

STUNTING PREVENTION BEHAVIORS AMONG EARLY MARRIAGE FAMILIES IN URBAN BANDUNG

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Abstract: In Indonesia's urban poor contexts, stunting reflects not merely nutritional deficiency but the intersection of structural inequality, gendered vulnerability, and constrained household agency. Early marriage is a critical social determinant shaping maternal capacity, health literacy, and caregiving practices. Situated in Sukahaji Subdistrict, Babakan Ciparay District, Bandung City, this study examines how early-marriage households construct and negotiate stunting-prevention behaviors under conditions of socioeconomic precarity. A three-level prevention framework (primary, secondary, tertiary) is employed as an analytical lens to map preventive capacity across stages of risk exposure, early detection, and recovery. Using a qualitative design with thematic analysis, data were generated through in-depth interviews with five mothers married before age 19, triangulated with community social workers and posyandu cadres, field observations, and document review. Iterative coding and cross-case comparison were applied to enhance analytical depth and credibility. Findings indicate that preventive behaviors are structurally mediated. Primary prevention is weakened by limited maternal health literacy, psychosocial immaturity, and food insecurity. Secondary prevention operates in a reactive, institution-dependent mode centered on posyandu surveillance rather than internalized nutritional knowledge. Tertiary prevention demonstrates

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adaptive learning but remains constrained by limited caregiving competencies and weak social support systems. This study advances the literature by offering an integrated prevention-level mapping of stunting behaviors within early marriage households, demonstrating how structural vulnerability reshapes preventive agency at the micro level. The findings contribute to social and public health scholarship by reframing stunting prevention as a relational and capability-based process rather than solely an individual behavioral issue.

Keywords: Stunting; Prevention Behavior; Early Marriage; Qualitative Study; Posyandu; Indonesia.

Introduction

Stunting is a chronic form of undernutrition marked by impaired linear growth due to prolonged nutritional deprivation, recurrent infections, and inadequate psychosocial stimulation, especially during the first 1,000 days of life. It is defined as height-for-age below -2 SD of the WHO Child Growth Standards and remains a major global public health problem, affecting 149.2 million children under five in 2020. Stunting reflects not only biological vulnerability but also broader social determinants such as poverty, education, and limited access to basic services.

In Indonesia, stunting prevalence remains high at 21.6 percent, with West Java at 20.2 percent and Bandung City at 19.4 percent. In Sukahaji Subdistrict, nutritional vulnerability is also evident, with local health data showing stunting, wasting, and underweight cases alongside high levels of poverty. This indicates that stunting in Sukahaji is not only a nutritional issue but also a result of structural inequality that limits families' ability to meet children's health and caregiving needs.

A key local vulnerability factor is early marriage. Preliminary findings suggest that early marriage contributes to persistent poverty, low parenting readiness, and limited education, which may weaken caregiving

practices and increase stunting risk. Although previous studies have shown an association between early marriage and stunting, they provide limited understanding of how prevention behaviors operate at the household level, including caregiving decisions, health service use, and the influence of economic constraints, knowledge, and social support.

This study addresses that gap by examining stunting prevention behaviors among families formed through early marriage in Sukahaji. Using a qualitative approach, it focuses on family experiences and organizes prevention efforts into primary, secondary, and tertiary levels based on the Leavell and Clark framework. The study aims to describe these household-level prevention practices and provide an empirical basis for more responsive community-based interventions and basic social services for young families.

Method

Understanding stunting prevention behaviors among early married families requires a framework that explains how caregiving decisions are influenced by biological and structural factors. Stunting is a long-term result of chronic undernutrition and recurrent infections during the first 1,000 days of life and is defined as height-for-age below -2 standard deviations (WHO, 2015; WHO, 2020). However, stunting also reflects broader social and environmental conditions, requiring a multidimensional approach that integrates health prevention theory, behavior change frameworks, family systems theory, and social work perspectives (Gitterman, 2001; Ellya, 2020; WHO, 2013).

The determinants of stunting can be viewed as a causal chain where structural factors such as poverty, education, policy, and the physical environment influence food access, sanitation, and health services, which then shape caregiving

practices, feeding patterns, and disease exposure, ultimately affecting child growth (UNICEF, 2013; WHO, 2013). In this study, early marriage is viewed as a social condition that may alter a family's position in this chain by limiting education, economic independence, and caregiving capacity, which can influence stunting prevention behaviors.

Prevention Behavior as the Core Analytic Focus

Prevention behavior refers to actions taken by individuals or families to prevent health problems, detect risks early, and reduce negative impacts. In public health, behavior includes not only practices but also knowledge, attitudes, beliefs, and perceptions influenced by social norms, economic conditions, institutional access, and social support (Notoatmodjo, 2011).

In early married families, prevention behavior is shaped by psychosocial immaturity, limited education, economic dependency, and weak household bargaining power. These conditions can affect maternal health literacy, decision-making capacity, social networks, and economic stability.

As a result, families may differ in how they interpret nutritional guidance, respond to child illness, use health services such as posyandu and primary health centers, follow immunization schedules, and maintain hygiene and sanitation (WHO, 2013; UNICEF, 2013). Thus, stunting prevention behavior reflects the interaction between individual agency and structural constraints.

Theoretical Strengthening Through Behavior Change Theories

This study applies three complementary behavior change theories to explain how stunting prevention behaviors are formed and constrained within early marriage households. These frameworks highlight that caregiving practices are influenced not only by knowledge but also by risk perception, social norms, and perceived agency.

The Health Belief Model (Rosenstock, 1974) explains how mothers assess the risk and severity of stunting and the benefits and barriers of preventive actions such as improved nutrition and posyandu participation. The Theory of Planned Behavior (Ajzen, 1991) emphasizes how attitudes, social norms, and perceived behavioral control shape behavioral intentions, which may be limited among young mothers with restricted decision-making power. Meanwhile, Social Cognitive Theory (Bandura, 1986) highlights the role of social learning, observation, and self-efficacy in shaping caregiving practices within community environments.

Together, these frameworks provide an integrated perspective for analyzing stunting prevention behavior as a process shaped by risk perception, social and structural constraints, and socially mediated learning within early marriage households.

Levels of Prevention: The Leavell and Clark Framework

The Leavell and Clark framework conceptualizes prevention as a staged process from health promotion to rehabilitation, making it useful for analyzing stunting prevention behaviors in early marriage households (Leavell and Clark, 1967).

Primary prevention focuses on controlling risk factors before health problems occur through health promotion, adequate maternal nutrition, immunization, and improved hygiene and sanitation, particularly during the first 1,000 days of life (WHO, 2020; WHO, 2013). In early married families, these efforts are often influenced by limited caregiving readiness and decision-making capacity.

Secondary prevention involves early detection and timely response, such as growth monitoring, identifying inadequate weight gain, and managing infections that contribute to malnutrition (WHO, 2013). Young families

may face barriers at this stage due to limited health literacy and inconsistent access to services.

Tertiary prevention focuses on rehabilitation and preventing further complications once nutritional problems occur, including referral, nutritional recovery, and improved caregiving practices (WHO, 2013). In early marriage households, effective tertiary prevention often requires integrated support from health and social services.

Stunting Determinants Most Relevant to Families Formed Through Early Marriage

Stunting is a key indicator of child health linked to cognitive development, learning capacity, and long-term productivity, and it may reinforce intergenerational poverty (WHO, 2013). This study focuses on determinants most relevant to families formed through early marriage.

First, poverty and household welfare act as structural determinants that increase stunting risk through limited access to nutritious food, health services, and adequate housing and sanitation (UNICEF, 2013). In Indonesia, poverty is positively associated with stunting prevalence, highlighting its socioeconomic roots (Laksono and Wulandari, 2021). Among early married families, poverty also restricts behavioral options related to nutrition, healthcare, and sanitation.

Second, maternal education and health literacy influence caregiving practices. Education improves the ability to access and apply health information, increasing service utilization and child care quality (Notoatmodjo, 2007; Boyle et al., 2006 cited in Hazarika, 2010). Early marriage often interrupts schooling, increasing vulnerability to misinformation about nutrition and childcare.

Third, environmental conditions and infections affect nutritional status through sanitation, water quality, and disease exposure, which can strengthen the malnutrition-infection cycle (WHO, 2013). Finally, sociocultural norms

and health perceptions, such as food taboos or the normalization of short stature, may reduce the urgency of prevention and influence caregiving decisions beyond biomedical considerations.

Early Marriage as a Triggering Condition for Prevention Vulnerability

Early marriage, defined as marriage before the age of 19 (Law Number 16 of 2019), is viewed in this study as a condition of vulnerability that may affect stunting prevention behaviors. It can influence prevention through several pathways, including biological and reproductive risks from adolescent pregnancy, limited psychosocial readiness for parenting, and educational and economic constraints due to school discontinuation and financial dependence (Bappenas et al., 2020). In addition, young mothers often have limited decision-making autonomy, as caregiving and health decisions may be influenced by spouses or extended family (Ajzen, 1991; Rohmat, 2010).

Empirical studies show that early age at marriage is associated with higher risks related to pregnancy and child health, making child marriage an important policy concern in stunting prevention (Demsa and Frensi, 2024). Research also highlights economic pressure and social environment as key drivers of child marriage, suggesting the need for interventions that integrate economic empowerment and improved access to education (Pourtaher et al., 2024).

Family Systems and Family Health Functions as the Arena of Behavior

The family is a primary social unit responsible for socialization, emotional support, and economic support, making it a central arena for shaping health behaviors (Arsini, 2014; Rohmat, 2010). Family systems theory explains that health behaviors are influenced by relational patterns, communication, and family rules rather than individual

decisions alone (Minuchin, 1974; Bowen, 1978). This is particularly relevant for families formed through early marriage, where caregiving decisions often involve both young parents and extended family members.

To understand family functioning in health, this study uses a family health task framework that includes recognizing health problems, making decisions, providing care, modifying the environment, and utilizing health services (Bailon and Maglaya, 1978 cited in Efendi and Makhfudli, 2009). In early married families, challenges may arise in recognizing health risks, making independent decisions, seeking timely care, maintaining supportive home environments, and consistently accessing health services.

Social Work Perspective: Person in Environment and Integrated Intervention

From a social work perspective, child-related problems such as stunting are interconnected with poverty, education, family relations, and access to services (Ellya, 2020). The person-in-environment perspective emphasizes that interventions should address not only individuals but also the social environment and service systems that influence family capacity (Gitterman, 2001). Because stunting in early married families often results from economic constraints, social norms, and limited service access, prevention requires integrated social support rather than solely medical interventions (Siporin cited in Huraerah, 2011).

In this context, social workers may act as educators to improve knowledge about nutrition and the first 1,000 days of life (Ife, 2002), brokers to connect families with health services and social assistance (Pujileksono and Wuryantari, 2017), enablers to strengthen families' ability to make healthy decisions, and advocates to promote equitable access to services (Ife, 2002). This framework highlights that stunting prevention in early married families depends on

supportive social systems and integrated interventions (Gitterman, 2001; Ellya, 2020).

Study Design

This study employed a qualitative approach with a descriptive design to develop an in depth understanding of the social phenomena within the everyday context of families formed through early marriage. This approach enabled a holistic and context sensitive exploration of behaviors, experiences, and prevention strategies among families who married at a young age, particularly in Sukahaji Subdistrict, Babakan Ciparay District.

Study Setting and Participants

The study was conducted in Sukahaji Subdistrict, Babakan Ciparay District, Bandung City, with a specific focus on Neighborhood Units RW 01 and RW 03 based on preliminary field screening conducted with Community Social Workers (PSM) and information provided by local cadres. The main participants were five mothers from families formed through early marriage, defined as marriage below 19 years of age. Participants were selected using purposive sampling to capture variation in pathways to early marriage, including unplanned pregnancy, family coercion, escape from adverse family circumstances, and conditions associated with serious health impacts or vulnerability. Key informants, including PSM, PKK and posyandu cadres, and or Puskesmas representatives, were involved to enrich contextual understanding and support data verification.

Data Sources and Data Collection

This study used primary and secondary data (Rustanto, 2013). Primary data were obtained from participants and local informants, including stunting related information from PKK and posyandu cadres and early marriage data

identified through field screening in Sukahaji Subdistrict, particularly in RW 01 and RW 03, conducted jointly with PSM. Secondary data consisted of supporting materials such as interview recordings, photographs and or videos, field notes, as well as relevant books and peer reviewed articles on stunting prevention.

Data Collection Procedures

In depth interviews were conducted with mothers from early married families and with key informants, including PSM, PKK and posyandu cadres, and Puskesmas, to explore prevention behaviors, constraints, and strategies related to stunting prevention. In situ observation was also conducted, supported by field notes, to document caregiving practices and household routines relevant to stunting prevention.

Sampling Strategy

Participants were selected through purposive sampling (Sugiyono, 2017). Five mothers from early married families were included because they were considered most relevant and knowledgeable regarding the study context. Participants reflected diverse backgrounds, including unplanned pregnancy, family coercion, escape from adverse family conditions, and serious health related impacts.

Trustworthiness

To ensure that the findings were credible and accountable, the study applied procedures to establish trustworthiness, including credibility, transferability, dependability, and confirmability.

Data Analysis

Data analysis was conducted systematically across interview transcripts, observation records, field notes, and documentation to identify patterns, themes, and meanings relevant to the study focus. The analytic process followed

commonly used stages of qualitative data analysis (Sugiyono, 2021):

1. Data reduction, in which raw data were selected, summarized, and focused on information most relevant to the research objectives, with preliminary grouping to identify emerging themes.
2. Data display, in which reduced data were organized in a structured form, for example thematic narratives, concise matrices or tables, interview quotations, or observation summaries, to clarify relationships across findings.

Conclusion drawing and verification, in which interpretations and conclusions were developed from identified themes and repeatedly checked against field data to ensure that conclusions were robust, consistent, and defensible

Result and Discussion

PRIMARY PREVENTION

Health Promotion

The first theme highlights limited physical and psychological readiness for parenthood among early marriage mothers. Many participants felt unprepared during pregnancy and early motherhood, often experiencing confusion and relying on external guidance. Early caregiving knowledge was uneven, and information about pregnancy and childcare was mainly obtained from nearby health services, particularly midwives.

The second theme shows low and fragmented health literacy. Most participants had limited understanding of stunting beyond recognizing short stature. Even when health practices were followed, such as taking iron tablets, many mothers did so without understanding their purpose. Midwives and posyandu cadres were the main information sources, but explanations were not always

fully understood, reflecting passive reception of information rather than informed prevention.

The third theme concerns access to and utilization of health services. Although posyandu, health centers, and midwives were geographically accessible, early service use was inconsistent due to psychosocial and motivational factors such as low perceived urgency, shyness, lack of confidence, and domestic responsibilities. Participation often increased after encouragement from posyandu cadres, who also served as informal educators through communication and peer interaction.

Overall, these findings indicate that early health promotion in early marriage households was influenced more by limited health literacy, psychosocial readiness, and low proactive engagement than by structural access barriers. Preventive behavior relied heavily on external guidance rather than internalized understanding.

Specific Protection

The first finding concerns social and economic support. Participants reported varying levels of support from spouses and extended family. Some mothers managed most responsibilities independently due to their husbands' work, while others relied on assistance from parents. Economic constraints were also reported to affect household needs.

The second finding relates to maternal nutrition during pregnancy. Food consumption generally followed what was available at home, with no specific dietary planning for pregnancy. Participants also reported limited ability to obtain more nutritious foods.

Summary of findings by domain in primary prevention

Overall, in health promotion, participants described limited physical and psychological readiness during early pregnancy, varying but generally low knowledge of

stunting, and accessible services with inconsistent early utilization. In specific protection, participants described varied social and economic support and pregnancy nutrition practices shaped largely by everyday food availability.

SECONDARY PREVENTION

Early Diagnosis

The first finding shows limited early recognition of stunting-related signs among most participants. Child health was commonly assessed through visual observation, such as smaller body size or comparison with peers, rather than through growth monitoring indicators. Awareness of potential growth problems often emerged only after guidance from posyandu cadres or after weighing and height measurement at posyandu, indicating that early detection relied more on external health monitoring than on parental understanding.

The second finding shows that health service responses occurred after growth problems were identified through posyandu monitoring. Participants described routine weight and height checks, after which children identified as at risk received support such as DASHAT assistance, supplementary foods through PMT (e.g., mung bean porridge, biscuits, and eggs), and in some cases home visits from health workers.

Timely Management

Participants reported management responses after receiving information from cadres or health workers, mainly by increasing food intake and adding milk supplementation. While these actions show responsiveness, they reflect a simplified understanding of nutrition focused on increasing quantity or specific foods rather than balanced diets, dietary diversity, and age-appropriate feeding practices.

Family support, especially reminders from parents or in-laws to attend posyandu, helped encourage service use. Programs such as PMT and DASHAT were perceived as helpful but mainly reinforced supplementary feeding rather than strengthening broader nutrition knowledge and caregiving skills. Overall, post-detection management tended to be reactive and nutritionally limited, indicating the need for more comprehensive, skills-based nutrition education.

Summary of findings by domain in secondary prevention

In early diagnosis, awareness of growth problems generally emerged after posyandu monitoring or guidance from cadres and health workers, followed by growth monitoring and program support once risk was identified. In timely management, responses included increased feeding and milk provision, more regular posyandu attendance, and utilization of available program resources.

TERTIARY PREVENTION

Caregiving changes after indications of growth problems

Participants described increased growth monitoring and changes in caregiving after receiving information from posyandu. Participant 4 described an initial passive approach followed by more regular posyandu attendance after cadre guidance. Participant 4 also described providing meals more regularly after receiving guidance, although uncertainty about appropriate menu selection remained.

Community outreach for early marriage prevention

Participants reported uneven exposure to programs aimed at preventing early marriage before marriage occurred. Several participants stated that they did not know about counseling activities or youth programs directly targeting early marriage prevention. Participant 5

reported never being involved in such activities. Participants also described early marriage as occurring in contexts linked to unplanned pregnancy or family circumstances. After marriage, several participants described informally advising peers not to marry too early.

Community outreach for stunting prevention

Participants emphasized the central role of posyandu cadres in delivering information, directing checkups, and encouraging attendance. Participant 3 initially perceived the child's condition as normal until cadres communicated concerns about possible undernutrition. Participants indicated that cadre communication encouraged growth assessment, routine monitoring, and linkage to available support programs, including PMT and DASHAT.

Summary of findings by domain in tertiary prevention

Participants described increased growth monitoring and more regular feeding practices following posyandu guidance. Exposure to early marriage prevention outreach was uneven and was often replaced by informal peer messaging after marriage. In contrast, stunting prevention outreach was more visible through cadre engagement that supported service attendance and linkage to nutrition support programs.

DISCUSSION

Primary prevention among families formed through early marriage in Sukahaji operated through health promotion and specific protection, but these did not function as an integrated continuum. This weakness was mainly shaped by low maternal health literacy and limited socioeconomic and family support. Although education from midwives and posyandu cadres was available, participants showed that communication was often one-way and not fully understood, so prevention remained

reactive rather than anticipatory. Service access was physically available, yet utilization was inconsistent because of embarrassment, limited spousal encouragement, and uncertainty about the importance of routine checks. Specific protection was also constrained by economic limitations, uneven spousal involvement, and dependence on extended family. Maternal nutrition and child feeding were largely shaped by household capacity, showing that prevention was weakened not by lack of services but by limited ability to translate access and information into sustained practice.

Secondary prevention mainly operated through early diagnosis and impact limitation, but mothers generally recognized growth problems only after weighing at posyandu or direct advice from cadres and midwives. This indicates that household responses were largely reactive and externally triggered rather than based on independent monitoring. Limited understanding of stunting and normalization of early signs contributed to delayed detection. After problems were identified, participants responded by increasing food intake, providing milk, or relying on supplementary foods, but these actions often reflected a narrow understanding of nutrition rather than balanced and age-appropriate feeding practices. Programs such as PMT and DASHAT helped provide supplementary intake and encourage attendance, yet their impact depended on mothers' engagement and understanding. Overall, secondary prevention moved mainly from outside to inside, shaped by external prompting, limited literacy, and uneven support.

Tertiary prevention was characterized by gradual behavior change that was commonly strengthened after external intervention. Rehabilitation did not usually emerge spontaneously but followed a trigger-response pattern, with cadres and health workers encouraging better feeding, routine checkups, and growth monitoring.

However, rehabilitation was often constrained by uncertainty in choosing affordable nutritious foods, limited understanding of balanced diets, and uneven family support. Participants also suggested that preventive outreach to adolescents before marriage was limited, which may explain why many entered parenthood with low readiness and knowledge. Posyandu cadres consistently appeared as key actors in rehabilitation by encouraging attendance, monitoring growth, providing explanations, and maintaining follow-up. This shows that tertiary prevention was more stable when continuous accompaniment was available.

Overall, stunting prevention behavior among families formed through early marriage in Sukahaji was an interconnected process across prevention levels. Weaknesses at the primary level contributed to reactive secondary prevention, while tertiary prevention depended on gradual, externally supported behavior change. The study's novelty lies in its integrated mapping of the three Leavell and Clark prevention levels within the UNICEF stunting framework. The findings show that prevention success depends not only on the existence of programs and services but also on mechanisms that translate them into daily practice, with posyandu cadres emerging as a central bridge in supporting health literacy, behavior change, and access for vulnerable families.

Conclusion

This study concludes that stunting prevention behaviors among families formed through early marriage in Sukahaji Subdistrict remain weak and inconsistent across prevention levels despite the presence of community-based services. At the primary prevention level, health promotion and protection were provided through midwives and posyandu cadres, but their implementation was limited by low health literacy, one-

way information delivery, psychosocial barriers, and socioeconomic constraints. At the secondary prevention level, household responses tended to be reactive and often occurred only after external prompting. Programs such as PMT and DASHAT supported early detection and nutrition support, but their effectiveness depended on maternal capacity and supportive environments. At the tertiary prevention level, behavior change occurred gradually with assistance from cadres and health workers, yet sustained rehabilitation was constrained by limited nutrition skills, economic barriers, and weak social support. Preventive outreach to adolescents to reduce early marriage also remained limited.

The novelty of this study lies in its integrated analysis of the three levels of prevention from the Leavell and Clark framework within early married households. The findings show that community-based stunting responses are strongly influenced by local bridging mechanisms, particularly the role of posyandu cadres as facilitators of information and behavior change, as well as by structural factors, especially socioeconomic conditions that affect families' ability to sustain nutrition and caregiving practices.

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