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STOP PATRIARCHY IS A KEY TO PREVENTING STUNTING: A QUALITATIVE STUDY OF INDIGENOUS PEOPLES IN CENTRAL MALUKU REGENCY

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ABSTRACT

Stunting among children under five remains a major public health problem in Indonesia, particularly within indigenous communities where social, cultural, and gender structures strongly influence caregiving practices. Despite numerous nutrition-specific interventions, the persistence of stunting suggests the presence of deeper sociocultural determinants, particularly patriarchal norms and unequal gender roles that affect maternal and child well-being. This qualitative case study was conducted from July to October 2023 in three indigenous villages of Central Maluku Regency: Ulahahan (coastal), Piliana, and Elemata (mountainous). Participants (n=34) were purposively recruited, including mothers of stunted children, community and traditional leaders, religious representatives, and healthcare providers. Data were collected through 30 in-depth interviews and four focus group discussions (FGDs), transcribed verbatim, and analyzed thematically. Five interlinked themes emerged: (1) child-related factors (irregular eating, non-exclusive breastfeeding, recurrent illness); (2) cultural practices (traditional birth attendants, early introduction of porridge/papeda); (3) patriarchal norms and gender roles (domestic labor as "women's oath," *pamali* prohibitions on men doing "women's work," women's double burden despite agricultural labor); (4) economic constraints (carbohydrate-heavy diets, low protein access, reliance on subsistence farming and social assistance); and (5) maternal factors (short birth intervals, early marriage, limited ANC, stress). Descriptively, most stunted children were aged 25–59 months (79.4%) and male (67.6%); 70.6% of mothers married before 20 years of age, and 82.3% had primary education or less. Stunting in these settings is embedded in patriarchal cultural systems that institutionalize unequal household responsibilities and constrain maternal time, autonomy, and caregiving quality. Gender-transformative, community-based strategies, such as engaging men and customary leaders, promoting equitable domestic roles, strengthening women's economic and decision-making power, and integrating gender-sensitive nutrition approaches, are essential to reduce stunting
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Kata Kunci:

Stunting;
SDGs;
Budaya patriarki;
Masyarakat adat;
Ketimpangan gender

ABSTRAK

Stunting pada anak balita masih menjadi masalah kesehatan masyarakat utama di Indonesia, terutama di komunitas adat di mana struktur sosial, budaya, dan gender sangat memengaruhi praktik pengasuhan. Meskipun berbagai intervensi gizi telah dilakukan, masih tingginya angka stunting menunjukkan adanya determinan sosial-budaya yang lebih dalam, terutama norma patriarki dan ketimpangan peran genderyang memengaruhi kesejahteraan ibu dan anak.Penelitian ini merupakan studi kasus kualitatif yang dilakukan pada Juli hingga Oktober 2023 di tiga desa adat di Kabupaten Maluku Tengah—Ulahahan (pesisir), Piliana, dan Elemata (pegunungan). Sebanyak 34 partisipan dipilih secara purposif, terdiri dari ibu yang memiliki anak stunting, tokoh masyarakat dan adat, tokoh agama, serta tenaga kesehatan. Data dikumpulkan melalui 30 wawancara mendalam dan empat FGD, ditranskrip secara verbatim, dan dianalisis. Hasil penelitian menemukan lima tema utama: (1) faktor yang berkaitan dengan anak, seperti pola makan tidak teratur, tidak mendapatkan ASI eksklusif, dan sering sakit; (2) faktor budaya, seperti ketergantungan pada dukun beranak dan pemberian makanan pendamping dini; (3) struktur patriarki dan peran gender yang menempatkan perempuan sebagai penanggung jawab penuh urusan domestik dan pengasuhan serta membatasi peran laki-laki; (4) kesulitan ekonomi yang menyebabkan kerawanan pangan dan ketergantungan pada bantuan sosial; dan (5) faktor ibu, seperti perkawinan dini, jarak kelahiran yang pendek, serta stres emosional tinggi. Dinamika ini menunjukkan bahwa sistem patriarki dan ketimpangan gender merupakan akar mendasar dari keberlangsungan stunting. Stunting pada masyarakat adat dipertahankan oleh budaya patriarki yang kuat dan pembagian

kerja berbasis gender. Upaya penanggulangan stunting perlu dilakukan melalui intervensi komunitas yang transformatif gender dengan memberdayakan perempuan secara ekonomi, melibatkan laki-laki dalam pengasuhan, dan mengintegrasikan perspektif kesetaraan gender dalam program gizi serta kesehatan ibu.

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INTRODUCTION

Stunting, a manifestation of chronic undernutrition in early childhood, remains a pressing public health challenge in many parts of the world (Black et al., 2013; UNICEF et al., 2021). In 2022, approximately 150 million children under five years old were reported to be stunted, with Asia contributing more than half (52%) of these cases (UNICEF et al., 2023). The 2023 Indonesian Health Survey revealed that one in every five Indonesian children under five experiences stunting. In particular, Maluku Province records a relatively high prevalence of 28.7% (Indonesian Ministry of Health, 2024).

A range of nations, such as Indonesia, have initiated maternal and child nutrition programs designed to curb stunting and improve early childhood growth outcomes (Nuraini et al. 2022; Li et al., 2020). However, most health and nutrition policies tend to place the primary responsibility for preventing stunting on women, particularly in their roles as wives and mothers. This perspective overlooks the deeply rooted gender role divisions within households. Socio-cultural factors, especially those related to patriarchal norms, remain complex and often neglected, particularly among indigenous communities where traditional customs persist. In patriarchal societies, decision-making is predominantly male-centered, reflecting unequal power relations between genders (Brulé & Gaikwad, 2021; Marasabessy & Suhron, 2020; Rao et al., 2022).

Patriarchal cultural practices have existed since ancient times and continue to persist today, especially in tribal communities with strong customary traditions (Brulé & Gaikwad, 2021; Rao et al., 2022). Gender inequality during pregnancy (Anjorin et al., 2020; Gyan et al., 2020) can lead to maternal health problems and adversely affect fetal development (Ratnawati & Prameswari, 2022). Pregnant women suffering from nutritional deficiencies are more likely to give birth to children at risk of stunting. Women in developing countries are particularly vulnerable to malnutrition due to socioeconomic limitations, short birth intervals, and inadequate dietary intake (Absori et al., 2022; Karimi et al., 2022; Kragel et al., 2020).

The socio-cultural context, especially patriarchal structures, appears to play a critical yet underexplored role. Patriarchal norms continue to shape maternal roles and decision-making within households, restricting women's authority over income, food allocation, and health-seeking behaviors. Such gendered power imbalances reduce mothers' capacity to provide adequate nutrition and care for their children, thereby heightening the risk of stunting. Evidence demonstrates that low maternal empowerment and unequal gender relations are consistently associated with poor child growth outcomes across diverse contexts (Eom et al., 2023; Mphangwe et al., 2024; Wassie et al., 2024).

Despite extensive governmental efforts, stunting remains a persistent challenge in many parts of Indonesia, including Maluku. Therefore, this study investigates how patriarchal cultural patterns contribute to stunting in indigenous communities of Central Maluku Regency, specifically in Ulahahan (Laimu District), Piliana (Tehoru District), and Elemata (North Seram District), areas identified with severe stunting prevalence. This study hypothesizes that the persistence of stunting extends beyond nutritional deficiencies to structural gender inequalities. It explores how patriarchal norms, gendered labor divisions, and socio-cultural expectations interact to shape maternal practices and child nutrition outcomes within traditional village contexts.

METHOD

Type of Research

This study utilized a qualitative case study approach to explore the primary concerns and perspectives related to stunting and child nutrition within indigenous communities in Central Maluku Regency.

Place and Time of Research

Three villages—Ulahahan Village in Laimu District, Piliana Village in Tehoru District, and Elemata Village in North Seram District—home to the indigenous population of Central Maluku Regency, served as the study sites. In these regions, stunting prevalence exceeded 20%. Ulahahan Village is located in the coastal area of Seram Island, Central Maluku Regency, while Elemata and Piliana Villages are situated in mountainous areas (Figure 1). The study took place between July and October 2023.

Population and Sample

Participants were recruited through a purposive sampling strategy to capture a comprehensive range of perspectives related to childhood stunting and maternal nutrition. Inclusion criteria consisted of: (1) mothers of children under five identified as stunted, (2) community and traditional leaders, (3) religious and indigenous representatives engaged in local governance and cultural practices, and (4) healthcare professionals such as nurses and midwives directly involved in maternal and child health services. These participants were purposefully selected for their contextual knowledge, lived experience, and social influence within their communities. The selection process was guided by the study's theoretical framework, which underscores the importance of understanding stunting through sociocultural and gender-responsive lenses. This approach ensured that data were drawn from multiple social strata, enhancing the depth and validity of cultural insights into stunting determinants.

Data Collection

Informants were interviewed using in-depth interviews and focus group discussions (FGDs). These instruments were piloted in a trial phase prior to the main data collection, which involved FGDs and in-depth interviews with mothers of stunted children from communities not included in the main study. This pilot process allowed the researchers to refine the tools to ensure that they effectively captured the required information from informants.

In the three study villages, four FGDs were conducted with community, religious, and indigenous leaders, along with thirty in-depth interviews with mothers of stunted children and three health workers. Each FGD involved seven to nine participants and lasted 45–60 minutes, while the in-depth interviews lasted 27–40 minutes. Both methods were used to explore reasons for the persistence of stunting, participants' understanding of stunting, maternal health conditions during pregnancy, antenatal care practices, infant feeding patterns, and the division of labor between husband and wife during pregnancy. The *Maternal and Child Health Book* was also used to provide information about maternal health during pregnancy. For pregnant women receiving antenatal care, this book serves as a communication tool between them and healthcare professionals.

Data collection continued until saturation was reached. With participants' consent, all interviews and FGDs were audio-recorded using a digital recorder and transcribed verbatim. The findings were validated and enhanced for credibility through data triangulation using secondary sources and other relevant information. Ethical approval for this study was granted by the Health Research Ethics Commission of Poltekkes Kemenkes Maluku (LB.02.03/6.2/1012/2023).

Data Analysis and Processing

Prior to data analysis, all focus groups and in-depth interviews were anonymized, recorded, and transcribed verbatim. Transcripts were imported into NVivo v.10 and categorized line by line using thematic content analysis techniques. All data were initially coded by one researcher (NBM), who grouped recurring themes and concepts into codes. Similar codes were then synthesized to develop broader themes. Subsequently, two other researchers (SR and FST) reviewed all codes and themes to ensure internal coherence and confirm that the identified themes accurately reflected the meanings evident across the dataset. The themes were then reviewed and refined through triangulation to ensure validity and reliability.

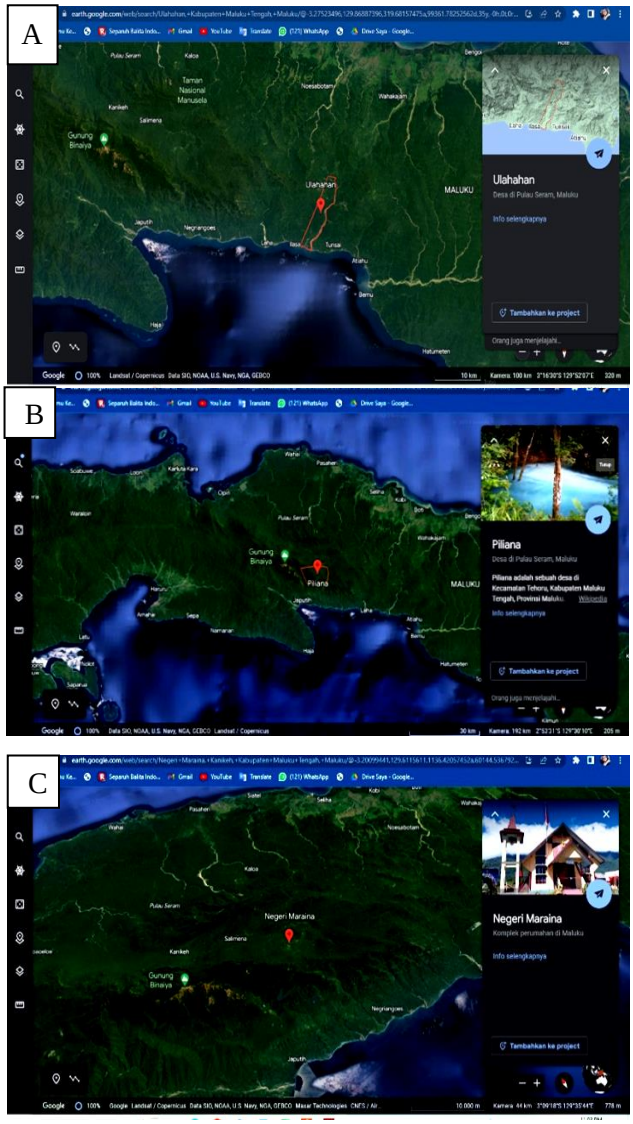

Figure 1 (A, B, C) villages with severe stunting categories in the Central Maluku Regency area, which is the location of the study (source: https://earth.google.com/)

RESULT

Participant characteristics

Table 1 shows the characteristics of mothers and their stunted toddlers. Most stunted toddlers were aged 25–59 months (79.4%), and the majority were male (67.6%). Mothers with stunted toddlers generally had more than three children (61.8%). Around 29.4% of mothers did not attend school, 52.9% had completed primary education, and only 17.6% had secondary education. As many as 70.6% of mothers were married before the age of 20 years.

Table 1. Characteristics of Stunting Mothers and Toddlers (N=34)

Characteristics	N	%
Age of toddler		
1 – 24 months	7	20.6
25 – 59 months	27	79.4
Gender		
Male	23	67.6
Female	11	32.4
The current age of the mother		
15 – 24 years old	9	26.5
25 – 34 years old	15	44.1
35 – 46 years old	10	29.4
Paritas		
Less than 4 children	13	38.2
4 – 6 Children	16	47.1
More than 6 children	5	14.7
Mother's education		
No schooling	10	29.4
Elementary School	19	52.9
Senior High School	6	17.6
Mother's age at marriage		
< 20 years	24	70.6
≥ 20 years	10	29.4

Themes

Five themes were identified after data analysis and generalization: (1) children-related factors, (2) cultural-related factors, (3) patriarchy-related factors, (4) economic-related factors, and (5) mother-related factors.

Theme 1: Children-related factors

This theme emerged from interviews concerning children's eating behavior within families. The study revealed several key factors related to children's eating behavior and health, highlighting the impact of parental responsibilities, feeding practices, and health issues on children's nutrition.

Eating behavior

Participants indicated that children's eating habits were often irregular and influenced by external factors. One mother mentioned:

> " *My child is lazy to eat. He only eats if we go out, but since I'm busy with household chores, I often neglect to pay attention to his eating. He only asks for food when he's hungry, and when playing, he often forgets to eat." / "Anak saya malas makan. Dia hanya mau makan kalau kami keluar rumah, tetapi karena saya sibuk dengan pekerjaan rumah tangga, saya sering lalai memperhatikan makannya. Dia biasanya baru meminta makan saat merasa lapar, dan ketika sedang bermain, dia sering lupa untuk makan.*" (BK-Informant 6, interview, Female).

Another participant shared:

> " *At 2 months old, my child started eating porridge... sometimes meals are delayed because I'm busy working." / "Saat berusia 2 bulan, anak saya sudah mulai makan bubur… terkadang jadwal makannya terlambat karena saya sibuk bekerja.*" (YM-Informant 2, interview, Female).

These responses reflect the challenges of balancing household tasks while ensuring proper nutrition for children.

Exclusive breastfeeding

Several mothers reported that their children did not receive exclusive breastfeeding.

" *I gave my child breast milk only until 2 months. After that, I started feeding papeda because I had no more breast milk." / "Saya hanya memberikan ASI kepada anak saya sampai usia 2 bulan. Setelah itu, saya mulai memberinya papeda karena ASI saya sudah tidak keluar lagi*" (AN-

Informant 1, interview, Female).

Furthermore, in some cases, when mothers were away working in the forest, children were fed water or tea, which led to breastfeeding cessation upon the mothers' return.

> " *Some of the children were given breast milk at birth, but when their mothers went to the forest, the children were given water or tea by their siblings, which led to the baby rejecting breast milk upon return, and eventually, the milk dried up." / "Beberapa anak diberi ASI saat lahir, tetapi ketika ibu mereka pergi ke hutan, anak-anak tersebut diberi air atau teh oleh saudara mereka. Akibatnya, bayi menolak menyusu ketika ibunya kembali, dan akhirnya ASI pun mengering*." (PD-FGD, Male).

These findings underscore the challenges mothers face in providing exclusive breastfeeding, often due to external factors such as work obligations and health constraints.

Health issue

Several participants reported that their children frequently experienced illness, which affected their eating patterns. One mother shared:

> " *My child is often sick—cough, fever, and flu. He gets sick every month and eats less when he is unwell." / "Anak saya sering sakit; batuk, demam, dan flu. Dia hampir setiap bulan jatuh sakit dan nafsu makannya menurun setiap kali sedang tidak enak badan*" (YRN-Informant 8, interview, Female).

Another participant echoed similar concerns:

> " *My child is often sick, and when ill, they eat less. His weight decreases every month." / "Anak saya sering sakit, dan ketika sakit, makannya berkurang. Berat badannya menurun setiap bulan*." (MT-Informant 7, interview, Female).

These reports suggest that recurrent illness may contribute to poor eating behavior and weight loss among children.

Theme 2: Cultural-related factors

This theme presents key findings regarding culture-related factors observed from interviews and FGDs.

Childbirth Assistance Practices

In rural communities, traditional childbirth assistance plays a significant role in maternal care practices. Several informants highlighted the role of *mama biang* (traditional birth attendants) in assisting with home births. For instance, Informant AK recounted:

> *" I gave birth at home with the help of mama biang. The child was given formula milk from birth due to the lack of breast milk, and solid food like porridge started at 4 months." / "Saya melahirkan di rumah dengan bantuan mama biang. Anak saya diberi susu formula sejak lahir karena ASI saya tidak keluar, dan mulai diberikan makanan padat seperti bubur pada usia 4 bulan.*" (AK, Informant 5; Interview, Male).

Similarly, Informant BK shared that breastfeeding is typically maintained for the first three months, followed by the introduction of additional foods such as porridge mixed with katuk or moringa leaves. These practices reflect deeply rooted cultural norms around childbirth and infant care, where traditional methods are preferred over medical interventions—often due to limited access to healthcare facilities.

Community behaviour

Community behaviors also significantly influence child health outcomes, particularly in relation to stunting. Several FGDs with local men and women revealed concerns about parental neglect and insufficient child nutrition. As one male FGD participant expressed:

> *" The mothers are lazy, lacking motivation to care for their children properly... many children become stunted due to this laziness and lack of funds." / "Ibu-ibu malas dan kurang memiliki motivasi untuk merawat anak-anak mereka dengan baik… banyak anak menjadi stunting karena kemalasan dan keterbatasan biaya." (FGD Toma, Male).*

This attitude was attributed to economic hardship, particularly the inability of fathers to secure steady employment, and a pervasive sense of helplessness. Women, burdened with childcare and household responsibilities, also face challenges in providing adequate nutrition for their children. Furthermore, a female participant remarked:

> *" Mothers who are pregnant often neglect to go to health centers, and some only eat basic foods like papeda with water after childbirth." / "Ibu-ibu hamil sering lalai pergi ke puskesmas, dan beberapa di antaranya hanya makan makanan sederhana seperti papeda dengan air setelah melahirkan." (*FGD Toma, Female*)*

This indicates a lack of knowledge about proper nutrition during pregnancy and postnatal care.

Theme 3: Pathriarchy-related factors

Gender role

Traditional gender roles are firmly entrenched in the community, with women shouldering the majority of household responsibilities. As one participant described:

> *" It is the wife's duty to take care of everything at home, including gathering firewood, cooking, fetching water, and managing the household. The husband assists only when it is absolutely necessary." / "Sudah menjadi tugas istri untuk mengurus semua pekerjaan di rumah, termasuk mengumpulkan kayu bakar, memasak, mengambil air, dan mengelola rumah tangga. Suami hanya membantu jika benar-benar diperlukan."* (YA-informant 22; interview, Male).

Women further described the double burden they face, balancing agricultural work and exhaustive household duties without male assistance. One woman recounted:

> "*Mothers handle all domestic work by themselves. Husbands only go to the garden. Even though wives also work in the garden, when they return home, they still have to do all the housework—washing, cooking, collecting firewood. If there is no food at home, the mother must find some before she can cook." / "Ibu-ibu mengerjakan semua pekerjaan rumah sendiri. Suami hanya pergi ke kebun. Meskipun istri juga ikut bekerja di kebun, ketika pulang ke rumah mereka tetap harus melakukan semua pekerjaan rumah; mencuci, memasak, dan mengumpulkan kayu bakar. Jika tidak ada makanan di rumah, ibu harus mencari bahan makanan terlebih dahulu sebelum bisa memasak.*" (YI – Female Informant 15).

Patriarchal practice

This division of labor leaves women solely responsible for both domestic chores and child-rearing tasks, while men contribute mainly through external work such as farming or gathering food from the forest. Moreover, economic hardship often forces women to take on additional tasks:

> " *When we return home, the wife is still expected to cook and manage the household, even though she also works in the field alongside her husband." / "Ketika kami pulang ke rumah, istri tetap diharapkan untuk memasak dan mengurus rumah tangga, meskipun ia juga bekerja di ladang bersama suaminya."* (YI-informant 15; interview, Female).

Another female participant noted:

> *"When the men go out to earn money and give it to their wives, the wives are ready to manage it; they can decide what to do with it." / "Kalau bapak-bapak kerja cari uang, lalu kasih uang ke istri, istri siap mengelola, mau buat apa saja bisa*." (FGD Toma, Female)

Several male participants articulated this ideology explicitly. One male informant stated*:*

> *"Women do all household chores because that is considered a woman's oath." / "Perempuan mengerjakan semua pekerjaan rumah tangga karena hal itu dianggap sebagai sumpah perempuan." (*FGD Toma, Male*).*

This notion of a "woman's oath" symbolizes a moralized gender contract, where women's subordination in household duties is culturally sanctified and rarely questioned. Collectively, these accounts highlight how patriarchal cultural practices assign women continuous and overlapping roles in both productive

and reproductive spheres, leaving them with limited rest or decision-making autonomy. Male dominance is maintained not only through control over external labor and resources but also through symbolic restrictions, such as *pamali* taboos, that define masculinity in opposition to domestic labor.

Theme 4: Economics-related factors

Food variety and consumption patterns

Food variety in rural communities often reflects the limited availability of resources, with many families relying on locally grown produce and basic staple foods. Informants shared that breakfast typically consists of fried snacks such as *goreng keladi* (fried taro) or banana fritters, while lunch usually includes *papeda* (a traditional starchy dish made from sago flour) served with leafy vegetables like cassava or melinjo leaves. Dinner often follows a similar pattern, with rice sometimes replacing *papeda*.

For example, Informant FM (Female, Informant 12) stated:

> *" In the morning, we have fried snacks like goreng keladi or bananas, and for lunch, we eat papeda with vegetables. Dinner is also rice, but papeda is more common." / "Pagi hari kami biasanya makan gorengan seperti goreng keladi atau pisang, dan untuk makan siang kami makan papeda dengan sayur. Makan malam juga nasi, tetapi papeda lebih sering dikonsumsi."*

Similarly, Informant HI (Female, Informant 16) mentioned:

> *" For breakfast, we eat cassava or taro with sautéed cassava leaves. At lunch and dinner, we mainly have papeda with vegetables, and meat or fish is rare." / "Untuk sarapan, kami makan singkong atau talas dengan tumis daun singkong. Saat makan siang dan malam, kami biasanya makan papeda dengan sayur, dan jarang sekali ada daging atau ikan."*

This pattern suggests a diet dominated by carbohydrates and vegetables, with limited access to protein-rich foods. In some households, the variety of food is even more restricted. Informant RM (Male, Informant 19) mentioned:

> *" We mainly eat what we grow—sweet potatoes, cassava, taro, and bananas. Meat is only consumed occasionally." / "Kami sebagian besar makan hasil dari kebun sendiri—ubi jalar, singkong, talas, dan pisang. Daging hanya dikonsumsi sesekali."*

This highlights the dependence on subsistence farming and the lack of dietary diversity in some families.

Access to proper nutrition and food insecurity

Many informants pointed out that food insecurity is a significant issue, especially for families with limited access to protein sources like fish or meat. During pregnancy, some women reported skipping meals, particularly lunch, due to work commitments. Informant YL (Female, Informant 13) shared:

> *" When I was pregnant, I only ate breakfast and dinner because I was too busy working in the fields. The whole family doesn't eat lunch; we all go to the fields and only eat when we get home in the evening." / "Saat saya hamil, saya hanya makan pagi dan malam karena terlalu sibuk bekerja di ladang. Seluruh keluarga tidak makan siang; kami semua pergi ke ladang dan baru makan ketika pulang ke rumah pada sore hari."*

Similarly, Informant YI (Female, Informant 15) stated:

> *" If there's no food, we just have papeda with vegetables for breakfast, and when we return from the field, we eat dinner with the same dish. If the children don't want to eat papeda, I boil cassava or taro for them, as there's no fish available." / "Kalau tidak ada makanan, kami hanya makan papeda dengan sayur untuk sarapan, dan ketika pulang dari ladang, kami makan malam dengan hidangan yang sama. Jika anak-anak tidak mau makan papeda, saya rebus singkong atau talas untuk mereka, karena tidak ada ikan yang tersedia."*

The lack of food during certain times of the day is also a recurring theme. Informant BT (Female, Informant 11) expressed:

> *" There are too many children and not enough food. When there's food, we eat; when there's none,*

we just have to wait." / "Anak terlalu banyak sementara makanan tidak cukup. Kalau ada makanan, kami makan; kalau tidak ada, kami hanya bisa menunggu."

Similarly, Informant YM (Female, Informant 23) stated:

" If we don't have food, we search for something in the fields before we eat." / "Kalau kami tidak punya makanan, kami harus mencari sesuatu di kebun terlebih dahulu sebelum makan."

This reliance on the local environment for food demonstrates the vulnerability of these communities to food insecurity. The economic situation further exacerbates the issue. Several informants pointed out that economic inactivity among men, partly due to government social assistance programs such as *Bantuan Langsung Tunai* (BLT, cash transfers) and *Program Keluarga Harapan* (PKH, conditional cash transfers), has reduced the incentive to work. Informant BK (Male, FGD) noted:

" Men are now lazy to earn a living because they receive social assistance every three months. So, when there's no food, the wife has to go to the forest to find something to eat." / "Laki-laki sekarang malas bekerja karena mereka mendapat bantuan sosial setiap tiga bulan. Jadi, ketika tidak ada makanan, istri yang harus pergi ke hutan untuk mencari sesuatu untuk dimakan."

This dynamic reflects a dependence on external aid, which can discourage efforts to improve local food security and economic resilience.

Theme 5: Mother-related factors

Birth spacing and parity

The spacing between births has significant implications for maternal and child health. Informants revealed that short birth intervals contribute to an increased risk of stunting in children. For instance, Informant AN (Female, Informant 1) reported that her fourth and fifth children had only a one-year gap, both of whom experienced stunting. Similarly, Informant YI (Female, Informant 15) shared that her fifth child, out of seven siblings, suffered from stunting. This suggests that frequent pregnancies with limited maternal recovery time may hinder optimal child growth and development, particularly when household resources are already constrained.

Prenatal care and access to healthcare

Maternal health during pregnancy plays a crucial role in preventing stunting. Many informants highlighted challenges such as nausea, vomiting, and lack of sleep due to both physical and emotional stress. Informant AN (Female, Informant 1) expressed:

" During pregnancy, I couldn't eat because I felt nauseous and dizzy, and I couldn't sleep at night because I kept worrying about what my children would eat." / "Saat hamil, saya tidak bisa makan karena merasa mual dan pusing, dan saya tidak bisa tidur pada malam hari karena terus memikirkan apa yang akan dimakan anak-anak saya."

Additionally, some women struggled with anemia and were advised to consume green vegetables by healthcare workers. However, due to physical discomfort such as joint pain, some mothers avoided eating vegetables. Informant FM (Female, Informant 12) stated:

" I was advised to eat green vegetables to improve my hemoglobin levels, but they caused pain in my knees, so I avoided them." / "Saya disarankan untuk makan sayuran hijau agar kadar hemoglobin saya meningkat, tetapi sayuran itu membuat lutut saya terasa sakit, jadi saya menghindarinya."

These health challenges, coupled with inadequate dietary intake, may contribute to nutritional deficiencies affecting both mother and fetus, potentially leading to stunting. Furthermore, poor prenatal care is prevalent, with many women not attending antenatal visits regularly. Some only seek medical attention when labor complications arise. One female participant in an FGD commented:

" Many pregnant women here don't go for check-ups. They only call the local midwife when they are about to give birth. Who will take responsibility if something goes wrong?" / "Banyak ibu

> *hamil di sini yang tidak pernah memeriksakan diri. Mereka hanya memanggil bidan desa ketika akan melahirkan. Kalau terjadi sesuatu, siapa yang akan bertanggung jawab?"*

This highlights the limited access to and utilization of preventive healthcare services, which could help manage pregnancy-related complications and improve maternal and child health outcomes.

Double burden of responsibilities

The concept of a double burden—balancing household duties and emotional stress—was frequently mentioned as a contributing factor to poor maternal health. Many mothers reported feeling overwhelmed by their responsibilities, including cooking, cleaning, childcare, and gathering firewood. Informant 4 (Female, FGD) remarked:

> *" I have to do everything—cook, take care of the children, clean the house, and go to the forest to fetch firewood. My husband only helps if he wants something." / "Saya harus melakukan semuanya—memasak, merawat anak-anak, membersihkan rumah, dan pergi ke hutan untuk mengambil kayu bakar. Suami saya hanya membantu kalau ada maunya."*

This constant strain can lead to stress, which, as some informants noted, negatively affects both maternal and child health. Emotional stress caused by marital conflicts, especially when husbands return home late or intoxicated, can further exacerbate these burdens. One participant shared:

> *"When my husband comes home late and drunk, I get angry and stressed. This makes everything worse." / "Ketika suami saya pulang larut malam dalam keadaan mabuk, saya menjadi marah dan stres. Hal ini membuat semuanya menjadi lebih buruk."*

In communities where gender roles are strictly defined, such as in one FGD where it was stated that:

> *"Men are not supposed to wash dishes or do women's work unless the woman is sick." / "Laki-laki tidak seharusnya mencuci piring atau mengerjakan pekerjaan perempuan, kecuali jika perempuan sedang sakit*."

The responsibility for household chores falls solely on women, adding to their physical and emotional load. This gender disparity in domestic roles often results in a lack of support for pregnant women, which can negatively impact their overall health and their ability to care for their children properly.

Early marriage and maternal age

Another key factor influencing maternal health and stunting is the age at which women marry and begin having children. Early marriages, especially before the age of 20, increase the risk of pregnancy complications and child stunting. Informant YRN (Female, Informant 8) shared:

> *"My third child, out of three siblings, has stunting. I married at the age of 19." / "Anak ketiga saya dari tiga bersaudara mengalami stunting. Saya menikah pada usia 19 tahun*."

Similarly, Informant HT (Female, Informant 9) mentioned that she married at the age of 18, which may have affected her health and that of her children. Early marriages often result in young mothers who may not be physically or emotionally prepared for motherhood, contributing to nutritional deficiencies and inadequate prenatal care.

DISCUSSION

This study reveals the multifactorial determinants influencing child nutrition, demonstrating how children-related, cultural, economic, and maternal factors interconnect to shape stunting outcomes in rural indigenous communities. Consistent with prior findings, stunting remains disproportionately prevalent among children from marginalized or indigenous populations (Tello et al., 2022). However, this research extends current understanding by uncovering the embedded influence of patriarchal norms and gendered labor divisions that indirectly but profoundly impact child nutrition and care.

This study found that for children-related factors, eating behavior, exclusive breastfeeding, and health issues were the main contributors. Participants emphasized that children's eating patterns are irregular and frequently impacted by external factors, including play distractions and parental availability. For example, one mother reported that her child only eats when prompted or when feeling hungry, while another mother mentioned that work obligations caused her to miss meals. It was

demonstrated that after six months of age, children who do not receive adequate quantity and quality of complementary foods will experience stunted growth, regardless of optimal breastfeeding (Black et al., 2008). This investigation also discovered that stunted children did not receive exclusive breastfeeding due to a lack of breast milk or the mother's busy schedule. Moreover, several participants noted that their children frequently experienced illness, which affected their appetite and led to weight loss. These findings indicate that addressing children's health concerns should be integrated into nutrition interventions, as the physical well-being of children directly affects their eating patterns and nutritional intake. In the end, these three elements exacerbate the likelihood of stunting based on child-related factors, as reported by previous studies conducted in Indonesia and other low- and middle-income countries (Beal et al., 2018; Black et al., 2013; Li et al., 2020; Tello et al., 2022). These challenges underscore the need for community-based support systems to promote and sustain proper nutrition and breastfeeding, particularly in rural areas.

In line with previous investigations, this study demonstrated that birth spacing, parity, prenatal care, early marriage, and maternal age are strongly associated with stunting among children under five (Akpinar & Teneler, 2023; Black et al., 2008; Gusnedi et al., 2023; Li et al., 2020; Sari & Sartika, 2021; Win et al., 2022; Yaya et al., 2022). Furthermore, a sub-theme pertaining to the double burden borne by mothers of stunted children was also identified in this study. The double burden and gendered domestic roles lead to emotional stress for mothers. Almost all household duties are performed by women, often without sufficient assistance from their partners. This study highlighted that societal norms dictate that men should not perform household tasks, which perpetuates unequal burdens. The statement *"Men are not supposed to wash dishes or do women's work unless the woman is sick"* exemplifies how rigid these roles are. Women who spend longer hours performing unpaid labor are more prone to stress than men due to the unequal distribution of caregiving responsibilities, which exacerbates the detrimental effects of caregiving on health (McDonald et al., 2005). Marital disputes, such as husbands coming home late or intoxicated, further increase stress. Maternal health is adversely affected by emotional strain, which can subsequently impact the child's health and the mother's ability to provide adequate care, including nutritional care (Khan, 2022). The results provide valuable insights into barriers to optimal nutrition and health, offering a basis for interventions aimed at improving maternal and child well-being.

Beyond individual and household-level factors, the findings demonstrate that patriarchal culture acts as a structural determinant of child stunting in indigenous communities. Traditional gender norms dictate that domestic and caregiving duties are the sole domain of women, whereas men are responsible only for work outside the home. As one male informant explained, *"It is the wife's duty to take care of everything at home, including gathering firewood, cooking, fetching water, and managing the household. The husband assists only when it is absolutely necessary."* This perception reinforces a rigid gender hierarchy in which women's labor is undervalued and normalized, while male disengagement from domestic responsibilities is culturally legitimized. Another mother confirmed this dynamic, saying, *"Men work in the forest and bring home raw food; it is the woman's responsibility to prepare it. Men's affairs are outside the home—domestic matters are not their concern."* These statements encapsulate the patriarchal logic that sustains women's double workload and limits their rest, autonomy, and capacity to provide consistent care for children.

Although a study in Ethiopia found that children from female-headed households were more likely to be stunted, linked to a lack of livelihood opportunities (Haidar et al., 2005), and that stunting is strongly correlated with the gender of the caregiver (Kwami et al., 2019), to the best of our knowledge, this study is the first to demonstrate that toddler stunting is influenced by patriarchal culture. This finding is further supported by recent literature, which shows that stunting is not gender-neutral (Rahmawati & Putri, 2023). These findings underscore that effective nutrition interventions must address not only food availability and feeding practices but also the cultural systems that regulate gendered power and labor.

Despite this novel discovery, there are still certain limitations to this study. First, the study's understanding of family dynamics and other pertinent factors influencing stunting may have been limited by the absence of other potential informants, such as fathers or alternative caregivers, even though it included key stakeholders such as mothers of stunted children and community leaders. Second, the findings are derived from three communities, each of which may have distinct socioeconomic or cultural contexts. Therefore, the generalizability of the findings to other areas or populations may be limited.

CONCLUSION AND SUGGESTION

This study demonstrates that child stunting in indigenous communities is not solely driven by nutritional or economic constraints but is deeply rooted in patriarchal cultural systems and gendered social structures. Women's dual burden of productive and reproductive labor, limited access to healthcare, and male disengagement from caregiving exacerbate child malnutrition. Patriarchal norms institutionalize unequal household responsibilities, restricting women's time, decision-making power, and emotional well-being, all of which critically influence children's health and nutritional outcomes.

Efforts to reduce stunting must incorporate gender-transformative strategies that challenge patriarchal norms, promote shared domestic responsibilities, and strengthen women's economic and decision-making power. Community-based interventions should actively engage men, local leaders, and health workers in fostering equitable family roles, ensuring that nutrition and health programs are both culturally sensitive and gender-responsive.

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