Maternal Attitudes Toward Stunting: A Study During Pregnancy and Early Childhood Periods

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ABSTRACT: Stunting is a chronic nutritional problem among children under five, caused by prolonged malnutrition and recurrent infections, particularly during the first 1,000 days of life. Despite government programs such as supplementary feeding, stunting prevalence remains high. This study aims to understand the attitudes of high-risk pregnant women and mothers with stunted children. The data collection procedures and research approach have been clarified by specifying the qualitative case study design and the use of semi-structured interviews, observations, and document analysis. The participants included high-risk pregnant women in their first to third trimesters and mothers with children aged 0–5 years diagnosed with stunting. Participants were recruited after obtaining research approval from the faculty and relevant institutions. Eligible participants were identified and contacted through community health centers (Puskesmas) in accordance with the predefined inclusion criteria. The findings indicate that the success of stunting prevention in pregnant women and stunting management in mothers with young children is influenced by nutritional knowledge, positive maternal attitudes, and support from family, community health workers, and the government. Pregnant women emphasized prevention, while mothers with stunted children focused on improving their children's condition. Based on the Theory of Planned Behavior, positive attitudes and behavioral control among mothers are key to forming healthy behaviors. Multi-stakeholder collaboration through nutrition education and support starting from pregnancy is crucial to reducing stunting.

INTRODUCTION

Stunting is a chronic nutritional problem that can begin during pregnancy and continue into early childhood (under-five children). Stunting is related to height-for-age index (HAZ) with a cutoff point (Z-score) < -2 (Ministry of Health, 2017). It is a chronic nutritional condition that can be identified from pregnancy through the under-five period, caused by chronic malnutrition, resulting in repeated infections, especially during the first 1,000 days of life (from conception to 23 months of age) (Ministry of Health of the Republic of Indonesia, 2018). Currently, the prevalence of stunting is still relatively high. According to the Indonesian Ministry of Health through the Health Development Policy Agency (BKPK), the official results of the Indonesian Nutritional Status Survey (SSGI) in 2024 showed a stunting rate of 19.8%, a decrease of 0.3% from the previous year, which was 21.3%. Although this decrease is positive, the target for 2025 is to reach 18%.

Stunting is a national issue that has long-term impacts on the quality of human resources, making it a priority for the Indonesian government. Efforts to address the problem of stunting are carried out in a multi-sectoral manner, ranging from implementing healthy lifestyles for pregnant women and young children to supplementary feeding programs (PMT) (Amir et al., 2023; Suhanda et al., 2022). However, the prevalence of stunting has not shown significant decline, indicating that the problem is not only influenced by biological factors or food availability but is also closely related to maternal behavior and psychological conditions in child care.

Several maternal factors are associated with stunting in children, including maternal education level (Amaha & Woldeamanuel, 2021; Chirande et al., 2015; Berhe et al., 2019; Tafesse et al., 2021). The other risk factors include anemia, chronic energy deficiency (CED), short interpregnancy intervals, and maternal age <21 or >35 years. Adequate nutrition before and during pregnancy is crucial for fetal health and stunting prevention (Arsin et al., 2020; Gokhale et al., 2021; Suriati & Farisni, 2022; Ruaida & Soumokil, 2018). Maternal knowledge about nutrition and health (Bukusuba et al., 2017), as well as suboptimal feeding practices during pregnancy and early childhood (Yazew, 2022; Shaka et al., 2020), also contribute to stunting risk.

Besides the biological factors, pregnant mothers' attitudes toward nutrition and health play an important role in preventing stunting. Attitudes reflect the positive or negative evaluations of mothers regarding nutritional fulfillment during pregnancy. Mothers with positive attitudes tend to understand that consuming nutritious food, taking supplements, and routinely attending health check-up support fetal growth and prevent the risk of low birth weight. Rimawati et al. (2018) showed that efforts to prevent anemia in pregnant women cannot rely solely on iron (Fe) supplements but need to be accompanied by consumption of nutrient-rich additional foods. This indicates that mothers who understand the importance of combining iron supplements with nutritious intake demonstrate a positive attitude in maintaining health.

Conversely, mothers who still hold negative attitudes due to myths or food taboos show less healthy practices. Magfirah et al. (2024) found that pregnant women's attitudes toward food are still negative, characterized by limited dietary diversity and avoidance of iron-rich sources due to myths, resulting in many mothers avoiding important nutrients. Irregular eating habits and consumption of coffee or tea further exacerbate the situation. Consequently, the prevalence of iron deficiency among pregnant women remains high, reaching 78%. Examples include prohibitions on consuming fish, believed to cause a "fishy" baby, or eggs, thought to make delivery difficult, which actually increase the risk of chronic malnutrition (Putriana et al., 2020; Hartiningrum, 2020). Therefore, pregnant women's attitudes toward balanced nutrition are a key determinant that influences actual behaviors in maintaining their own health and that of the fetus.

Reducing stunting prevalence is not solely influenced by biological factors and nutritional adequacy but is also constrained by psychosocial factors faced by mothers with stunted children. In a study in Barrang Lompo, Makassar, more than half of the mothers reported low self-efficacy, particularly related to the quality and quantity of complementary feeding (MP-ASI) and responsive feeding practices, with stunting prevalence recorded at 31% (Putri et al., 2023).

For mothers with stunted children, intervention cannot rely solely on Supplementary Feeding Programs (PMT) or nutrition education. From a health psychology perspective, the success of interventions is also determined by the mother's ability to handle the child's refusal of food, for example by persuading them or modifying food presentation. This indicates that maternal behavior is influenced by beliefs, perceived self-control, and social norms. In the context of health psychology, mothers' behaviors related to stunting management are shaped by how they respond to their children. This emphasizes that the availability of nutrients alone is not enough, maternal caregiving skills are also essential.

Attitudes reflect the mother's positive or negative evaluation of child-rearing. Habineza et al. (2025) found that mothers' attitudes toward child malnutrition are still mixed. Many mothers

understand the importance of exclusive breastfeeding, the benefits of breastfeeding, hygiene, and vaccination. However, knowledge gaps remain, such as confusion regarding complementary feeding (MPASI), negative perceptions about breastfeeding beyond two years, and doubts about the relationship between hygiene, vaccination, and child nutrition. Thus, even with positive understanding, incorrect practices may still risk hindering malnutrition prevention.

Sarker et al. (2023) reported that nearly half of mothers misperceived their child's nutritional status, and 37% underestimated stunting conditions. These errors often occur because the child appears active or feels light when carried. Many Indonesians still believe that short stature in children is often inherited from parents, so if there is a family history of short stature, the child is expected to be short as well (Yuningsih et al., 2024; Saputri & Tumangger, 2019). If stunting is considered hereditary and perceived as unavoidable, mothers may accept their child's short stature as fate (Saputri & Tumangger, 2019). This attitude is considered negative because such misconceptions reduce maternal awareness of nutritional problems and hinder stunting prevention. This study revealed that limited information about infant and child feeding is one of the barriers to implementing proper practices. For example, some mothers consider colostrum to be dirty or harmful, leading them to discard it instead of giving it to the newborn immediately.

Ikasari et al. (2025) explained that mothers demonstrate positive attitudes through accurate understanding, such as being able to recognize stunting symptoms according to medical criteria (low weight, small body size, developmental delays, frequent illness) and taking preventive measures by providing nutritious food, vitamins, and regularly attending community health posts (posyandu). They also show proactivity by seeking assistance from healthcare professionals. However, there are also negative attitudes that pose barriers. Some mothers believe stunting is caused by genetic factors (short stature inheritance) or local beliefs, such as "buyu," which are thought to deplete the child's nutrition. In addition, some mothers have inaccurate perceptions of stunting symptoms, associating them only with small body size and low weight, without understanding height-for-age indicators.

Rationale of the Study

Stunting remains a significant public health problem in Indonesia, with long-term consequences for children's physical and cognitive development. While various nutritional interventions have been implemented, stunting prevalence remains high, indicating that nutritional factors alone are insufficient to address the problem. Maternal attitudes during pregnancy and early childhood play a crucial role in child growth, yet this aspect has received limited attention in qualitative research. Therefore, a deeper exploration of maternal attitudes toward stunting is necessary to better understand both internal and external factors contributing to stunting.

Purpose of the Study

The purpose of this study is to explore the attitudes of pregnant women and mothers of children with stunting toward stunting during pregnancy and early childhood periods.

METHODS

Design

This study employs a qualitative case study approach to explore maternal attitudes toward stunting among pregnant women and mothers of children with stunting. The Theory of Planned Behavior was used as a guiding framework to inform the exploration of attitudes and influencing factors, while maintaining an open and inductive analytical process.

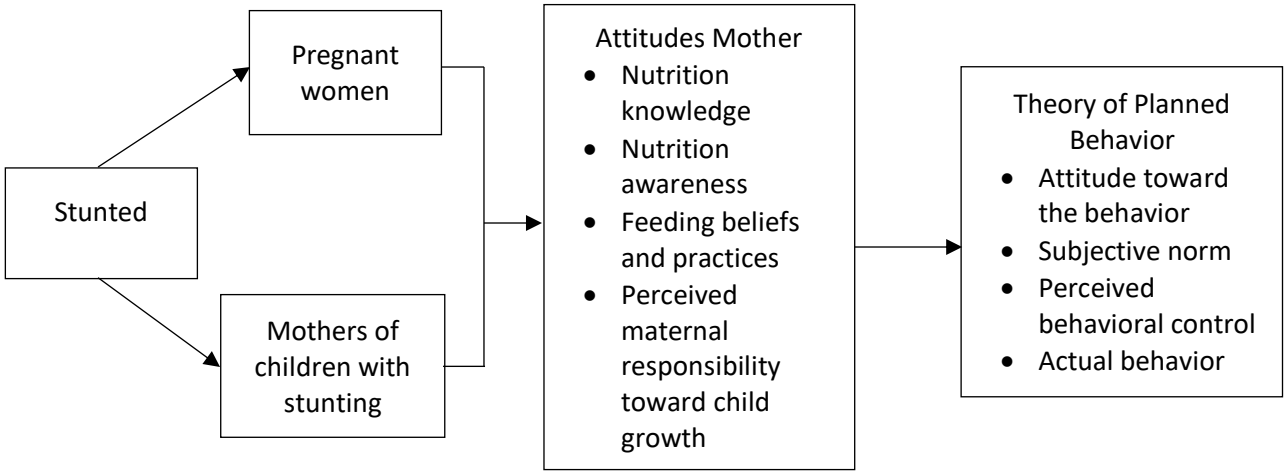

Figure 1. Design Diagram

Participants

This study involved eight participants, consisting of four high-risk pregnant women in their first to third trimesters and four mothers with children aged 0–5 years diagnosed with stunting, all residing in Salatiga City, Indonesia. Participant data were obtained through coordination with local community health centres to ensure accuracy and validity.

Table 1. Mother participants with Stunted Children

Description	Participant I	Participant D	Participant N	Participant H
Age	41 years	22 years	32 years	32 years
Education	Elementary school	Senior High School	Vocational High School	Vocational High School
Occupation	Housewife	Housewife and students	Housewife	Housewife
Number of Children	4 (the youngest child is stunted)	1 (stunted child)	3 (the youngest child is stunted)	3 (the youngest child is stunted)
Age of Stunted Child	4/5 months	2 years	8 months	1 years

Table 2. High-Risk Pregnant Women Participants

Description	Participant S	Participant D	Participant R	Participant A
Age	23 years	43 years	42 years	37 years
Education	Junior High School	Bachelor's Degree	Elementary School	Vocational High School
Occupation	Private Sector	Entrepreneur	Housewife	Housewife
Hight- Risk Factors	Chronic Energy Deficiency (CED) / Upper Arm Circumference (MUAC)	Anemia	Maternal age and birth spacing	Maternal age
Number of children	Children	3 children	2 children	3 children

Data Collection Instruments

Data were collected through in-depth interviews, observations, and document review. Semi-structured interviews were used to explore participants' responses flexibly, anecdotal observations recorded behaviors naturally, and document review included maternal and child health (KIA) books, antenatal care (ANC) records, and community health centre data to validate the mothers' conditions and child development.

Data Analysis

The data analysis process involved several stages, including data processing, in-depth reading of the entire dataset, coding the data, applying the coding process, identifying emerging themes, and interpreting the meaning of the coded data (Creswell, 2014).

RESULTS AND DISCUSSION

Results

High-Risk Pregnant Women Background

The findings of this study indicate that high-risk pregnant women come from diverse educational backgrounds, occupations, and pregnancy experiences. The participants had educational levels ranging from elementary school to higher education and occupied different social roles, including housewives, private-sector employees, and self-employed entrepreneurs. These findings suggest that high-risk pregnancies and the potential for stunting are not confined to specific social groups but can occur across various segments of society.

> *"...Junior high school. I didn't quite finish senior high school*." (S160225P1, 8)*. "Private sector..."(*S160225P1, 13)
> *"...Bachelor's degree in Psychology at UKSW..."* (D180225P1, 42).
> *"...It's a laundry business..."* (D180225P1, 44)
> *"...My last level of education was elementary school..."* (R200225P1, 89).
> *"...Homemaker."* (R200225P1, 91)
> *"...Senior high school..."* (A230225P1, 35).
> *"...Homemaker..."* (A230225P1, 93)

The results of the study indicate that all participants were pregnant women with varying risk conditions that have the potential to affect the quality of pregnancy and fetal growth and development. These risks included chronic energy deficiency (CED), anemia, advanced maternal age, long interpregnancy intervals, and a history of recurrent miscarriage. Such conditions shaped the mothers' early awareness of the importance of maintaining a healthy pregnancy and encouraged adjustments in health-related behaviors, particularly in meeting nutritional needs.

> *"…It turned out that my MUAC was low… I was told to gain weight so that my MUAC would increase…"* (S160225P1, 31–35).
> *"…Yes, anemia…"* (D180225P1, 56).
> *"…The second one was 20 years later…"* (R200225P1, 102).
> *"…I often had miscarriages… frequent curettage. Twice…"* (A230225P1, 109–112).

Beyond medical factors, this study also highlights the personality tendencies and decision-making patterns of pregnant women in dealing with high-risk pregnancies. The participants demonstrated a rational attitude toward pregnancy-related myths and prioritized logical reasoning, showed an optimistic and pragmatic outlook in facing economic constraints, adopted a rational and flexible approach to meeting nutritional needs by considering real-world conditions.

> *"...As long as it is still reasonable, it does have an effect, but if it is already unreasonable, then we just go along with it..."* (S160225P1, 427–428).
> *"...It is still being made an effort… as much as we are able to..."* (D180225P1, 941–946).
> *"...Um (thinking), I just use logic. If it still contains nutrients, then it should still be eaten, right?..."* (R200225P1, 449–450).
> *"...Um, yes, I still try to meet the nutritional needs, ma'am. I don't really pay much attention to what other people say..."* (A230225P1, 616–620).

Attitude

The study results reveal unique dynamics among each participant. All participants demonstrated a strong sense of responsibility toward their own health and the health of the fetus. Pregnancy was perceived as a condition that requires greater attention, particularly in meeting nutritional needs, as mothers are no longer responsible solely for themselves. Participants S and D explicitly recognized the change in roles and the consequences of pregnancy on eating behaviors.

> *"[...]that's why we need to understand nutrition, because we are not alone anymore [...]"* (S220225P2, 414–415)
> *"[...] Because we are not alone anymore, miss. When we are alone, we can eat whatever we want. But in this condition, there are two of us, so we also think about the baby inside. I am afraid that if I eat carelessly or eat various kinds of food without consideration, something might happen [...]"* (D180225P1, 180–187)

Participants R and A emphasized that a child's growth process begins in the womb; therefore, maternal nutrition fulfillment is viewed as the primary foundation.

> *"...Well, umm […] it starts from inside the womb, so the structure and formation are shaped there. That is why the selection of nutrition also has to be maintained, miss..."* (R200225P1, 863–864)
> *"...Yes, the nutrition has to be fulfilled first for the baby..."* (A230225P1, 723)

Beyond responsibility, optimism emerged as a key driver of health-related behaviors. Participants S and D perceived stunting not as a fatalistic condition, but as one that can be prevented through effort.

> *"...In my opinion […] it is important because destiny can be changed, ma'am. Destiny can be changed [...]"* (S160225P1, 365–367)
> *"...It's okay, umm, it depends, ma'am things like that depend on whether we provide nutritious food; over time, the child's growth and development will improve. It's not just about prayer, ma'am..."* (D180225P1, 356–359)

This optimism functioned as a form of psychological capital that strengthened the consistency of health-related behaviors, even when mothers faced challenges.

Pregnant women's understanding of stunting showed variation. Participant S had a relatively limited understanding, although she had recognized the role of nutrition.

> *"...I haven't really learned much about stunting yet..."* (S160225P1, 104)

In contrast, participants D, R, and A were able to associate stunting with impaired linear growth and long-term nutritional intake.

> *"...I know it from the community health worker, miss. First, it's about undernutrition, and second, the child's development is not the same as others [...]"* (D180225P1, 143–146)
> *"...The reason is that it starts from the beginning of the formation process, from nutritious food. You can't just give whatever food and expect it to turn out well, right?..."* (R260225P2, 964–967)
> *"...Yes, I know. It's not about body weight, right? It's about height height that is below what it should be for the child's age..."* (A230225P1, 282–283)

Subjective Norms

Nevertheless, pregnant women's medical understanding does not stand alone. Cultural perceptions, myths, and social norms continue to influence behavior, particularly in relation to food taboos and traditional practices.

> *"...It's like papaya, ma'am. So I was told that I'm not allowed to eat papaya because it could damage the placenta. And also not allowed to drink coconut water because they say the baby would be born dirty. But that doesn't make sense [...]"* (S160225P1, 562–566)
> *"...Sometimes I just look at it a little and feel like having ice, ma'am. Because sometimes there are people who say you shouldn't drink iced drinks from early pregnancy until later on, because they say the baby will become big..."* (D180225P1, 801–805)
> *"[...] Sometimes people say that consuming sea fish can increase cholesterol. But we also think about the baby as well, right, ma'am..."* (R200225P1, 455–458)

Social pressure also emerged in the form of comments, fear of being judged, and the obligation to maintain family harmony.

> *"[....] But here, everything is considered permissible, right? My mother-in-law once said, 'As long as it goes into the body, just eat it. There's no need to believe in those kinds of things..."* (S160225P1, 600–603)
> *"[...] Since childhood, we have been indoctrinated like that. Even if we want to violate it, we have to think carefully first we can't just break it outright. There is still a sense of fear..."* (R260225P2, 694–696)
> *"...I'm more afraid of what my parents will say, so in the end I just follow along..."* (A230225P1)

Nevertheless, all participants demonstrated a process of negotiation between traditional norms and medical knowledge. Trust in healthcare professionals emerged as a key balancing factor in decision-making.

> *"...I personally rely more on doctors. I trust them more because, well, they know what the nutritional needs of pregnant women and their babies are like [...]"* (S160225P1, 307–310)
> *"...If we follow what the doctor has already explained this and that we are supposed to follow it, right?..."* (D180225P1, 516–518)
> *"[...] in my opinion, doctors' advice is indeed the best. That's because it is based on research. Community beliefs, on the other hand, are sometimes still limited and based on guesswork..."* (R200225P1, 555–558)
> *"...When it comes to factual information, it comes from the community health center and the posyandu health cadres..."* (A230225P1, 1368–1369)

On the other hand, the participants also received support from both their families and other social environments.

> *"...It really has a big influence, ma'am a very big one. Because during pregnancy, you can't do everything on your own. There has to be assistance from someone..."* (S160225P1, 827–829)
>
> *"...From their perspective, they are supportive, ma'am. For example, when I go for a check-up, sometimes my husband asks about the results why my hemoglobin level has dropped, how it could decrease, and what the doctor's recommendations are [...]."* (D180225P1, 666–670)
>
> *"...Usually, the one who is the most attentive is my husband, ma'am like asking what I want to eat. Especially when I feel unmotivated, he reminds me..."* (R200225P1, 780–783)
>
> *"...From the family, they are able to provide what is needed, ma'am for example, when we need more nutrition than usual..."* (A230225P1, 829–831)

Perceived Environmental Behavioral

Perceptions of the environment influenced the extent to which mothers felt capable of engaging in stunting prevention behaviors. The main challenges stemmed from physical conditions, economic constraints, as well as experiences related to breastfeeding and supplement consumption.

> *"...Because right now I'm also in a condition where I can't really eat much, miss. If I don't eat, then what can I do? So I just eat whatever I'm able to eat..."* (S160225P1, 112–115)

Participant D faced barriers in breast milk production despite having made various efforts.

> *"[...] when I had my first child, my breast milk didn't come out. I wanted to be like other mothers. Even though I already drank herbal remedies, took this and that, and was told to eat certain foods, it still didn't come out, miss [...]"* (D180225P1, 215–219)

Economic factors also influenced mothers' perceived control.

> *"...It also depends on the money, right, miss?..."* (R200225P1, 989)
>
> *"...Difficulties? Not really when it comes to shopping. It's just that financially, there are some limitations..."* (A230225P1, 1308–1310)

The availability of food in their surrounding environment was relatively good and did not constitute a barrier to meeting daily consumption needs.

> *"...Everything is close by from here..."* (S220225P2, 599)
>
> *"...Yes, here everything is easily accessible, miss. It also depends on the money, right?..." (laughing)* (R200225P1, 988)
>
> *"...Yes, I usually just order food around here..."* (A030325P2, 371)

Intention of Pregnant Women

All participants demonstrated a strong intention to maintain health and prevent stunting. This intention was driven by internal motivation, personal commitment, and a non-resigned attitude toward their circumstances.

> *"...Eating patterns? (pauses, thinking) um… for me, maybe smaller portions but more frequent meals. Maybe, yes. Because it's still about the future, right?..."* (S160225P1, 100–102)
> *"...Because we are making an effort, not because of other factors, right?..."* (D180225P1, 749–750)
> *"...We try our best as well, right?..."* (laughing) (R200225P1, 591)
> *"[...] but as humans we are encouraged to make efforts, right? So we must try to ensure that nutritional needs are fulfilled. Even if the destiny turns out that way, we surrender only after making our best effort first..."* (A230225P1, 717–721)

Behavior of Pregnant Women

Maternal behavior during pregnancy was reflected in adaptive eating patterns, health information-seeking behavior, adherence to medical recommendations, and emotional responses throughout pregnancy. Eating patterns were adjusted to the mother's physical condition and comfort.

> *"...I tend to crave ice, ma'am. I keep buying ice. It's like I just enjoy ice, so now I have to drink iced beverages all the time..."* (S160225P1, 524–525)
> *"...But with this fourth one, I don't eat that much, ma'am. I don't really snack either, ma'am. So I feel lazy, ma'am. Snacking like that is actually necessary, right, ma'am, even though it should be done..."* (D180225P1, 924–927)
> *"[...] Even during breastfeeding it was the same, ma'am if it was three times a day, then that was enough for me. I really can't increase it..."* (R200225P1, 920–923)
> *"[...] So it was indeed more frequentfor example, usually three times a day, but during pregnancy it could be four to five times, ma'am [...]"* (A230225P1, 581–585)

Pregnant women also actively seek information through digital media and healthcare professionals.

> *"...From TikTok, I've never really studied it before [....]"* (S160225P1, 67–68)
> *"...I look it up on YouTube or Google, miss, to check whether stunting is really like this. [...]. But for me, I'm more open to looking it up on Google or similar platforms to really find out what stunting actually is..."* (D180225P1, 979–983)
> *"...Usually, before eating, I look it up first, I Google it what are the benefits of this food..."* (R260225P2, 1098–1100)
> *"[...]Then, for example, during antenatal classes or when we have consultations, we ask a lot of questions..."* (A230225P1, 532–533)

However, this behavior was accompanied by emotional responses in the form of anxiety and emotional exhaustion due to social pressure and conflicting information.

> *"[...] I'm afraid something might happen, you know. After taking care of the pregnancy for nine months, I'm scared if something goes wrong later. That's what I'm most afraid of..."* (S160225P1, 80–84).
> *"...It ended up being confusing, like people saying, 'What exactly is the Hb level? If the blood pressure doesn't go up or down, then the Hb level can easily fluctuate,' things like that. It makes you wonder what the doctor is*

really thinking. In the end, it just makes you feel uncomfortable..." (D180225P1, 111–115).
"[...] people used to say, 'A pregnant woman is not allowed to eat certain foods because it could damage the placenta,' that's what parents used to say. 'Why?' 'Because it's not proper, it's taboo..." (A030325P2, 851–859).

Mothers of Children With Stunting Background

The occurrence of stunting in children is closely associated with early life, particularly during the first 1,000 days, which represent the most vulnerable period for growth disturbances. The age at which stunting was first detected among the participants' children varied, ranging from 5 months to 2 years.

"…Maybe at around 5 months or 6 months…" (I010225P1, 21).
"…It was only at around 2 years old…" (D160225P1, 33–34).
"…At 8 months" (N170225P1, 35)
"…It initially started at around 1 year old; the weight did not increase for three months…" (H250225P1, 48–49).

Regarding educational background, the majority of participants had only completed formal schooling and had not continued to higher education.

"…Only elementary school. I did not want to continue school at that time…" (I010225P1, 15–16).
"…STIAMA. (D160225P1, 13) and "Management…" (D160225P1, 15).
"…SMK PGRI 1. Fashion design…" (N170225P1, 23).
"…SMK 1…" (H250225P1, 28)

From a sociodemographic perspective, the majority of participants were in the early adulthood age range (20–40 years), and most worked as housewives. Which indicates the presence of additional challenges in balancing time between academic responsibilities and child-rearing roles.

"…I am a housewife…" (I010225P1, 15)
"…Management, miss…" (D160225P1, 15)
"…A housewife, miss…" (N170225P1, 17)
"…A housewife, miss..." (H250225P1, 30)

This study also reveals variations in personality traits and social adaptation strategies in responding to comments and environmental pressures related to the caregiving of children with stunting.

"...Let people say whatever they want… what matters is that I keep trying so that my child will no longer be stunted..." (I060225P2, 443–445).
"...I just observe, I don't complain or argue..." (D160225P1, 392–396).
"...If the advice is good, then I will follow it..." (N170225P1, 515–518).
"...If I see that someone's way is good, then I will just imitate it..." (H030325P2, 470–473).

Mothers' Attitudes toward Children with Stunting

All participants demonstrated generally positive attitudes toward their children's condition, reflected in a strong sense of maternal responsibility, including attention to food hygiene, moral commitment to child care, continued provision of nutritious food despite eating difficulties, and consistency between nutritional knowledge and practice by avoiding processed foods.

> *"[...] We really pay attention to the food given to the child; it must be truly hygienic. It does not necessarily have to be nutritious, but it must be clean..."* (I010225P1, 924–926).
> "...*It's impossible, for a mother to be negligent toward her own child like that..."* (D160225P1, 184–185).
> *"...Yes, providing nutritious food is important, ma'am. You wouldn't possibly feed a child just rice with salt, right? That wouldn't make sense, ma'am. And how could the child develop properly if that were the case?...*" (N170225P1, 777–780).
> *"...Foods like sausages and nuggets are not nutritious. I never give those to my child. It's better to give eggs cooked with soy sauce. I also give tempeh instead..."* (H250225P1, 432–434).

Optimism also emerged as an important component of maternal attitudes, reflected in prayer and effort. Even when a child's development is slow, mothers tend to remain optimistic.

> "*We keep praying and making efforts, right [...].*" (I060225P1, 851–852).
> "*[...] How should I say this[..] children with stunting can still grow because their growth process is basically the same as other children, just maybe a bit different, a little slower...*" (D160225P1, 551–555).
> "...*Yes, yes, if in the next month there is an increase, I'm already happy, Miss Eating has become easier now...*" (N170225P1, 297–298).
> "...*But now, if the child is already around three years old, the minimum increase is about 200 grams. That's already acceptable. We just need to catch up gradually...*" (H250225P1, 108–110).

A mother's acceptance of her child's stunting condition varies. Some participants accept having a stunted child without perceiving it as a burden at times, acceptance is accompanied by negative emotions, followed by gradual acceptance while continuing to make efforts**.**

> *"…It's not a burden, miss. Everything should be made happy. It turns out everything has its own homework. It's more like figuring out how to deal with it, that's all. It's not a burden. […]* (I010225P1, 770–774)
> *"...I do accept it,, but there is also a sense of hurt, like wondering why my child is like this..."* (D220225P2, 439–440)
> *"...Yes, well, whatever it is […] the important thing is to keep trying and to be sincere in going through it. We can only accept it, but changing it can be done slowly, right..."* (N170225P1, 292–294)
> *"...Yes, I really didn't expect. At first, I was also shocked [...]*
> (H030325P2, 11–13)

Participants exhibited diverse levels of understanding and perceptions of stunting, primarily shaped by personal experience, information seeking, and guidance from healthcare professionals. This understanding influenced their attitudes toward their child's condition, including nutritional awareness and preventive and management efforts.

> *"...I ended up browsing on my own, about what stunting actually is..."* (I010225P1, 320–322)
> *"...The child's weight did not increase for three months, and the weight was below the standard, below normal..."* (D160225P1, 64–65)
> *"...Especially the protein intake, which needs to be doubled,? It really needs to be doubled..."* (N170225P1, 249–250)

"...Yes, I know. From there, I learned more after being told about stunting the height is insufficient and the weight is also lacking. According to age standards, it should be at a certain level, but it hasn't reached that yet..." (H250225P1, 84–87)

Subjective Norms

Mothers' subjective norms are shaped by cultural beliefs, social judgments, and medical authority. Several participants were sometimes influenced by traditional community beliefs, such as the use of herbal or traditional remedies to increase children's appetite, family practices that are still maintained, and community perceptions that normalize small body size as a hereditary factor.

"[...] . But in the past, in Cekoi, there was something called rotten tempeh. You could find it at places that sell herbal medicine [...]
(1060225P2, 741–745)

"[...] People said that giving children tea or coffee could make their heart healthier. Some people even said that if a child was sick, you could try giving them coffee so they would recover faster [...]" (D160225P1, 298–302)

"...Back then it was like that, just like the mother or the father. If the father, when he was little, was treated that way too." (N240225P2, 583–584)

"...The grandmother sometimes gives the child tea, ma'am. She says it's okay, just a little. It's common, right, [...]" H250225P1, 591-594).

Social pressure is experienced differently by each mother, such as pressure from the social environment.

"...Some people are like that, but there are also those who say, 'What's wrong with you, why isn't your child growing big?..." (I010225P1, 253-254)

"...Yes, if someone says something like that, I just stay silent, ma'am. Because if I respond, I'm afraid it might come across as showing off or being arrogant in society..." (D160225P1, 217-220)

"...My reaction is just to stay silent. I'm not brave enough to speak up because I'm afraid people will think I'm pretending to know everything or something like that..." (H030325P2, 549-551)

"...Yes, sometimes it's even the community health worker [...] criticizing like that, ma'am (in a slightly annoyed tone)..." (N170225P1, 345-346)

Although cultural norms remain strong, all participants demonstrated trust in healthcare professionals.

"...I still choose vitamins or medicine from the doctor. It's uncertain if traditional remedies are suitable, you know. [...]" (1060225P2, 761–764)

"...So, you really have to go to the doctor first, ma'am, to know more completely and in detail what it's like." (D160225P1, 716–717)

"...The child's doctor immediately said that tea is not allowed. For example, if the child is already accustomed to it, it should be reduced gradually, just slowly like that. That's what the pediatrician said, [...]"
(N170225P1, 469–475)

"...As for the schedule, if we're instructed by the community health center, then the food is given little by little, that's fine, as long as it's consistent. In the past, the child really had difficulty eating, ma'am." (H250225P1, 138–141)

Social support for mothers of children with stunting comes from various sources, including family, health services, and the community, and involves emotional, practical, and informational assistance. However, the quality and intensity of support vary, particularly from husbands as key family figures.

> *"...The father never really pays attention. At most, I just tell him, 'This younger child is still affected by stunting.' He never takes care of the stunting issue [...]"* (I060225P2, 639–641)
> *"He pays very little attentio. So I end up paying attention to it myself..."* (D160225P1, 360–361)
> *"...Support from my husband, ya. Well, it's just my husband. There's no one else, right..."* (N170225P1, 821–822)
> *"...Well, my husband supports me. If I ask him to go to the market and buy something, for example buying fish, he supports it. Basically, he's supportive..."* (H250225P1, 491–493)

Perceived Environmental Behavioral Factors

The study results indicate that mothers have developed an awareness of the importance of nutrition for children and during pregnancy. However, the implementation of adequate nutritional intake continues to face various barriers, including economic limitations, children's eating behavior, and time constraints due to work.

> *"...Nutritious food is the cheapest option, like buying just enough, you know, miss… but when money is tight, the important thing is that the child still gets some nutrition, for example by just giving eggs..."* (I010225P1, 862–866)
> *"...Vegetables are rarely given, miss..."* (D160225P1, 99)
> *"...I feel confused, miss, because I want to provide proper nutrition, but the child doesn't want to eat it..."* (D160225P1, 72–73)
> *"...Nowadays, children tend to snack all the time, eating chips and similar foods, which makes it even more difficult. So now the snacks are usually things like bread..."* (N240225P2, 56–59)
> *"...In the past, the child only liked shredded meat. But the portion was small..."* (H250225P1, 77–78)

The study found that government assistance programs, particularly the Supplementary Feeding Program (PMT), were perceived as quite helpful for families with stunted children. However, the effectiveness of the assistance was still influenced by the child's eating behavior.

> *"...Every morning there was PMT. It was for 90 days. Then it was extended again, miss. At first, it was given in raw form..."* (N170225P1, 118–120)
> *"...Actually, the government has made many efforts. it's just that sometimes the child has difficulty eating..."* (H250225P1, 269–274)

Access to nutritious food ingredients varied among participants and was strongly influenced by the environmental conditions of their place of residence.

> *"...In this area, it is quite difficult to find such ingredients,… so in the end we have to look for them in the city..."* (D160225P1, 676–680)
> *"...Yes, there are vegetable vendors, but sometimes we only shop every few days. S ometimes we have to go to the market ourselves, right..."* (N170225P1, 816–817)

Mother's intention

The results of the study indicate that mothers' internal motivation serves as the primary foundation in caregiving and fulfilling the nutritional needs of children with stunting. Mothers naturally possess a strong drive to provide the best for their children, even when their knowledge and experience are limited. They demonstrate a belief that consistent efforts, accompanied by prayer and active problem-solving, can improve the child's condition.

> *"…I was really trying to find a solution on how to make my child want to eat… so that the child could gain weight how to do that, basically..."* (I060225P2, 94–98)
>
> *"…I try to provide nutritious food… and also give snacks that are high in calories..."* (D220225P2, 444–445)
>
> *"…Yes, we continue with prayer and effort. We keep praying so that the stunting will not persist. It's not possible to only pray without making any effort, right?"* (N170225P1, 790–792)
>
> *"…As long as we are willing to pursue it, we try, ma'am, to make the effort to feed our child and to provide nutritious food..."* (H250225P1, 166–168)

Mother Behavior

The results of the study indicate that mothers' feeding parenting behaviors are adaptive and flexible, adjusted to the child's condition and the family situation.

> *"...Even if the child only eats about ten spoonfuls, that's already quite good [...]"* (I010225P1, 239–244)
>
> *"...The child is selective with vegetables, but I focus more on protein first to increase body weight, right, ma'am. So vegetables are rarely given. Maybe once a week..."* (D160225P1, 102–105)
>
> *"...If eating is forced according to a schedule, it's not possible. Because sometimes after eating, when the child sees their sibling eating, they ask for food [...]"* (N170225P1, 224–227)
>
> *"...For rice, it's usually rice with eggs. Later, if at noon the child doesn't want to eat again, then I make vegetables..."* (H250225P1, 152–153)

All participants demonstrated initiative in seeking information about stunting though the internet and social media as a form of concern for their childs condition.

> *"…My child has stunting, so I searched on the internet." (I010225P1, 51–53)*
>
> *"It was from TikTok. Sometimes I search for it, or it just appears on my FYP […]* (D220225P2, 473–474)
>
> *"…Then I opened Google and realized, oh, it means being short…"* (N170225P1, 214–215)
>
> *"…So, I searched on my own about what the effects are if a child drinks tea like that…"* (H030325P2, 649–651)

Participants also experienced various emotional responses such as worry, confusion, fatigue, feeling offended, fear, and low self-esteem, which influenced their caregiving behaviors.

> *"...Yes, I felt down, miss. Why isn't the child gaining weight, staying so small. They said, 'You shouldn't be like that.' We had already met before, so why say that again? Of course, I felt hurt, miss..."* (I010225P1, 69–71)
>
> *"...Well, it doesn't really disturb me, miss, but it makes me keep thinking about it like, if the baby is like this, what will happen later?"* (D220225P2, 534–536)

"...Sometimes, as a person, I do feel annoyed, miss. But it's not like I would show it. Sometimes I feel irritated, but I just let it go. Everyone is different, miss, so there's no need to say anything..." (N170225P1, 763–767)
"...Yes, sometimes I feel insecure like that, miss..." (H250225P1, 546)

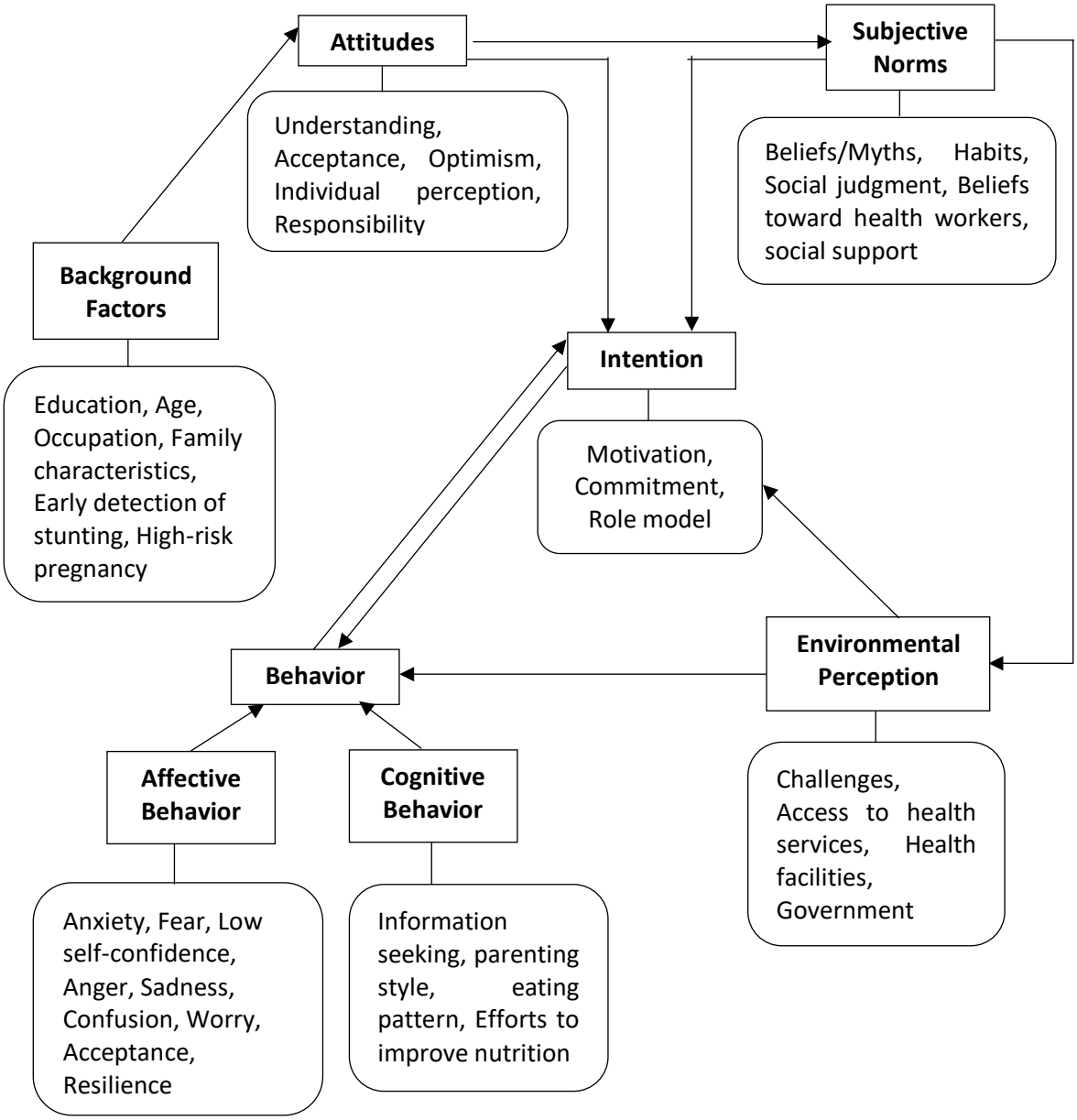

Figure 2. Results Diagram

Discussion

Background of Factors Shaping Mothers' Attitudes toward Stunting

The findings of this study indicate that mothers' attitudes toward stunting are shaped by a combination of educational, economic, health-related, and personal characteristics. Maternal education contributes to more rational attitudes toward stunting prevention, in line with the findings of Soekatri, Sandjaja, and Syauqi (2020). However, this study also reinforces the results of Guo et al. (2022), showing that formal education does not always directly correlate with children's nutritional status. Mothers with lower educational attainment may still demonstrate positive

attitudes when they have access to information from *posyandu*, community health volunteers, and media, as also reported by Faridah et al. (2024) and Haryanti et al. (2024).

From an economic perspective, this study finds that economic constraints do not necessarily lead to negative attitudes toward stunting prevention. This finding is consistent with Setiawan et al. (2018) and Wahyudi et al. (2024), who showed that mothers' ability to manage local food resources can offset limited purchasing power. Thus, economic conditions function as a supporting factor rather than the primary determinant of attitudes. In addition, mothers' health experiences, such as anemia or chronic energy deficiency, increase awareness of stunting risks. This result aligns with Azzahra et al. (2024) and supports the findings of Suen et al. (2021) that personal medical experiences contribute to the formation of health-related attitudes.

The study also reveals that mothers' personality traits and cognitive orientations influence their acceptance of health information. Mothers with a rational orientation tend to accept medical recommendations, whereas those who are strongly bound to traditional beliefs remain influenced by myths, in line with the findings of Mahmoud and Sarraf (2020) and Mandryk (2023). The range of attitudes identified ranging from responsibility and optimism to rejection of the belief that stunting is hereditary reinforces previous research indicating that mothers' attitudes are the result of multidimensional interactions (Damanik et al., 2020; Hardini & Wirjatmadi, 2024; Killion et al., 2024).

Mothers' Attitudes Toward Stunting Have Been Shown to Play an Important Role in Shaping Subjective Norms

Positive attitudes such as a sense of responsibility, optimism, acceptance, nutritional knowledge, trust in medical information, and spiritual beliefs influence how mothers evaluate and respond to social pressures and cultural norms related to stunting prevention. These findings are consistent with Albornoz et al. (2021), who emphasize that positive health attitudes facilitate the internalization of more rational norms.

This study also highlights differences in focus between pregnant women and mothers of children with stunting, whereby pregnant women emphasize prevention during pregnancy, while mothers of children with stunting place greater emphasis on nutritional fulfillment and developmental stimulation (Nafista et al., 2023). Support from fathers and *posyandu* health cadres functions as a reinforcement of subjective norms through practical, emotional, and educational support, as reported in previous studies (Tahapary et al., 2023; Wiliyanarti et al., 2022; Gupta & Khan, 2024).

Optimism serves as an adaptive coping mechanism that helps mothers interpret social pressure more positively and increases adherence to stunting prevention practices, particularly when supported by guidance from *posyandu* cadres (Trisnawati et al., 2025; Kilion et al., 2024). In addition, an attitude of acceptance enables mothers to manage social stigma without abandoning evidence-based parenting practices (Caksen et al., 2025; Juniarti et al., 2025).

Although gaps between maternal perceptions and medical understanding persist, support from fathers and *posyandu* cadres plays a crucial role in correcting nutritional misconceptions and strengthening evidence-based subjective norms (Suen et al., 2021; Hardini & Wirjatmadi, 2024). Overall, these findings reinforce the evidence that positive maternal attitudes, supported by the social environment, contribute to the formation of subjective norms that promote intentions and behaviors related to stunting prevention (Wu & Pei, 2022; Savita & Pradana, 2023; Wahyuni et al., 2024).

Subjective Norms Influence the Perception of Environmental Behavior

This study demonstrates that social pressure and environmental expectations play a significant role in shaping mothers' perceptions of family support, caregiving practices, and

acceptance of health interventions. Cultural norms, intergenerational habits, social judgments, and trust in medical authority emerge as the primary sources of subjective norms, in line with Scheffler et al. (2022) and Alfaeni et al. (2023).

Although some mothers hold positive attitudes toward stunting prevention, its implementation is often adjusted to align with prevailing environmental norms. This finding supports Ajzen's (1991) theory and the results of Haryanti et al. (2024), which indicate that subjective norms function as a filter that can either reinforce or inhibit the application of positive attitudes. Social pressure and stigma further influence mothers' evaluations of environmental support, determining whether health interventions are perceived as assistance or as a social risk (Diana et al., 2022; Santosa et al., 2024).

Trust in health professionals emerges as a form of subjective norm that strengthens evidence-based environmental perceptions, as reported by Setyobudihono and Istiqomah (2024) and Hardini and Wirjatmadi (2024). Support from husbands and *posyandu* cadres acts as an important mediating factor, whereby social support is perceived as effective when it aligns with mothers' subjective norms (Oktalia et al., 2024; Siswati et al., 2025). Overall, subjective norms not only shape perceptions of the social environment but also influence perceived behavioral control and the availability of caregiving resources (Abageda et al., 2024).

Attitudes Toward Stunting Influence Intentions

The findings of this study indicate that positive maternal attitudes encompassing a sense of responsibility, optimism, and acceptance of the child's condition play an important role in shaping intentions toward healthy behaviors. Among pregnant women, a sense of responsibility is manifested through preventive efforts, such as maintaining adequate nutritional intake and adhering to health education during pregnancy. In contrast, among mothers of children with stunting, this attitude is more curative in nature, focusing on improving the child's condition through nutritional fulfilment and developmental stimulation.

These results are consistent with previous studies demonstrating that positive parental attitudes are associated with intentions to improve family nutritional quality and maintain consistency in healthy caregiving practices (Damanik et al., 2020; Trisnawati et al., 2025). Optimism and acceptance of the child's condition also strengthen maternal psychological resilience, thereby encouraging sustained efforts despite existing constraints, as reported in studies by Nafista et al. (2023) which emphasize the importance of acceptance-based coping strategies.

Beyond attitudes, this study also finds that maternal understanding and nutritional literacy function as cognitive factors that reinforce intentions for both prevention and improvement of children's dietary patterns. This finding supports prior research by Haryanti et al. (2024) and Kusumarini et al. (2024), which shows that nutritional literacy has a significant influence on intentions and behaviors related to healthy food consumption. Social support, particularly from husbands and community health volunteers (posyandu cadres), also serves as a reinforcing factor in the relationship between attitudes and intentions, in line with the findings of Tahapary et al. (2023) and Soviyati (2023).

However, this study also identifies that inaccurate cultural perceptions such as the belief that a child's small body size is solely hereditary can weaken positive attitudes and hinder the formation of intentions to prevent stunting. Such perceptions lead stunting to be viewed as an unchangeable condition, thereby reducing maternal motivation to engage in behavioral change. These findings are consistent with studies by Alfianti et al. (2023), and are further supported by research highlighting the strong influence of myths, intergenerational beliefs, and food-related cultural practices on the occurrence of stunting and family responses (Putriana et al., 2020; Sarilisnawati et al., 2024). Qualitative studies by Dewi et al. (2024) also demonstrate that perceiving stunting as a hereditary condition tends to undermine mothers' motivation to change. Overall, these findings underscore

the importance of culturally sensitive and contextualized nutrition education interventions to ensure that maternal attitudes are aligned with medical knowledge, thereby fostering stronger and more sustainable intentions in stunting prevention efforts.

Subjective Norms Influence Intention

This study confirms that subjective norms are an important determinant in shaping pregnant women's intentions to engage in health behaviors related to stunting prevention. Subjective norms are formed through social pressures originating from culture, traditions, social stigma, as well as support from family members and health professionals. As a result, mothers' decisions are not purely individual but are influenced by the surrounding social expectations.

These findings are consistent with previous studies showing that deeply rooted culture and traditions, including food taboos during pregnancy, continue to strongly influence health-related decision-making and may weaken adherence to medical recommendations (Owusu, 2024; Alfaeni et al., 2023). Pressure to maintain social harmony often places mothers in a dilemma between health knowledge and prevailing cultural norms.

In addition, this study found that social stigma further reinforces subjective norms. Concerns about negative judgment and shame culture encourage mothers to conform to social norms, even when these norms do not fully align with health knowledge. This finding supports earlier studies highlighting the role of stigma and social values such as *isin* and *sungkan* in shaping compliance with cultural norms (Diana et al., 2022; Mukti & Widyastuti, 2018; Santosa et al., 2024).

Conversely, trust in health professionals emerges as a positive source of subjective norms. Recommendations from doctors, midwives, and community health volunteers (*posyandu* cadres), who possess scientific legitimacy, increase mothers' intentions to engage in health-promoting behaviors. These results are consistent with studies by Trisnalanjani and Kurniati (2022) and Setyobudihono and Istiqomah (2024), which emphasize the role of medical authority in maternal health decision-making. Furthermore, support from husbands, family members, and the community has been shown to strengthen mothers' intentions to maintain health during pregnancy, in line with the findings of Savita and Pradana (2023) and Zhou et al. (2024). However, intergenerational dynamics within families may also serve as an ambivalent source of social pressure, potentially both hindering and facilitating behavioral change, as reported by Latifah et al. (2016).

Perceptions of Environmental Behavior Play an Important Role in Shaping Intention

The findings of this study indicate that environmental perceptions are a key factor in shaping perceived behavioral control and mothers' intentions to practice healthy nutrition. Barriers such as economic constraints, limited access to nutritious food, and children's picky eating behaviors tend to weaken behavioral control, whereas support from husbands, *posyandu* cadres, and ease of access to food strengthen intentions for stunting prevention. Among pregnant women, barriers are more internal in nature, such as nausea and decreased appetite; however, social support continues to sustain intention, in line with Simmons et al. (2022) and Mizutani et al. (2022). Among mothers of children with stunting, environmental perceptions are more complex because they are influenced by external factors, consistent with Sambo et al. (2023) and Ferdianto et al. (2025). In contrast to previous studies that positioned environmental barriers as structural factors that weaken intention, this study emphasizes that environmental perceptions are dynamic and can be modified through social support and adaptive strategies. These findings extend the work of Brown and Smith (2022), and Subirto and Ibrahim (2024) by demonstrating that the involvement of family members and *posyandu* cadres helps maintain the consistency of mothers' intentions despite existing constraints.

Intention Influences Actual Behavior

Intention is a key determinant of actual behavior among pregnant women and mothers with stunted children, as it reflects motivation and commitment that guide health-related actions. Previous studies indicate that pregnant women's intentions are primarily preventive, focusing on dietary regulation, adherence to medical recommendations, and adaptation to physical changes during pregnancy (Adylbekova et al., 2025). In contrast, mothers with stunted children tend to form recovery-oriented intentions, such as improving food quality, providing supplements, and applying adaptive feeding strategies to support optimal child growth (Rahmadiyah et al., 2024; Harahap et al., 2023).

In line with the Theory of Planned Behavior, intention mediates the relationship between attitudes, subjective norms, perceived behavioral control, and actual behavior. Internal motivation and a sense of responsibility encourage consistent practices such as managing diet, taking supplements, and seeking health information, while social support from husbands and community health workers strengthens intentions and facilitates their translation into action (Moreno et al., 2023; Siregar et al., 2025). This confirms earlier findings that social environments play a crucial role in reinforcing intention-driven behaviors.

Furthermore, previous research highlights the role of intention in sustaining behavior under challenging conditions. Pregnant women with strong nutritional intentions maintain adaptive eating practices despite nausea or limited food availability, and mothers of stunted children persist in efforts to improve their child's condition despite economic or informational constraints (Olajide et al., 2024; Rahmi & Yulianti, 2023; Noviarini et al., 2024). These findings support evidence that intention functions as a behavioral stabilizer, ensuring that health-related actions are consistently implemented and supported by ongoing social reinforcement (Li et al., 2025; Salifu et al., 2024; Turkmen et al., 2024; Carter et al., 2021).

Perception of the Environment Plays a Significant Role in Shaping Actual Behavior

Pregnant women and mothers with stunted children face internal challenges, such as nausea and decreased appetite, as well as external challenges, including picky-eating children, limited finances, and time constraints, which affect nutrition fulfillment and caregiving practices (Sambo et al., 2023; Ferdinanto et al., 2025). Support from husbands and community health volunteers provides education, practical guidance, and emotional backing, while government assistance, such as staple food packages or supplementary feeding programs, strengthens maternal motivation, although its effectiveness depends on parental involvement and adaptive feeding strategies (Nursalam & Rosyidah, 2022; Ernawati, Maimunah & Hanifah, 2024). Mothers' self-control and discipline, including adherence to supplement intake, regulation of dietary patterns, and adaptive caregiving, are reflected in menu adjustments, nutritional substitutions, and adaptive strategies to cope with limited food access. Emotional responses, such as worry, frustration, and fatigue, can affect behavioral consistency, but social support helps balance the psychological burden.

Implication

This study strengthens the applicability of the Theory of Planned Behavior (TPB) in explaining maternal behaviors related to the prevention and management of stunting. The findings demonstrate that attitudes, subjective norms, and perceived behavioral control operate simultaneously and interactively in shaping caregiving intentions and practices, from pregnancy through the care of children experiencing stunting. Importantly, the results indicate that stunting is not solely determined by nutritional knowledge, but rather represents a complex psychosocial process influenced by maternal beliefs, social pressures, environmental support, and perceived self-efficacy.

From a practical perspective, stunting interventions should be designed in a more contextualized, empathetic, and flexible manner. Programs need to move beyond information delivery and consider mothers' emotional conditions, cultural contexts, and economic constraints, while actively strengthening maternal motivation and self-efficacy to support sustained behavior change. At the policy level, stunting prevention strategies should be integrated starting from the prenatal period and implemented across the continuum of maternal and child care. Greater involvement of the nuclear family is essential, alongside the enhancement of culturally sensitive and evidence-based health communication strategies, to ensure that preventive messages are effectively understood, accepted, and translated into practice.

Limitation and Recomendation

The number of participants was limited; therefore, the findings cannot be generalized. The study was conducted in a single geographic area (one city). The majority of participants, particularly mothers of children with stunting, were housewives, which does not adequately represent the perspectives of working mothers. Future studies should more thoroughly explore the role of husbands as primary participants to better understand how paternal support can more effectively contribute to maternal health and stunting prevention. Although triangulation with husbands in the present study indicated a significant role, their experiences and perspectives were not examined in depth as primary participants.

Based on the findings of this study, several recommendations are proposed for multiple stakeholders. For mothers and families, efforts should focus on strengthening nutritional literacy through reliable medical sources, promoting the adoption of balanced dietary practices from pregnancy onward, and optimizing family support, particularly the involvement of fathers in childcare and nutrition-related decision-making. At the community level, it is important to foster supportive social environments that are free from stigma, reduce reliance on traditional practices that lack medical evidence, and strengthen the role of local communities as platforms for culturally appropriate health education. For *posyandu* cadres, targeted capacity-building initiatives are needed to enhance the delivery of evidence-based nutrition education, particularly by promoting the use of locally available and affordable food resources.

In addition, further development of integrated nutrition education strategies that combine medical knowledge with culturally and spiritually sensitive approaches is recommended, given the persistent influence of myths and traditional beliefs. Expanding the role of *posyandu* cadres to include basic psychosocial support may also help reduce stigma, enhance maternal motivation, and encourage sustained caregiving practices. Moreover, cadre-led interventions that actively engage fathers in caregiving and nutritional practices should be further explored. At the municipal government level, policy efforts should prioritize strengthening culturally grounded nutrition education programs, ensuring the sustainability of nutritious food assistance initiatives, and supporting family economic empowerment to address structural barriers to optimal child nutrition.

Finally, future research is encouraged to employ quantitative or mixed-methods designs to generate more comprehensive evidence. Greater emphasis should be placed on involving husbands as primary participants, as triangulation findings in this study highlighted their substantial role in maternal health and stunting prevention, yet their perspectives were not explored in depth.

CONCLUSION

This study shows that maternal attitudes, both during pregnancy and in caring for children with stunting, are influenced by attitudes, subjective norms, perceived environmental behavioral control, intentions, and maternal behaviors within the framework of the Theory of Planned Behavior. Family support particularly from husbands as well as support from *Posyandu* cadres, was found to strengthen mothers' motivation despite the presence of cultural barriers, economic

limitations, and food access constraints. Mothers continued to employ adaptive strategies to meet their children's nutritional needs; therefore, stunting prevention efforts should be directed toward improving nutrition literacy, increasing fathers' involvement, and providing culturally sensitive education to ensure greater effectiveness and sustainability.

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AUTHOR CONTRIBUTIONS STATEMENT

All authors accept and agree to the final version of this article.

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