changes in regard to health practices have to happen gradually, with the aid of persuasive and consistent communication rather than being imposed in any way. The second source of resistance can be found in how the community perceives the health of the children. "The main thing here is that the child should be lively and not whiny." (Mother 3).

3.2 Discussion

3.2.1 Governing Through Policy and Surveillance

From the results presented above, we may conclude that the process of stunting governance is not simply the realization of health policy but is rather the process of exercising power through surveillance and normalization apparatuses that exist within social relations. Posyandu, KMS, and standardized measurements of child growth are the tools that the government uses to implement its power over children's bodies.

Such a finding corroborates past findings emphasizing the importance of community-based health care systems in influencing the health status of children. For example, in their studies conducted in Indonesia, researchers have identified the strategic value of posyandu cadres in monitoring the growth and development of children and promoting behavioral changes within households (Muslimin & Mursyidah, 2024; Yasmine et al., 2024). Again, researchers have noted that routine monitoring practices are critical in integrated nutrition interventions targeting children, and such practices can enhance child nutrition outcomes (Elisaria et al., 2021; Fahmida et al., 2020). While monitoring has been viewed mainly as a programmatic process in past research, the present study goes further to illustrate how such processes constitute governance practices.

This process, from Michel Foucault's point of view, demonstrates normalization wherein norms regarding growth are created and serve to establish what constitutes normality and abnormality. Children who are not within the standard norms become targets for intervention as their body shapes are controlled to be according to the set norms. This idea is in accordance with the wider discussion within public health on the discipline of health promotion practices in shaping individual behavior based on normative standards (Mattioni et al., 2021; Zago et al., 2022).

Also, the results show biopolitical elements, whereby the state rules over populations via the control of life processes such as nutrition, growth, and development of children. The documentation of data, monitoring and intervention programs on the basis of risk groups point to a larger trend of managing populations. This is consistent with the observation made globally, which is that stunting interventions at a large scale require standardized indicators and surveillance (Bhutta et al., 2020; Vaivada et al., 2020).

Unlike many other studies that stress the effectiveness of such system, this study shows that the mechanism of governance through surveillance is not entirely deterministic. The existence of alternative interpretations within the community suggests that the use of medical categorization alone is not enough to ensure consensus. Such a conclusion is supported by sociological investigations that demonstrate the role of local knowledge in interpreting health issues (Heriawan et al., 2021; Hidayah & Sadewo, 2022).

This means that for the mechanism of surveillance to have the capacity to stunt governance, its effectiveness will depend on how it is read and applied in the particular social setting. The implication is that stunting governance can be approached both in terms of the technology of surveillance and its practice in a localized context.

3.2.2 Producing Truth: Medical Discourse vs. Local Knowledge

Such results indicate that there are not single forms of truth production on the issue of stunting in Ngusikan Village. In addition, the process of such production involves

both medical and local epistemic discourses. Moreover, medical knowledge does not exist in isolation, but rather is socially constructed in different ways.

The current finding is in line with other researches that emphasize on the role of mother's knowledge and awareness in the formation of child nutrition practices (Majid et al., 2024; Ramadhan et al., 2024). It has been observed that higher engagement with health education especially via community platforms like posyandu, is effective in bringing about changes in mothers' awareness regarding stunting and children's health (Astarani et al., 2020; Evi et al., 2023). The limitation with respect to other researches is that they consider knowledge acquisition as a linear and non-contested process.

The results show that mothers not only use the practice of replacing the local knowledge with medical knowledge, but also that they involve themselves in a process of selection, adaptation, and negotiation. This is consistent with the literature on cultural belief system and practices influencing child-rearing behaviors despite the introduction of new health-related practices (Heriawan et al., 2021; Hidayah & Sadewo, 2022). In addition, studies related to traditional medicines indicate that individuals adopt biomedical and traditional knowledge concurrently instead of using one at the exclusion of the other (D'Almeida et al., 2024; Okrofa, 2024).

Taking the view of Michel Foucault, these processes demonstrate the working of discourse as a regime of truth in which what constitutes legitimate knowledge and practice is constructed. In this regard, medical discourse operates as a dominant force whose objective is to establish standardized practices of rearing children via scientific knowledge and institutions. Such processes are seen in the systematic communication process through health workers, cadres, and online portals in constructing a biomedical notion of stunting.

Nevertheless, it should be noted that this is just one of the many ways in which the results of the study show that the medical discourse does not work in isolation or in complete dominance. On the contrary, there exists the discourse of the locality itself which comes up against the medical one and possesses its own kind of legitimacy based on culture, family tradition, etc.

More importantly, this study advances the current literature through the demonstration that the process of creating truths is not only related to knowledge transmission but rather also to power dynamics entrenched in practical activities. Following the Foucauldian approach applied in the field of health research, it becomes clear that there cannot be any knowledge without power and that the power of the medical discourse is upheld through its normalization and repetition in practical activity (Mattioni et al., 2021; Torres-Cuello & Pinzón-Salcedo, 2022). However, as shown in the current study, people have agency to do so.

For that reason, the construction of truth within the domain of stunting cannot be viewed in a straightforward manner as a linear process of communication of facts by experts to populations. Instead, the concept holds critical lessons for health policy in that an intervention strategy that only focuses on communicating facts can hardly succeed.

3.2.3 Negotiating and Resisting Health Interventions in Everyday Practices

According to this theory, medical standards may not necessarily be the main point of reference in the daily life of the community members, as each community may interpret health issues from its own stand-point. Nevertheless, the study findings prove that resistance may not necessarily be a barrier to program implementation. There are situations where resistance is overcome by the adaptive nature of the health programs to local realities.

These results show that the health programs that deal with stunting cannot be considered to be working in a totally dominating power dynamic, but more along the lines of negotiation and adaptation. Mothers, as being the ones taking care of the children, are constantly interpreting, modifying, and selecting medical recommendations according to their experiences and circumstances.

This result correlates with other research findings concerning the significance of maternal autonomy as well as socio-economic factors in the context of child health behavior. Previous studies demonstrate that maternal caregiving is largely influenced by structural factors including economic stress, poverty, as well as family circumstances (Abreha et al., 2020; Mulyaningsih et al., 2021). The same applies to Indonesian studies indicating that mother's decision making regarding child feeding and upbringing is also affected by cultural as well as societal factors (Bella et al., 2019; Loya & Nuryanto, 2017).

Yet, while previous research often tends to regard these elements as impediments to appropriate intervention, this particular study provides another take on the issue by revealing that what is seen as "non-compliance" may be better regarded as an expression of situated rationality. Rather than rejecting professional recommendations, mothers adjust them according to their own experience. Such conclusion coincides with the findings of other research related to local health customs and showing how local populations integrate biomedical and indigenous practices (D'Almeida et al., 2024; Okrofa, 2024).

According to the view of Michel Foucault, it means that one cannot exercise power without simultaneously creating a space where it can be challenged. The act of resistance does not take place openly or in a confrontational manner, rather, it lies in the subtle acts of daily life such as changing feeding methods, selectively choosing certain advice, and defining a "healthy" child.

The above observation is supported by Foucault-inspired research in public health that highlights the fact that people are not just passive receivers of health interventions but rather subjects who interpret and sometimes resist the hegemonic discourse (Mattioni et al., 2021; Zago et al., 2022). However, the current research goes beyond that as it illustrates resistance against the hegemony through a particular case, namely stunting governance.

However, crucially, the findings undermine the notion that the success of the policies hinges on the effectiveness of the design and technicalities. Rather, what the findings show is that policy success arises from co-production, i.e., the interaction

between institutional actors and the community people. This is consistent with research on policy implementation in Indonesia on stunting (Herawati & Sunjaya, 2022; Noerjoedianto et al., 2024).

Resistance and negotiation must thus not be seen simply as hindrances but rather as essential elements of the process itself. Acknowledgment of these elements will lead to a deeper appreciation of the process of governance, where effectiveness lies not just in compliance but also in the capacity of policies to adjust to and interact with reality on the ground. This means that greater flexibility and participation, which involve acknowledging the importance of both science and experience, are necessary in stunting governance.

The current paper makes an important contribution to existing literature by connecting the biomedical and the critical approach and illustrating how processes involved in stunting governance function as an arena of power relations that revolve around surveillance, discourse, and resistance.

4. Conclusion and Recommendations

The findings of this research clearly show that the phenomenon of stunting should not only be treated from the perspective of health but also as a practice of power exercised through policies, discourses, and social control in the local setting. The practices like posyandu, Kartu Menuju Sehat (KMS), and global standards for growth help the state not only carry out health-related activities but also establish a form of surveillance system in which the body of children can always be controlled, categorized, and intervened.

However, at the same time, the results obtained from the study also suggest that the people cannot be viewed only as a passive subject of such interventions. The medical knowledge provided through the mechanisms of the state comes into conflict with the knowledge that is deeply rooted in social processes, which leads to the emergence of a dynamic negotiation process. Mothers as the main actors involved in taking care of children have the capacity to analyze and make selections from the different types of knowledge available.

The results presented in the study make a substantial contribution to knowledge, insofar as they highlight the importance of considering stunting from the perspective of a power relation based on the construction of knowledge, discourse practices, and community-level social processes. This is a valuable addition to previous studies, which typically analyze stunting from the perspective of biomedicine and technicalities, in that it underscores the impact of interpretation and implementation on policy effectiveness.

However, the policy implications arising from this study imply that a combination between the top-down approaches characterized by universal standards with more participatory approaches should be made. The inclusion of local knowledge, the empowerment of community actors, and the adoption of flexible communication approaches are some of the strategies needed to ensure

the efficiency of stunting interventions. It therefore implies that the health policies cannot only take into consideration issues related to technicality but also those associated with the social and cultural dynamics of health practices within the communities. In summary, it can be noted that managing stunting involves politics and sociology as much as it involves governance.

5. Declarations

5.1 Ethical Considerations

Ethical approval for this study was granted by the Social Science Research Ethics Committee of Darul Ulum University, Indonesia (Approval No. 021/F-UDR/ETIK/IX/2024). Written informed consent was obtained from all participants prior to data collection. Participants were informed of the purpose of the study and assured that their participation was voluntary. Confidentiality and anonymity were maintained throughout the research process.

5.2 Use of Artificial Intelligence (AI)

The authors declare that the generative artificial intelligence (AI) tool ChatGPT (OpenAI) was used exclusively to assist with language editing, grammar refinement, and improving the clarity and readability of the manuscript. The use of AI did not influence the research design, data collection, data analysis, interpretation of findings, results, or conclusions. All scientific content, interpretations, and final editorial decisions remain the sole responsibility of the authors.

5.3 Conflict of Interest

The authors declare no conflicts of interest.

5.4 Funding

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5.5 Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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