Journal of Rural Community Nursing Practice (JRCNP)
Volume 3 Issue 1, March 2025, pp 129-149
https://ebsina.or.id/journals/index.php/JRCNP
eISSN 2986-7401, pISSN 2986-8424

Exploring Mothers' Experiences in Accessing Primary Healthcare Service Facilities in Rural Indonesia: Implication for Stunting Prevention

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Article History
Submitted: 15-11-2024
Revised: 09-03-2025
Accepted: 11-03-2025

ABSTRACT

Background: Primary healthcare service facilities are essential in preventing stunting by providing comprehensive support for mothers and children. The low usage of the primary health services by pregnant women and mothers with toddlers in rural Indonesia limits the effectiveness of the services and contributes to poor stunting prevention. **Purpose:** This study aimed to explore mothers' experiences in accessing healthcare services at primary healthcare facilities in Indonesia. **Methods:** This descriptive qualitative study was conducted in the Melawi district of West Kalimantan Province. Employing a purposive sampling technique, data were collected through in-depth interviews with six mothers, two pregnant and four mothers with children under two years. The data were analyzed through content analysis. **Results:** Most mothers in this study were high school graduates, of low economic status, aged 22 to 36 years, and from Dayak and Malay cultural backgrounds. Seven categories were identified: stigma in children with stunting, cultural and social norms influence, problems of knowledge and awareness, hierarchical communication between healthcare providers and mothers, trust issues with healthcare providers, equity and accessibility of healthcare service facilities, as well as limited information and education. **Conclusions:** Encouraging awareness campaigns is vital to address stunting stigmatization. Healthcare providers should improve communication, education strategy, and nutrition competency through targeted training to better support and rebuild trust with mothers. Healthcare institutions and policymakers should develop policies that improve health service quality. Strengthening advocacy roles and collaborating with community organizations could ensure equitable healthcare access.

KEYWORDS

Health service accessibility, Indonesia, Mother, Primary health care, Stunting

How to cite:
Ramadhaniyati, Lestari, L., Saito, R., & Tsuda, A. (2025). Exploring Mothers' Experiences in Accessing Primary Healthcare Service Facilities in Rural Indonesia: Implication for Stunting Prevention. Journal of Rural Community Nursing Practice. 3(1), 129-149. https://doi.org/10.58545/jrcnp.v3i1.414

1. BACKGROUND

Stunting is a condition that arises from chronic malnutrition and recurrent infections during the critical 1000-day period from a woman's pregnancy to her child reaches 2 years old (World Health Organization, 2014). The impact of stunting extends beyond physical impairments, affecting the individual's future quality of life and productivity (De Onis & Branca, 2016). Globally, the target to reduce stunting cases by 3.9% annually has not been consistently met (De Onis et al., 2013). Indonesia ranks second after Cambodia in stunting cases in Southeast Asia, with a rate of 30.8% in 2018 (World Health Organization; United Nations Children's Fund (UNICEF); & World Bank., 2021) and a yearly decline of only 1.3% from 2013 to 2018 (Implementing Institution the Child Stunting Prevention Program, 2018). In West Kalimantan province, the decline in stunting cases was particularly slow, with a decrease of only 5.3% over five years; from 38.6% in 2013 to 33.3% in 2018 (Ministry of Health of Republic Indonesia, 2018). Alarmingly, the Melawi district in West Kalimantan province even experienced a significant increase in stunting cases in 2022, reaching 44.1% (Kementerian Kesehatan Republik Indonesia, 2023). Therefore, stunting remains a significant public health problem in this region. Effective intervention in stunting prevention requires comprehensive disease prevention, health promotion, and nutrition support during the first two years of life (Bhutta et al., 2013), which can be achieved by facilitating mothers' access to primary healthcare facilities.

Public health centers (Puskesmas), integrated service posts (Posyandu), and village-level delivery posts (Polindes) form the backbone of Indonesia's healthcare system, especially in rural areas (World Bank, 2020). Accessing these primary healthcare facilities by mothers is essential to reducing childhood stunting due to their important role in providing comprehensive healthcare support for mothers and children, including antenatal care, regular growth monitoring, immunization, education and counseling services related to maternal and child health and nutrition, and safe childbirth support (Rajpal et al., 2020; World Health Organization, 2018). Unfortunately, access to primary healthcare services for pregnant women and children under two years old in Indonesia remains low (Implementing Institution the Child Stunting Prevention Program, 2018). Only about 27.0% of families in Indonesia can access basic nutrition-related services, such

as growth and development monitoring, additional treatment for malnutrition, and supplementary nutrition for low-income families (Mulyaningsih et al., 2021). In the Melawi district, the utilization of primary healthcare by pregnant women and toddlers is particularly low compared to other areas, with antenatal care services, childbirth in health facilities, and postpartum visits at 40.2%, 47.6%, and 56.2%, respectively. Additionally, neonatal, infant, and toddler visits coverage was 65.0%, 61.6%, and 40.2%, respectively (Provincial Health Office of West Kalimantan, 2022). This low utilization of primary healthcare services by mothers is closely linked to poor stunting prevention in this area, indicating the need to understand the problem mothers face in accessing these healthcare services.

While previous studies have extensively explored mothers' role and behavior in stunting prevention, limited research examines maternal and child healthcare delivery related to stunting prevention in primary healthcare service facilities from mothers' perspectives. Research is needed to address these gaps by exploring how mothers experience, perceive, and interact with primary healthcare services facilities. Understanding these experiences can provide valuable insights into the barriers mothers face in accessing healthcare services. This leads to targeted improvement strategies in service delivery and effective policy adjustments that are more responsive to mothers' needs to promote stunting reduction and healthier outcomes for children. Therefore, this study aimed to explore mothers' experiences in accessing healthcare services at primary health service facilities.

2. METHODS

Design

The study employed a descriptive qualitative design to explore mothers' experiences in accessing healthcare services at primary healthcare facilities in Melawi District, West Kalimantan Province, Indonesia. This approach allowed for clear descriptions of the unique lived experiences of each mother, enabling the researcher to capture their extensive personal experiences (Doyle et al., 2020). By understanding the challenges mothers face in accessing and receiving primary healthcare services, this study's findings provide valuable insights into the need to improve primary healthcare services for this population.

The total number of participants in this study was determined using the principle of

data saturation, which is reached when no new information or themes emerge from the last data. After conducting interviews and analyzing the data, it was concluded that six participants, comprising two pregnant women and four mothers with children under two years of age, were sufficient to achieve saturation (Guest et al., 2020). This number of participants fits with qualitative research standards as Fridlund & Hildingh (2000) suggested, which typically involve 1 to 30 participants and meet the information criteria needed (Bengtsson, 2016).

Participants and Setting

Participants were selected using purposive sampling, a method that ensures the inclusion of individuals who are most relevant to the research objectives (Doyle et al., 2020). The participants chosen for this study were pregnant women and mothers with children under two years of age, who were directly involved with the primary healthcare services in Melawi District. The selection was facilitated by healthcare providers (HCPs) at both the Puskesmas and Posyandu to ensure that the participants were both suitable for the study and comfortable with participating in the study. Once the potential participants had expressed their willingness to take part in the study, the HCPs provided their contact details to the researcher. The researcher then reached out to these individuals via telephone, introducing themselves and providing a thorough explanation of this study.

Ethical consideration

Before the interview process was conducted, the researcher provided a thorough explanation both verbally and in writing to the participants. This included details about the study's purpose, process, form of participation to be carried out, and guarantee of anonymity for involvement in the research. This step was crucial in establishing rapport and ensuring participants fully understood their role in the research before providing informed consent to proceed. Participation was entirely voluntary, with no coercion for those who chose not to participate. For those who agreed, the researcher and participants scheduled interviews at mutually convenient times and locations. The interviews were conducted in each participant's home to ensure comfort, convenience, and privacy. This study is part of a series of main studies on developing a program to prevent stunting in West Kalimantan Province. The

ethical approval for this study uses the same approval number as the main study issued by the ITEKES Muhammadiyah Kalbar Ethics Committee: 385/II.I.AU/KET.ETIK/XII/2022.

Data collection

The data collection for this study was conducted from January to February 2024. The researchers prepared a semi-structured interview guide to direct the interview process. In-depth and one-on-one interviews were recorded using an audio recorder, with the duration of the interviews ranging from 45 to 60 minutes. In addition to the audio recordings, the researcher maintained detailed field notes throughout the data collection process. These notes served to capture additional contextual information, such as the participants' nonverbal cues, environmental conditions, and any other observations that might not be fully conveyed through the audio recordings alone. This approach helped a comprehensive understanding of the participants' experiences and enriched the qualitative data collected (Sutton & Austin, 2015).

Since participants communicated in Bahasa and the local language, Malay, the interviews were conducted in both languages, requiring careful transcription and translation. The interview data were first transcribed in their original languages, Bahasa and Malay, and then translated into English. According to van Nes et al., (2010), this translation process was carefully managed to preserve the participants' statements accurately, ensuring that the original context and nuances were maintained to prevent any misinterpretation of their intended meanings.

Data analysis

The content analysis approach was used in the data analysis aligned with the design and objectives of descriptive qualitative research (Bengtsson, 2016). The content analysis began with data familiarization, involving carefully reading each transcription to capture the meaning and understand the overall data. Open coding was then applied to meaningful quotes and organized into data management coding sheets. The similar codes were grouped carefully into subcategories, reviewed, refined, and then combined into categories. Ultimately, the results of this study identified seven main categories representing mothers' experiences accessing primary healthcare services.

Trustworthiness

The trustworthiness of this study was ensured through a comprehensive approach developed by Lincoln and Guba (1985). Credibility was achieved by meticulously reviewing participant interview transcripts, addressing any unclear statements with the participants, and triangulating data with the investigators. Dependability was maintained by involving research members in internal peer reviews or member checks on all research processes and findings before the study was published. Transferability was supported by providing detailed descriptions of all study processes and the research findings. Confirmability was addressed by seeking input from qualitative research experts to ensure objectivity and neutrality of the results (Rose & Johnson, 2020).

3. RESULTS

Characteristics of participants

In this study, 6 mothers (2 pregnant mothers and 4 mothers with children under 2 years old) were interviewed. Most of the mothers had graduated from senior high school, were aged 22-36 years, had Dayak and Malay cultural backgrounds, and were housewives. Among the participants, one pregnant mother had Chronic Energy Deficiency (CED) and one had a child with stunting. The demographic characteristics of the participants are shown in Table 1.

Table 1. Demographic characteristics of Mothers (n = 6)

Code	Education Level	Age in Years	Culture	Occupation	Annotation
P.1	Senior High School	22	Malay	Housewife	Mother with child aged 13 months and stunted
P.2	Senior High School	23	Dayaknese	Housewife	Pregnant women with 6 months of gestation and with chronic energy deficiency (CED)
P.3	Bachelor	36	Malay	District Social Welfare Worker	Mother with child aged 7 months
P.4	Senior High School	29	Malay	Housewife	Pregnant women with 7 months of gestation
P.5	Elementary School	33	Dayaknese	Housewife	Mother with child aged 2 months
P.6	Senior High School	22	Dayaknese	Housewife	Mother with child aged 18 months

Key categories

This study identified seven categories, twenty-three subcategories, and thirty - seven codes as presented in Table 2.

Table 2. Experience of mothers in accessing healthcare services in primary healthcare facilities
(Continues to page 137)

Categories	Subcategories	Codes
Stigma of children with stunting	Mother's emotional burden regarding the stigma of having a child with stunting	The mother feels ashamed and frustrated because her child often experiences recurring illnesses and suspected stunting. The mother felt worried that her child was judged as stunting.
The influence of cultural and social norms	Knowledge and feeding practices are inherited from elders	Mothers learn and follow how to feed children based on their culture and elders in the family.
	Involvement and authority of elders regarding decision-making in caring and feeding practices	The mother lacks authority and elders determine the type of food that should consume during breastfeeding.
	Concerns about deviating from the culture	Mothers concerned about complying with their cultural food restrictions for their child Mothers are concerned about complying with their cultural food restrictions during breastfeeding, even though mothers have received advice from HCPs.
Problems of knowledge and awareness of mothers	Lack of knowledge on stunting in children.	The mother has not been exposed to the information about stunting and its prevention by the HCP
	Lack of knowledge and awareness in maintaining children's health and nutrition status.	The mother feels normal and is not worried about the child's weight remaining the same every month. Mothers assume that every change in a child's development will make their children definitely experience illness/fever
	Lack of knowledge about proper feeding as children's health conditions and eating behavior as children grow up.	The mother feels confused about providing good food choices for her children during diarrhea. The mother feels confused about the child's eating behavior as the child grows up The mother faces challenges in feeding the child who has difficulty eating
	Lack of basic nutritional knowledge and understanding of nutrition fulfillment during pregnancy and postpartum.	Pregnant women only follow their desires, such as frequently eating durian during pregnancy Mothers' misconceptions about postpartum diet and breastfeeding.

Categories	Subcategories	Codes
	Lack of awareness in using medicines without visiting health services	The mother treated her child by buying/using over-the-counter medicine without visiting the doctor.
Hierarchical communication between Mothers and Healthcare Providers	Coercive and judgmental communication from HCP.	Mothers got judgemental advice about the pregnancy from HCP. Forced recommendation about iron consumption for pregnant mothers without detailed explanation.
	Lack of empathy from HCPs for the mother's needs and inquiries.	HCPs didn't pay attention to the mother's worries about the correctness of pregnancy age. HCPs lack empathy and are less responsive to mother's worriedness about their child's weight status.
	Mothers feel inferior and reluctant when asking HCPs for assistance.	Hesitant and uncomfortable asking HCPs about the child's weight gain. Didn't want to blame the HCP for their lack of understanding of the health information provided during the counseling.
Trust issues to Healthcare Providers	Lack of trust in preventive care service.	The service provided at Puskesmas is very quick, has less information, and is only for treatment.
	Lack of trust in HCP's skills.	The mother denied and distrusted the child's weight measurement skill of the HCPs at the Puskesmas.
	Lack of trust in the competency/expertise of HCPs.	The mother feels worried about taking her baby for treatment at the Puskesmas and prefers to go to the pediatrician at a private clinic.
	HCPs did not work as mothers expected.	The mother felt that her husband was not invited or allowed when carry out examinations at the Puskesmas.
Equity and accessibility of health services	Inadequate healthcare service due to the HCP's busyness.	Mother refrained from asking the midwife because conditions at the Posyandu were very busy and only one midwife at Posyandu
	Less convenient primary health care services.	The administrative services at the Puskesmas were very uncomfortable and unfair.
	Poor mothers' difficulties in accessing paid and conditional primary health services.	Poor pregnant women cannot follow the free ultrasound examination program because they don't have health insurance. There is a fee that must be paid by the mothers when visiting the Posyandu.
Limited information and education	Limited education on stunting and its prevention	Information/education about Stunting is only given to pregnant women and children with nutritional problems
	Lack of education on child immunization and feeding practices.	Lack of information about immunization given to the children.

Categories	Subcategories	Codes
		HCP is not proactive in explanation and give support only when mothers ask about child feeding, including question about food restriction behavior.
	Lack of information on pregnancy care and nutrition fulfillment for pregnant women.	Midwife only suggests taking supplements to pregnant women who have challenges in fulfilling nutrition. Less relevant explanations about iron supplementation consumption from HCPs to pregnant women. There is no health education for pregnant women from HCP when visiting the Puskesmas.
	Lack of information on free programs of antenatal and giving birth services for poor mothers	Poor pregnant women were late in getting information regarding the free delivery program. Lacked information support regarding free birth assistance for the poor from HCPs.

Each category is explained as follows:

Category 1. Stigma in children with stunting

Mothers in this study expressed concern about social judgment and pressure due to the stigma of having a child with stunting and poor health. Even mothers with healthy children experience similar feelings when discussing stunting, as reflected in the following quotes:

"…he also had the flu. He often had colds and coughs, also. He has been treated twice and recovered twice, but it recurred (feels annoyed and ashamed)." – **P1**

"Neveeer (with a slightly high voice in shock). My daughter has never been stunted (looks anxious when asked about stunting)" – **P6**

Category 2. The influence of cultural and social norms

The study found that cultural influences and social norms affect mothers' nutritional practices during pregnancy, breastfeeding, and child feeding. Mothers' knowledge of nutrition is often inherited from elders who are also decision-makers in the family, as stated by the mothers below:

"It's been passed down through generations. Learned and observed from siblings and mothers when feeding their children. I'm used to seeing it, so I understand." - **P1**

"…it was my mother-in-law who cooked (after giving birth). So, I just ate what she cooked. But even though later I could cook again, I still followed the meals they

recommended for breastfeeding mothers." – **P2**

This situation further makes the mothers concerned about deviating from the culture and not following dietary recommendations even though HCPs informed them. The following statement illustrates the situation:

"Yes, actually it was already explained (by HCPs). Eggs and fish can be eaten, they said. But I must follow the rules of the people there. I feel bad if I have to violate elder's rules." – **P6**

Category 3. Problems of knowledge and awareness of mothers

Critical issues surrounding mothers' knowledge and awareness were explored. Mothers lack essential knowledge about stunting, maintaining a child's health and nutrition status, choosing appropriate food during illness, and changing eating behaviors as the child grows. The following statements explain the situation:

"…I actually don't understand very well (about stunting and prevention); I don't know for sure about it, because I feel that during the routine to the Posyandu, there has been no midwife or HCP from the Puskesmas who provides such information." – **P4**

"…(the child's weight gain) sometimes goes up and down. If she is sick, it usually drops about 2 oz (200 grams). Usually, the weight also remains. She is very underfed. She eats three times per day. But it just a little bit, only 2-3 mouthfuls of meal." – **P6**

"Before he turned 1 year old, he could eat three times a day. However, after he could crawl and walk, his appetite decreased significantly. Sometimes, only once a day, and even then, he must be forced." – **P1**

Additionally, mothers also show a lack of basic nutrition knowledge during pregnancy and postpartum, and conduct self-medication without prescription, as indicated by the following statement:

"I enjoy eating durian. I've been eating durian frequently since the early stages of pregnancy." – **P2**

"I was worried that if I coughed (due to eating greasy food during breastfeeding), my baby would cough too. Because he drinks breast milk. So, it made him cough." – **P5**

"If she gets sick, for example, if she has only been sick for one day, I will give her ordinary medicine like 'Insana' (fever reliever). I bought it at stalls." – **P6**

Category 4. Hierarchical communication between Mothers and Healthcare Providers

Mothers often encounter coercive and judgmental communication when interacting with HCPs in primary healthcare services and a lack of empathy for mothers' needs and questions. The following quotation illustrates the situation:

"...the midwife said, "The baby is already 5 months old but seems small. The mother is malnourished; from your arm circumference, it is malnourished." – **P2**

"When the doctor said, "This gestational age starts to enter 6 months and will giving birth in May, ma'am". I said, "But the midwife at Polindes said I will give birth in the 3rd month (March), doc". But the one who answered the midwife. The midwife said, "That's correct, right? As I said. You will give birth in the 5th month (May)". So, I didn't continue to ask anymore; I only said OK, and then I went home." – **P4**

Mothers then also feel inferior and hesitant to seek assistance from HCPs, which limits their ability to advocate for themselves and get the explanations they need.

"I felt hesitant to ask even if I wanted to. But they also didn't explain anything. If they had explained directly, like 'Mam, your child's weight hasn't increased, so the solution is like this, like this!', then I could have understood. Because I'm not a person with a health background, I don't know what to do." – **P3**

Category 5. Trust issues to Healthcare Providers

Mothers in this study faced various trust issues with HCPs. They perceived that primary healthcare prioritizes curative care and does not provide information on prevention care. The following statement reflects mothers' perspective:

"... we haven't been given information on that (nutrition for babies over 6 months). When we go to the Puskesmas, we register, get examined quickly, then the child gets vaccinated, and we're done and go home." – **P3**

Mothers questioned the skills and competencies of HCPs, and even HCPs' attitudes often fall short of their expectations, as some mothers prefer their family members to be involved in their care. The following statements reflect mothers' situations:

"... they (the HCPs) didn't measure length; they just guessed. It's like this: they while looking at the MCH book. So, for example, if the child is at this age, their

height might be only as much as this. Just like that" – **P3**

"I immediately took him to the pediatrician for treatment at that time because he was still a baby. I was afraid to take him there (Puskesmas), so I thought I just take him to the pediatrician (private clinics) immediately." – **P1**

"No. There's not. In case the midwife invites him in, for example, "Come in, sir." Maybe my husband is willing to go in. But because he wasn't invited, he felt embarrassed." – **P5**

Category 6. Equity and accessibility of health services

The busyness of HCPs and inconvenient services in primary healthcare facilities further complicate access. Mothers' needs are often unmet due to the limited number and high workload of HCPs. The following quotes illustrate this situation:

"The midwife is usually busy; she administers injections to other children as well. Because in the Posyandu, the midwife works alone. Maybe she doesn't have much time." – **P2**

Mothers also experience discomfort with services at the Puskesmas, particularly during the registration process and waiting queue, as indicated in the following statement:

"Ideally, she (the HCP at the registration desk) could have spoken in a friendly manner. Instead, she got angry, "Didn't you register?" as if we didn't know, whereas I think I followed the instruction." – **P3**

"…sometimes our files get misplaced. Even though we were the first in line, we got skipped. Sometimes, newcomers can go straight in for the examination, making us confused." – **P1**

Poor pregnant mothers still experience difficulties in accessing paid and conditional health services in Puskesmas, as the following mother's statement:

"I don't have health insurance. I tried to get health insurance, but the monthly fee is Rp 35,000 and the other requirements are to have a balance and debit card, whereas I don't have any of that. So, I didn't register for insurance and couldn't join the free USG at Puskesmas." – **P2**

Category 7. Limited information and education

The current study revealed that mothers often lack essential information and educational support from HCPs about stunting, child immunization, and feeding

practices, as reflected by the following statements:

"Because my daughter is not stunted, so we didn't participate in the meeting. Those who participate in the meeting are mothers with children who are malnourished and stunted." – **P6**

"I don't know (the benefits of the immunization). I don't know its name. Nor I didn't ask about it. She just explained that this injection does not cause a fever." – **P5**

Mothers often obtain irrelevant information about pregnancy care including nutrition fulfilment, as indicated by the following statements:

"…during my 1-3 months of pregnancy, I didn't eat rice much; I only drank iced beverages. The midwife told me to take vitamins and iron supplements." – **P2**

"There is an explanation about blood tablets (iron supplements) from the midwife. She said, "Because your blood is lacking (low blood pressure), it must be regularly taken so that at birth time, your condition remains good." – **P4**

Additionally, poor mothers are unexposed to information about the available program for free birth services for the poor, as revealed by the statement below:

"I have concerns about giving birth funding. I want to give birth at the Puskesmas, but I lack funds. Making BPJS Insurance also needs money. For free birth, I ever asked the midwife, she said "There's not enough time". I have to go to the village office first and it takes a long time and is not easy to take care of it." – **P2**

4. Discussion

Mothers in this study faced complex challenges that hindered their ability to prevent stunting in children under two, triggered by several internal factors, including stigma related to stunted children, the influence of cultural and social norms, and various knowledge gaps. Both mothers with and without stunted children in this study experience stigma surrounding childhood stunting. This stigma often impacts mothers' psychological well-being and caregiving capabilities (Bliss et al., 2016). Community organization, local governance, and primary health institutions should promote advocacy-based strategies, such as public awareness campaigns, community mobilization and participation, and support groups for mothers to foster empathy and tolerance among the general public (Bliss et

al., 2016; Nayar et al., 2014; Undlien et al., 2016).

Culture and social norms in households and communities are dominant factors that hinder recommended nutrition fulfillment for pregnant women and children under two. Elders play significant roles as custodians of culture and decision-makers in the family (Lestari & Ramadhaniyati, 2019), making it difficult for mothers to avoid cultural advice due to fear of social repercussions, which negatively impacts child growth (Amare et al., 2022; Meyer-Rochow, 2009). Additionally, mothers' lack of knowledge about stunting, basic nutrition, child health, child feeding practice during illness and in eating behaviors changes as the child grows, often makes them consider slow growth as a normal condition and further complicates maternal and child health practices (Hall et al., 2018; Muraya et al., 2016). The use of over-the-counter medicines by mothers for children under two also raises concerns, as these can mask symptoms of infections that lead to stunting, delay treatment, worsen the child's condition, and hinder nutrient absorption, negatively impacting growth (Kbede et al., 2021; Zyoud et al., 2019). As health educators, HCPs should improve educational strategies incorporating culturally sensitive and collaborative approaches involving family members, elders, and community leaders in comprehensive nutrition and health education to tackle these issues. These strategies aimed to bridge the gap between traditional practices and health recommendations and improve mothers' health literacy and knowledge in stunting prevention.

Despite the significant need of mothers for HCPs' support in overcoming their challenges, the attitude of HCPs towards mothers and families does not meet their expectations. Mothers reported negative experiences while interacting with HCPs, noting that HCPs tended to use hierarchical communication, which is judgmental and coercive language when advising mothers. This power imbalance in communication makes mothers mistrust to HCPs, feel inferior and negatively impacts the continuity of care, or disengagement with healthcare service (Campbell et al., 2018; Vermeir et al., 2015). Combine with mothers' mistrust with preventive care service, HCPs' skill and competencies, as well as support that unmeet mothers expectation, these factors further compromise mothers trust to HCPs and reduce mother's willingness to follow advice

(Abbott et al., 2014; Campbell et al., 2018; Srivastava et al., 2015). Improving HCPs' communication strategy by using a respectful and nonjudgmental approach through targeted training and ongoing professional development, along with improving the quality of maternal and child health services, could rebuild mothers' trust in HCPs and primary healthcare facilities.

Primary healthcare facilities must ensure equitable access for individuals of all socioeconomic statuses, locations, or races, and provide comprehensive disease prevention and health promotion. However, primary healthcare facilities in this study area inadequately meet these standards. The busyness and heavy workload of HCPs, inconvenient administrative services, and poor mothers face challenges accessing conditional and paid maternal and child health services, hindering mothers from receiving quality, comprehensive, and equitable access to service, especially for the poor (Mahendradhata et al., 2017). Additionally, primary HCPs, as essential learning resources for mothers, fail to provide essential information and education on child stunting prevention, which reduces mothers' ability to make informed choices in caring for their health and their child's health (Elhady et al., 2023). Furthermore, the limited information about health insurance for poor mothers from HCPs limits their ability to benefit from available primary healthcare service. These indicate that primary healthcare institution and policymakers should develop policies to enhance service quality by optimizing workforce efficiency and improving service accessibility. HCPs should strengthen their advocacy efforts and collaborate with community organization to promote pro-poor programs and policies, ensuring equitable healthcare for poor families. Additionally, HCPs also should improve their nutritional competencies through intensive training to better educate mothers on health and nutrition, so that improving mothers' ability to prevent stunting during pregnancy, breastfeeding, and childcare.

5. CONCLUSION

The mothers in this study face various challenges in accessing primary healthcare service facilities during pregnancy and their children's first two years. To address the stigma around childhood stunting, primary healthcare facilities and the government should promote awareness campaigns to support mothers with stunted children. Healthcare Providers (HCPs) also must adopt a culturally sensitive approach,

comprehensive educational programs, using respectful and non-judgemental communication, and fostering a supportive environment. Therefore, improving HCPs' communication strategy through targeted training and ongoing professional development, along with ensuring quality in maternal and child health services, is essential for rebuilding trust with mothers and ensuring adherence to health advice.

Primary healthcare institutions and policymakers should develop policies that improve the quality of health service by optimizing workforces and facilities. Furthermore, HCPs should strengthen their advocacy role and collaborate with community organizations to promote pro-poor programs and policies to ensure equitable healthcare access. Additionally, HCPs must strengthen their nutritional competency through intensive training to effectively educate mothers in health and nutrition and improve their efforts on stunting prevention.

ACKNOWLEDGMENT

We appreciate all the participants, the research team, ITEKES Muhammadiyah Kalbar, and Kanazawa University for supporting this study.

AUTHOR CONTRIBUTIONS

Substantial contributions to conception, data collection, analysis, writing, and manuscript revisions: Ramadhaniyati, Lilis Lestari, Ruka Saito, and Akiko Tsuda.

CONFLICT OF INTEREST

There are no potential conflicts of interest to declare.

FUNDING

This study was funded by ITEKES Muhammadiyah Kalbar.

DATA AVAILABILITY

The datasets generated and/or analyzed during the current study are not publicly available due to ethical standards upholding and protecting participants' privacy but are available from the corresponding author on reasonable request.

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