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Pastoral Health Communication in Reducing Health Inequalities Among Rural Mothers

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ABSTRACT

Health disparities remain a major challenge in developing countries, with stunting representing a key indicator of structural inequality. This study examines how pastoral health communication contributes to stunting prevention and health equity in Ngusikan Village, East Java. A qualitative ethnographic case study was conducted from February to May 2025 using in-depth interviews, participant observation, focus group discussions, and document analysis involving health workers, posyandu cadres, religious leaders, and mothers of young children. Data were analysed thematically through Foucault's concepts of pastoral power and governance of care. The findings show that health communication functions as a moral and relational process grounded in faith, trust, and collective responsibility. Health messages gain legitimacy when linked to local moral values and are reinforced through collaboration among health workers, community volunteers, and religious leaders. Digital platforms such as Poskozio Online further extend care and participation through what this study terms digital pastoralism. The study proposes a governance-of-care framework that conceptualises "Care as Power," demonstrating how moral communication, collaborative participation, and digital engagement contribute to reducing health inequalities in rural communities.

Keywords: Digital pastoralism, governance of care, health communication, pastoral health communication, rural communities, stunting

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INTRODUCTION

Stunting remains one of the most persistent public health challenges worldwide, particularly in developing countries. As a chronic form of malnutrition, stunting affects children's physical growth, cognitive development, educational achievement, and future productivity.

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According to the World Health Organisation, nearly one in five children under five years of age experiences stunted growth. Beyond nutritional deficiencies, stunting reflects broader health inequalities associated with poverty, limited access to healthcare services, and inadequate health information (WHO, 2023). Recent studies indicate that biomedical interventions alone are often insufficient to address these inequalities when health messages lack cultural relevance and community trust (Harper et al., 2023; Mattioni et al., 2021).

In Indonesia, stunting remains a major public health concern despite extensive government efforts through multisectoral programs involving health, sanitation, education, and social protection. Previous studies have primarily focused on nutritional supplementation, maternal education, and policy implementation as determinants of stunting reduction (Ardianti & Sumarmi, 2023; Bella et al., 2019; Herawati & Sunjaya, 2022). While these approaches provide important insights, they often overlook the communicative and sociocultural processes through which communities interpret, accept, and practice health recommendations.

Health communication in rural communities is closely linked to social trust, religious values, and local cultural norms. Community actors such as midwives, posyandu cadres, family planning officers (PLKB), and religious leaders frequently serve as intermediaries who translate biomedical information into locally meaningful messages. Existing studies have highlighted the importance of community participation and women's empowerment in improving child nutrition outcomes (Abreha et al., 2020; Mahmudah et al., 2024; Waisawati et al., 2024). However, limited attention has been given to how moral legitimacy, faith-based guidance, and community care function as communication mechanisms that support health equity.

Drawing on Foucault's concept of pastoral power, this study introduces the concept of pastoral health communication, referring to a form of communication that integrates biomedical knowledge with moral and spiritual guidance. In this perspective, health communication operates through care, empathy, and trust, encouraging voluntary participation rather than coercive compliance. The study further argues that pastoral health communication develops through collaborative governance of care among health workers, community volunteers, mothers, and religious leaders, and is increasingly supported by digital communication platforms that extend care beyond face-to-face interaction.

This study was conducted in Ngusikan Village, Jombang Regency, East Java, a rural community that successfully reduced stunting prevalence from 14.2% in 2021 to 6.7% in 2023. The village provides a unique context for examining how moral values, social solidarity, and digital communication practices contribute to community-based health governance and the reduction of health inequalities among rural families.

PROBLEM STATEMENT

Existing studies on stunting prevention primarily focus on biomedical and policy interventions, while the roles of moral legitimacy, faith-based communication, and governance of care in reducing health inequalities remain underexplored.

RESEARCH QUESTIONS

How does pastoral health communication contribute to stunting prevention and the reduction of health inequalities in rural communities?

METHODS

This study employed a qualitative ethnographic case study in Ngusikan Village, Jombang Regency, East Java. Data were collected from February to May 2025 through in-depth interviews, participant observation, focus group discussions, and document analysis. Thirteen informants, including health workers, posyandu cadres, religious leaders, and mothers of young children, were selected purposively. Data were analysed thematically using Foucault's concepts of pastoral power and governance of care, while credibility was ensured through triangulation and member checking.

RESULTS AND DISCUSSION

The findings indicate that the reduction of stunting in Ngusikan Village is not solely the outcome of biomedical interventions but also the result of a communication system rooted in trust, faith, and collective responsibility. Health communication functions as a social process through which medical knowledge is translated into locally meaningful values, enabling families to participate actively in child health programs. This process forms what this study conceptualises as pastoral health communication, a model that integrates moral guidance, collaborative care, and digital engagement to support health equity in rural communities.

Pastoral Health Communication and Moral Legitimacy

A central finding of this study is that health messages become more effective when they are communicated through moral and religious values familiar to the community. Midwives, nutritionists, posyandu cadres, PLKB officers, religious leaders, and mothers collectively participate in translating biomedical recommendations into ethical responsibilities. Expressions such as "a child is God's entrusted gift" transform nutrition, sanitation, and child-care practices into moral obligations rather than technical requirements. As a result, health advice gains legitimacy because it is aligned with local beliefs and everyday experiences.

This process reflects Foucault's notion of pastoral power, where influence is exercised through care, guidance, and trust rather than coercion. Religious leaders reinforce health messages through sermons and informal counselling, while cadres provide continuous assistance during posyandu activities and household visits. Consequently, health communication becomes an ethical dialogue that encourages voluntary participation and strengthens community commitment to child well-being.

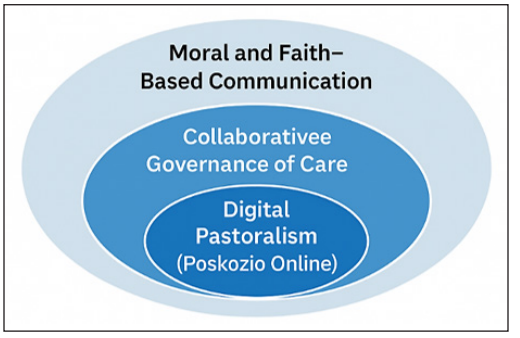

Figure 1. Pastoral health communication in Ngusikan (Governance of care model)

Figure 1 presents the Pastoral Health Communication Model identified in Ngusikan. The model demonstrates how moral and faith-based communication provides the foundation for collective action by linking biomedical knowledge with local values and social trust.

Governance of Care and Community Participation

The findings further reveal that health governance in Ngusikan operates through collaborative relationships among health workers, cadres, religious leaders, and mothers. Rather than relying on hierarchical authority, health programs are implemented through dialogue, mutual assistance, and shared responsibility. This arrangement forms a governance of care in which authority is distributed across multiple actors who contribute different forms of knowledge and support.

Posyandu cadres play a strategic role as intermediaries between formal health institutions and households. Their close relationships with local families enable them to communicate health information in accessible ways and provide personalised assistance. Likewise, religious leaders contribute moral legitimacy, while health professionals provide technical expertise. Through these interactions, scientific knowledge is adapted to local realities, increasing community participation and sustaining health programs despite limited resources.

The governance-of-care model demonstrates that successful health interventions depend not only on institutional capacity but also on social trust and collective solidarity. In this context, participation emerges from relationships of care rather than bureaucratic enforcement, allowing communities to become active agents in health promotion.

Digital Pastoralism and Care as Power

Another significant finding concerns the role of digital technology in extending community-based care. The introduction of Poskozio Online and WhatsApp-based communication

has expanded access to health information while maintaining the relational character of communication. Mothers regularly receive nutritional advice, reminders, and emotional support from cadres and health workers, often accompanied by prayers and encouraging messages.

This study conceptualises this phenomenon as digital pastoralism, where care and guidance are extended into digital spaces. Monitoring activities are interpreted not as surveillance but as expressions of concern and solidarity. Digital communication therefore strengthens community engagement while supporting accountability and continuity of care.

The integration of moral communication, collaborative governance, and digital pastoralism is synthesised in the "Care as Power" Pyramid shown in Figure 2.

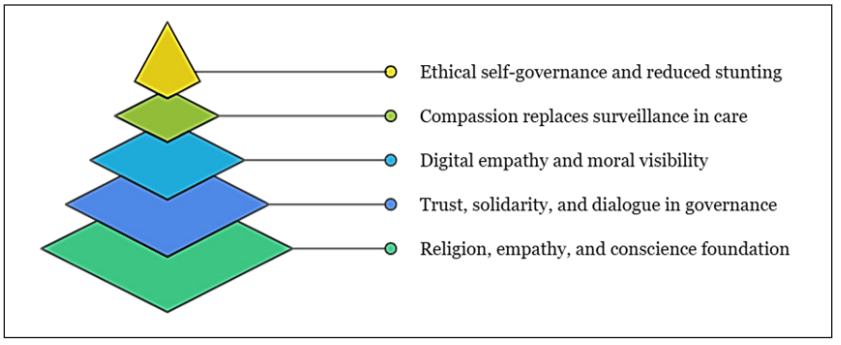

Figure 2. Care as power pyramid – Integrative model of governance of care

The pyramid illustrates how moral legitimacy forms the foundation of health communication, collaborative governance strengthens participation, and digital pastoralism extends care through technology. Together, these dimensions create a form of power rooted in empathy, trust, and collective responsibility. Rather than operating through sanctions or control, power functions through relationships of care that encourage self-regulation and community engagement.

The findings suggest that pastoral health communication contributes to reducing health inequalities by improving access to health information, strengthening social support networks, and increasing participation among rural families. The study therefore extends Foucault's concept of pastoral power into the field of rural health communication and proposes a governance-of-care framework that integrates moral legitimacy, collaborative participation, and digital engagement as mechanisms for promoting health equity.

CONCLUSION

This study shows that stunting reduction in Ngusikan Village is supported not only by biomedical interventions but also by pastoral health communication rooted in care, trust,

and faith. Health messages gain legitimacy when they are translated into local moral values and reinforced through collaboration among health workers, community volunteers, religious leaders, and mothers. The findings identify a governance-of-care model that integrates moral communication, collaborative participation, and digital pastoralism into what this study conceptualises as "Care as Power." This model demonstrates that health inequalities can be reduced when health communication is grounded in empathy, social trust, and collective responsibility. The study contributes to the development of a culturally responsive framework for community-based health promotion in rural settings.

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