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# Hegemonic dynamics and social inequalities in child stunting: An interpretive qualitative study in Indonesia

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**ABSTRACT**

**Introduction:** Child stunting remains a major public health concern in low- and middle-income countries, reflecting not only nutritional deficiencies but also broader social and structural inequalities. This study aimed to analyze child stunting as a socially constructed phenomenon shaped by hegemonic processes, focusing on how power relations, knowledge systems, and structural constraints contribute to its persistence in a local Indonesian context.

**Research Methodology:** This study employed an interpretive qualitative design within a health sociology framework. Data were collected in Jeneponto Regency, South Sulawesi, Indonesia, between February and March 2026. A total of 18 participants were recruited using purposive and snowball sampling, including mothers of stunted children, healthcare workers, and community leaders. Data collection involved in-depth interviews, participant observation, and document analysis. Thematic analysis was conducted using NVivo software, following iterative coding and theme development procedures.

**Results:** Five major themes emerged: (1) normalization of stunting as a non-pathological condition, (2) dominance of biomedical knowledge alongside partial adherence to local practices, (3) unequal access to nutritional and health resources, (4) top-down implementation of health programs limiting community agency, and (5) reproduction of caregiving practices under structural constraints. Data saturation was achieved at the 16th interview and confirmed with 18 participants. These findings indicate that stunting is maintained through interconnected social, economic, and ideological processes.

**Conclusion:** Child stunting is sustained not only by material deprivation but also by hegemonic processes that normalize inequality and shape health practices. Effective interventions should move beyond technical solutions by incorporating community participation, addressing structural inequities, and integrating local knowledge into health strategies. Such approaches are essential to achieve more equitable and sustainable outcomes.

**Keywords:** child nutrition; health inequality; social determinants of health.

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## INTRODUCTION

Child stunting remains a persistent global public health challenge, reflecting not only nutritional deficiencies but also deeply rooted structural inequities (Ataullahjan et al., 2025). Recent global estimates indicate that more than one in five children under five years of age experience stunting, with disproportionate burdens concentrated in low- and middle-income countries (Correa-Urquiza et al., 2025). In Indonesia, despite measurable progress over the past decade, prevalence rates remain above global targets, particularly in regions characterized by socioeconomic vulnerability, such as South Sulawesi. These patterns suggest that conventional nutrition-focused interventions have not sufficiently addressed the underlying determinants of stunting (Değer et al., 2024). Consequently, there is a need to reframe stunting beyond a biomedical condition toward a socially constructed phenomenon shaped by power relations, resource distribution, and cultural practices (Gómez, 2025).

Existing literature has extensively examined stunting through the lens of social determinants of health, emphasizing factors such as maternal education, household income, sanitation, and access to health services (Gyan & Okyere, 2026). Quantitative cross-sectional and longitudinal studies consistently demonstrate that children from disadvantaged households are at higher risk of impaired growth outcomes (Hairuddin et al., 2026). While these studies provide robust epidemiological evidence, they often adopt a risk-factor approach that isolates variables without adequately interrogating the mechanisms through which these factors are produced and sustained within broader social systems (Harmon et al., 2022). Furthermore, qualitative studies exploring maternal experiences and child feeding practices have provided valuable contextual insights, yet they tend to remain descriptive and under-theorized in relation to structural power dynamics (Juniarti et al., 2025).

More critically, there is limited integration of critical social theory, particularly the concept of hegemony, into stunting research (Machio, 2026). Hegemony, as conceptualized in social theory, refers to the subtle and pervasive forms of dominance through which certain knowledge systems, norms, and practices become normalized and accepted as common sense (Matovu et al., 2026). In the context of child stunting, hegemonic processes may manifest in the privileging of biomedical knowledge over local practices, the top-down implementation of health programs, and the internalization of nutritional deprivation as a normal condition among marginalized populations. Despite its analytical potential, this perspective remains underutilized, especially in localized settings where cultural and structural complexities intersect (Miah & Aktar, 2026).

This gap is particularly evident in Indonesian contexts, where most studies focus on identifying determinants rather than examining how social inequalities and power relations actively produce and reproduce stunting conditions. There is a lack of empirical research connecting everyday practices, such as feeding behaviors and health service utilization, with the broader ideological and institutional structures that shape them (L M Mpobane & Gqaleni, 2026). As a result, current policy approaches risk being technocratic, overlooking the lived realities of communities and the power asymmetries embedded in intervention strategies (Lerato Motale Mpobane & Gqaleni, 2026).

Addressing this gap, the present study introduces a novel analytical framework that integrates a hegemonic perspective into qualitative health research on stunting. Unlike prior studies that primarily focus on causal determinants, this research shifts the analytical focus toward understanding how stunting is socially produced, normalized, and maintained through interconnected processes of domination and consent. The novelty of this study lies in its effort to bridge micro-level practices with macro-level structures, offering a more comprehensive

interpretation of stunting as both a material and ideological phenomenon. Additionally, by situating the analysis within a specific local context, this study provides nuanced insights that are often overlooked in generalized national or global analyses.

Therefore, this study aims to analyze child stunting as a socially constructed phenomenon shaped by hegemonic processes, with particular attention to how power relations, knowledge hierarchies, and structural inequalities interact to sustain the condition in a local Indonesian setting. By doing so, the study seeks to contribute to a more critical and context-sensitive understanding of stunting, informing the development of interventions that are not only technically effective but also socially responsive and equitable.

# RESEARCH METHODOLOGY

## Study Design

This study employed an interpretive qualitative design grounded in the perspective of health sociology and informed by hegemonic theory to examine child stunting as a socially constructed phenomenon. This design was selected to move beyond positivistic and variable-driven explanations, enabling an in-depth exploration of how power relations, knowledge hierarchies, and everyday practices shape and reproduce stunting within specific socio-cultural contexts. The interpretive approach facilitates understanding of participants lived experiences and meaning-making processes, which are essential for uncovering the subtle mechanisms of domination and normalization embedded in health practices.

## Setting & Participants

The study was conducted in Jeneponto Regency, South Sulawesi, Indonesia, a region characterized by persistently high stunting prevalence and marked socioeconomic disparities. Data collection took place between February and March 2026, allowing contextual immersion and iterative data gathering. Participants were selected using purposive sampling, followed by snowball sampling to identify additional relevant informants. Inclusion criteria for primary participants were: (1) mothers with children under five diagnosed with stunting, (2) residents of the study area for at least one year, and (3) willingness to participate. Secondary participants included healthcare workers (midwives, nutrition officers), community leaders, and local government representatives involved in child health programs. Exclusion criteria included inability to communicate effectively or refusal to provide informed consent.

A total of 18 participants were recruited, consisting of 10 key informants and 8 supporting informants. Sample size was determined based on data saturation, defined as the point at which no new themes or insights emerged from subsequent interviews. Unlike quantitative studies, no statistical sample size calculation was applied, as the emphasis was on depth rather than generalizability.

## Variables & Measurement

In qualitative inquiry, variables are conceptualized as analytical constructs rather than measurable entities. The key constructs explored in this study included: Perceptions of child growth and nutrition. Knowledge systems (biomedical vs. local practices). Access to health and nutritional resources. Power relations in health program implementation. Everyday caregiving practices. These constructs were operationalized through semi-structured interview guides and observational protocols developed based on theoretical frameworks of social determinants of health and hegemony. Content validity was ensured through expert review, while reliability was strengthened through iterative refinement of interview questions and consistency in data collection procedures. Primary data were obtained directly from participants through interviews

and observations, while secondary data included relevant policy documents, health reports, and program records.

**Data Collection**

Data were collected using multiple qualitative techniques to ensure methodological triangulation:

1. In-depth interviews were conducted using semi-structured guides to explore participants' experiences, beliefs, and practices related to child nutrition and health services.
2. Participant observation was conducted to capture real-life caregiving practices and interactions in community settings.
3. Document analysis included a review of local health policies and program implementation reports.

Each interview lasted approximately 45–60 minutes and was audio-recorded with participants' consent. Field notes were documented to capture contextual and non-verbal information. Quality control measures included: Pilot testing of interview guides. Triangulation across data sources. Regular peer debriefing among researchers. Maintaining an audit trail of decisions and coding processes

**Data Analysis**

Data were analyzed using thematic analysis, following a systematic and iterative process. The analysis involved: Data familiarization through repeated reading of transcripts. Initial coding to identify meaningful units of data. Categorization of codes into broader themes. Development of thematic patterns linked to theoretical constructs. Interpretation within the framework of hegemonic processes and social inequalities. Data management and coding were supported by NVivo software (version 12) to enhance organization and transparency.

**Trustworthiness**

To ensure rigor, the study adhered to qualitative trustworthiness criteria: Credibility: achieved through triangulation and member checking. Dependability: ensured via systematic documentation and audit trail. Confirmability: maintained through reflexivity and researcher transparency. Transferability: supported by rich, contextualized descriptions

**Ethical Approval**

Ethical approval for this study was obtained from the Health Research Ethics Committee of Sekolah Tinggi Ilmu Kesehatan Amanah Makassar, South Sulawesi, Indonesia, under approval number 002/LPPMUIM/B.07/KET/I/2026. The study was conducted in accordance with established ethical principles for research involving human participants, including respect for autonomy, confidentiality, and voluntary participation. Written informed consent was obtained from all participants before data collection. Participants were assured of their right to withdraw at any stage without any consequences, and all data were anonymized to protect privacy.

# RESULT

Data collection and analysis were conducted concurrently following an iterative process. Data saturation was achieved at the 16th interview, where no new codes, categories, or conceptual insights emerged. Two additional interviews were conducted to confirm analytical stability, bringing the total to 18 participants. Saturation was verified through constant comparison and code recurrence analysis using NVivo, ensuring both code saturation and meaning saturation. The analysis generated five overarching themes, each supported by multiple subthemes. A hierarchical coding structure (parent–child nodes) was developed in NVivo to organize patterns and relationships across the dataset.

**Table 1.** Themes, Subthemes, and Illustrative Codes

| Theme | Subthemes | Example Codes |
|---|---|---|
| Naturalization of nutritional deprivation | Normal perception of stunting; Genetic attribution; Low growth awareness | *"Normal child", "heredity belief", "no need for check-up"* |
| Dominance of biomedical knowledge | Medical authority; Partial compliance; Knowledge tension | *"Nutrition standards", "follow advice selectively."* |
| Inequitable access to resources | Economic barriers; Food insecurity; Unequal aid distribution | *"Expensive food", "limited options", "aid not equal"* |
| Power relations in program implementation | Top-down governance; Passive compliance; Limited agency | *"Program from above", "just follow orders"* |
| Reproduction of social practices | Survival prioritization; Economic trade-offs; Habitual practices | *"Eat what exists", "other needs first."* |

**Thematic Map (Interpretive Integration)**

The findings reveal an interconnected system in which structural inequality shapes access to resources. Hegemonic knowledge systems legitimize dominant practices. Every day practices reproduce deprivation. This interaction forms a cycle of hegemonic reproduction of stunting, in which normalization, limited agency, and structural constraints reinforce one another.

**Theme 1: Naturalization of Nutritional Deprivation**

Participants frequently interpreted stunting as a normal or non-pathological condition. This reflects a hegemonic internalization where deprivation is normalized.

*"A thin and small child is normal, as long as the child is not sick." (A3)*

*"It runs in the family, so it is normal." (A7)*

This theme demonstrates how health inequalities become culturally accepted and depoliticized.

**Theme 2: Dominance of Biomedical Knowledge and Subordination of Local Practices**

Biomedical discourse was recognized as authoritative but not fully internalized. Participants negotiated between formal recommendations and inherited practices.

*"Children must eat according to nutritional standards." (B14)*

*"We follow the way our parents raised us." (A2)*

This indicates an epistemic hierarchy in which biomedical knowledge dominates but does not fully displace local systems.

**Theme 3: Inequitable Access to Health and Nutritional Resources**

Economic and structural barriers significantly influenced caregiving capacity.

*"Sometimes it is difficult to buy nutritious food because it is expensive." (A1)*

*"We eat whatever is available." (A6)*

These findings confirm that material constraints limit the translation of knowledge into practice.

**Theme 4: Power Relations in Health Program Implementation**

Participants described health programs as externally driven, reflecting asymmetrical governance structures.

*"The program is already determined from above." (B13)*

*"We just follow what we are told." (A8)*

This suggests limited community agency and reinforces hegemonic control in policy implementation.

**Theme 5: Reproduction of Social Practices within Structural Inequality**

Daily decision-making reflects adaptation to structural limitations, reinforcing stunting conditions.

*"As long as we can eat, nutrition is not the priority." (A4)*

*"Money is used for other urgent needs." (A9)*

These practices illustrate how inequality is reproduced through routine behaviors shaped by necessity.

**Integrative Interpretation**

The findings demonstrate that stunting is sustained through a hegemonic cycle involving: Normalization of deprivation. Dominance of biomedical discourse. Structural inequality in resource access. Top-down governance. Reproduction of constrained practices. This cycle highlights that stunting is not merely a biological outcome but a socially reproduced condition embedded within power relations and institutional structures.

# DISCUSSION

This study reinterprets child stunting not merely as a biomedical or nutritional deficiency, but as a socially constructed phenomenon embedded within hegemonic structures and systemic inequalities. The findings demonstrate that stunting persists through a dynamic interaction between the normalization of deprivation, the dominance of biomedical knowledge, unequal access to resources, and asymmetrical power relations in health governance. These interrelated processes indicate that stunting is sustained not only by material limitations but also by symbolic and ideological mechanisms that shape how communities perceive, interpret, and respond to child growth and nutrition. In this sense, stunting reflects a broader social order in which inequality is both experienced and internalized, reinforcing its persistence across generations (G Nduwayezu & Zhao, 2025).

A central insight from this study is the normalization of stunting as an ordinary and non-pathological condition. Participants frequently perceived short stature as a natural or hereditary trait rather than a manifestation of chronic undernutrition. This perception suggests the internalization of deprivation, in which structural inequalities become normalized in everyday life. Such normalization aligns with the concept of hegemonic consent, in which marginalized groups come to accept their conditions as inevitable. As a result, the perceived urgency to address stunting diminishes, and health interventions may fail to resonate with community priorities (Gilbert Nduwayezu et al., 2025). This highlights that the challenge of stunting is not solely about improving nutritional intake but also about transforming the social meanings attached to health and growth.

The study also reveals a complex relationship between biomedical knowledge and local practices. Although biomedical standards are recognized as authoritative, they are not fully incorporated into everyday caregiving practices. Instead, participants navigate between formal recommendations and inherited cultural practices, selectively integrating elements from both. This coexistence reflects an epistemic hierarchy in which biomedical knowledge dominates institutionally but does not entirely displace local knowledge systems (Nelson, 2025). The partial acceptance of biomedical advice suggests that hegemonic influence operates through negotiation

rather than complete control. Consequently, interventions that rely exclusively on standardized guidelines without engaging with local knowledge may encounter resistance or limited effectiveness (X Pan & Zhao, 2025).

In addition to knowledge dynamics, structural constraints play a significant role in shaping caregiving practices. Limited access to nutritious food, economic hardship, and the unequal distribution of health resources limit families' ability to implement recommended nutritional practices. Even when awareness of proper nutrition exists, the capacity to act on that knowledge is constrained by material conditions. This gap between knowledge and practice underscores the importance of viewing health behaviors within their structural context (Xiang Pan et al., 2025). It also challenges the tendency to attribute stunting to individual or household-level failures, emphasizing the role of systemic inequality in shaping health outcomes.

The findings further highlight the influence of power relations in the implementation of health programs. Participants described these programs as externally imposed and largely determined by higher authorities, with limited opportunities for community participation (Suprapto, 2026). This top-down approach reflects an imbalance of power, positioning communities as passive recipients rather than active agents (Patsouras et al., 2026). Such dynamics may lead to compliance without genuine understanding or engagement, ultimately reducing the effectiveness and sustainability of interventions.

Moreover, the study illustrates how everyday practices contribute to the reproduction of stunting within structurally constrained environments. Decisions regarding food consumption and resource allocation are shaped by immediate survival needs, leading to a prioritization of food quantity over nutritional quality (Soofi et al., 2023). These practices are not merely behavioral choices but adaptive responses to economic limitations. Over time, such responses become habitual and are transmitted across generations, perpetuating the cycle of undernutrition (Pauzi et al., 2025).

When compared with previous studies, these findings are consistent with research highlighting the role of social determinants such as poverty, education, and access to health services in influencing child stunting. Quantitative studies have established strong associations between socioeconomic disadvantage and impaired growth outcomes (Sarifudin Andi Latif et al., 2025). However, many of these studies focus on identifying risk factors without examining how these factors are socially produced and maintained (Daniel Smithers & Waitzkin, 2022). Similarly, qualitative research has documented the influence of maternal perceptions and cultural practices on child nutrition, but often lacks a theoretical framework to explain the underlying power dynamics (V Sharifi & Dimitropoulos, 2026).

The incorporation of hegemonic theory represents a key contribution of this study. By examining how dominance is exercised through normalization, knowledge control, and institutional practices, the study provides a deeper analysis of the mechanisms that sustain stunting (D Smithers & Waitzkin, 2022). This approach moves beyond descriptive accounts of inequality to explore the processes through which inequality is reproduced and legitimized (Vandad Sharifi et al., 2026). As such, it contributes to the growing body of critical public health research that calls for a more nuanced understanding of health disparities.

Despite these contributions, several limitations should be acknowledged. The study is based on a relatively small sample within a specific local context, which may limit the transferability of the findings to other settings. Additionally, the reliance on self-reported data introduces the possibility of recall bias or social desirability bias. Although triangulation and observational methods were used to enhance credibility, these limitations cannot be eliminated.

The interpretive nature of the analysis also means that the researchers' theoretical orientation influences findings.

### Recommendations for Future Research

Future research should adopt multilevel and mixed-method designs to capture the interactions among structural determinants, power relations, and individual practices in child stunting. Comparative studies across different regions are needed to examine how hegemonic processes vary across socio-cultural contexts. Additionally, intervention-based research should focus on participatory and community-driven approaches that integrate local knowledge with biomedical frameworks. Further theoretical work is also recommended to expand the application of critical perspectives, such as hegemony and structural inequality, in public health research on child nutrition.

## CONCLUSION

This study demonstrates that child stunting is not solely a nutritional or biomedical problem but a socially constructed condition shaped by hegemonic processes, structural inequalities, and power relations within the community. The findings show that stunting is sustained through the normalization of deprivation, the dominance of biomedical knowledge over local practices, unequal access to health and nutritional resources, and top-down program implementation that limits community agency. These interconnected factors contribute to the intergenerational reproduction of stunting, underscoring the inadequacy of purely technical or nutrition-focused interventions. Addressing stunting, therefore, requires a shift toward more context-sensitive and equity-oriented strategies. Policy and intervention efforts should integrate community participation, strengthen access to nutritious food and essential services, and bridge the gap between biomedical recommendations and local knowledge systems. In addition, health programs should adopt more participatory and decentralized approaches to enhance local ownership and effectiveness. By acknowledging the social and structural dimensions of stunting, interventions can become more sustainable, inclusive, and responsive to the realities of vulnerable populations.

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### Conflict of Interest

The authors declare that there are no financial or non-financial conflicts of interest that could have influenced the design, analysis, or interpretation of the study.

### Authors' Contributions

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**Declaration of Generative AI Use**

The authors declare that generative artificial intelligence tools were used solely to assist in language refinement and structuring of the manuscript. All conceptualization, data collection, analysis, and interpretation were conducted independently by the authors. The authors take full responsibility for the integrity and originality of the content.

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