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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

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 characterized by impaired linear growth resulting from prolonged nutritional deprivation, recurrent infections, and inadequate psychosocial stimulation. The condition is most critical during the first 1,000 days of life and is associated with long term consequences for cognitive development and educational attainment. Anthropometrically, stunting is defined as height for age below −2 standard deviations (SD) of the WHO Child Growth Standards. Stunting remains a major global public health challenge: in 2020, an estimated 149.2 million children under five years of age (approximately 22 percent) were stunted, and in 2021 the global prevalence was estimated at 22.9 percent. Progress toward malnutrition reduction targets is increasingly difficult because stunting reflects not only biological vulnerability but also broader social determinants, including poverty, education, and limited access to basic services.

In Indonesia, stunting prevalence remains high at 21.6 percent (SSGI 2022). West Java Province reported 20.2 percent, while Bandung City recorded 19.4 percent, indicating that stunting persists as a serious concern despite a downward trend. At the community level, Sukahaji Subdistrict in Babakan Ciparay District exhibits

marked nutritional vulnerability. Sukahaji Primary Health Center data from 2022 reported stunting at 12.7 percent, wasting at 4.26 percent, and underweight measured by weight for age at 11.1 percent, indicating an area at nutritional risk. These outcomes are closely linked to poverty. Babakan Ciparay has the highest number of children under five living in low-income households, and Sukahaji accounts for 357 of 1,452 children. Thus, stunting in Sukahaji should not be understood solely as a nutritional problem, but also as an expression of structural inequality that constrains families' ability to meet children's health and caregiving needs.

The local context further highlights a specific vulnerability factor, namely early marriage. Preliminary assessments conducted with TKSK, PSM, and Puskesos suggest that early marriage contributes to persistent poverty and limited readiness for parenting, potentially undermining caregiving practices and increasing the risk of stunting. This vulnerability is compounded by low educational attainment, as 46 percent of residents did not complete primary education, limiting access to information on reproductive health and evidence-based childcare. Prior studies have consistently reported an association between early marriage and higher stunting risk, including differences between mothers younger than 20 years and those aged 20 years or older. However, correlational evidence alone does not elucidate household level behavioral pathways, including how young mothers make caregiving decisions, how children's nutritional needs are met, whether and how health services are utilized, and how economic constraints, limited knowledge, and social support shape daily prevention practices.

Despite growing evidence linking early marriage to a higher risk of child stunting, little is known about how stunting prevention behaviors operate within early married households. Much of the existing literature

emphasizes prevalence rates and associated risk factors, yet offers limited insight into how families formed through early marriage enact prevention across stages before onset, during early detection, and in subsequent management tional problem. It is the outcome of layered causal processes that include poverty, maternal education, cultural norms, sanitation, access to health services, and intra-household powparticularly in nutritionally vulnerable urban poor settings such as Sukahaji.

A behavioral focus is critical, as field observations suggest that effective prevention must extend beyond the delivery of health information toward sustained empowerment that enables meaningful behavior change and strengthens family capacity. Accordingly, this study conceptualizes young families not merely as a high-risk population but as contextually situated actors whose preventive practices are shaped by structural constraints, social relations, and lived experience. By examining these practices across prevention levels, the study seeks to generate a more grounded understanding capable of informing targeted and context-responsive interventions.

This study contributes in two ways. First, it employs a qualitative approach to capture clients' voices and the subjective realities of families experiencing early marriage, with a specific focus on the distinct challenges associated with early marriage rather than treating families as a homogeneous nutrition affected population. Second, it systematically organizes stunting prevention behaviors using a three-level prevention framework, consisting of primary, secondary, and tertiary prevention, to map preventive actions, early detection, and subsequent management within families formed through early marriage. This framework is informed by the model proposed by Leavell and Clark, which distinguishes primary prevention through health promotion and specific protection, secondary prevention through early diagnosis

and limitation of impact, and tertiary prevention through rehabilitation.

Against this background, the objective of this study is to examine household level stunting prevention efforts among families formed through early marriage in Sukahaji Subdistrict, Babakan Ciparay District, Bandung City. Specifically, the study aims to describe primary stunting prevention practices, secondary prevention practices, and tertiary prevention practices among families experiencing early marriage. The findings are expected to provide an empirical basis for developing community-based interventions and strengthening basic social services that are more responsive to the vulnerabilities of young families in stunting prevention.

Method

Understanding stunting prevention behaviors among early married families requires a conceptual framework that explains how caregiving decisions are shaped by both biological and structural conditions. Stunting represents a long-term manifestation of chronic undernutrition and/or recurrent infection, particularly during the first 1,000 days of life, and is operationally defined as height-for-age below −2 standard deviations (SD) according to child growth standards (WHO, 2015; WHO, 2020).

However, stunting is not solely a nutrier relations. Addressing stunting, therefore, requires a multidimensional perspective that integrates health prevention theory, behavior change frameworks, family systems theory, and social work approaches grounded in the person-in-environment perspective and child protection principles (Gitterman, 2001; Ellya, 2020; WHO, 2013).

Conceptually, the determinants of stunting can be understood as a causal chain. Structural factors such as poverty, education, policy, and the physical environment shape intermediate determinants including food access, sanitation, and services, which then influence proximal determinants such as feeding practices, caregiving patterns, and exposure to disease, ultimately shaping child nutritional status and growth (UNICEF, 2013; WHO, 2013). In this study, early marriage is treated not merely as a demographic characteristic but as a social condition that alters a family's position within this causal chain, for example through lower educational attainment, constrained economic independence, and limited caregiving capacity, which may in turn affect stunting prevention behaviors.

Prevention Behavior as the Core Analytic Focus

Prevention behavior refers to individual or family actions undertaken to prevent the onset of health problems, enable early risk detection, and mitigate adverse impacts once problems occur. In public health scholarship, behavior encompasses not only observable practices but also cognitive and affective dimensions knowledge, attitudes, beliefs, and perceptions that interact with external influences such as social norms, economic conditions, institutional access, and social support (Notoatmodjo, 2011).

In the context of early marriage families, prevention behavior becomes analytically significant because caregiving decisions are often shaped within conditions of psychosocial immaturity, limited educational attainment, economic dependency, and constrained bargaining power within the household. Early marriage may distort internal determinants of behavior by limiting maternal health literacy, weakening critical decision-making capacity, and reinforcing compliance-based rather than informed health practices. Simultaneously, it may reshape external determinants by narrowing social networks, increasing

economic vulnerability, and intensifying dependence on extended family structures or community actors.

Within stunting prevention, these distortions influence how families interpret nutritional guidance, respond to child illness, utilize community-based health services such as posyandu and primary health centers, comply with immunization schedules, and manage environmental hygiene and sanitation (WHO, 2013; UNICEF, 2013). Thus, prevention behavior in early marriage households cannot be understood solely as an individual choice but must be examined as a relational and structurally mediated process that reflects the interaction between agency and constraint.

Theoretical Strengthening Through Behavior Change Theories

To sharpen the analysis, this study applies three complementary behavior change frameworks to explain how stunting formed, constrained, and sustained within early marriage households. Rather than assuming that knowledge automatically produces action, these theories collectively illuminate how cognitive appraisal, social norms, and perceived agency interact in shaping caregiving practices.

The Health Belief Model (Rosenstock, 1974) provides a lens to understand how mothers assess stunting risk and the value of preventive action. Prevention behaviors depend on whether mothers perceive their children as susceptible to growth failure, recognize its severity, believe in the benefits of posyandu participation and improved nutrition, and perceive barriers as manageable. In early marriage contexts, stunting may be normalized within the community, lowering perceived susceptibility, while economic hardship and limited mobility may amplify perceived barriers.

The Theory of Planned Behavior (Ajzen, 1991) extends this understanding by explaining how intention is shaped by attitudes, subjective norms, and perceived behavioral control. Among young mothers whose decision-making

autonomy may be constrained by economic dependence or hierarchical family structures, positive attitudes toward child nutrition may not translate into consistent preventive practices. Social norms such as food taboos or beliefs that short stature is hereditary may further weaken behavioral intention.

Social Cognitive Theory (Bandura, 1986) complements these perspectives by highlighting how caregiving behaviors are learned and reinforced through observation and social modeling. In densely populated urban environments, feeding and hygiene practices are often shaped by peer influence and community norms. When prevailing practices are suboptimal, prevention requires not only information but also role modeling, reinforcement, and strengthened self-efficacy.

Taken together, these frameworks provide an integrated analytical basis for examining prevention behavior as a contextually embedded process shaped by risk perception (HBM), normative and structural constraints on intention (TPB), and socially mediated learning and efficacy (SCT). This integration ensures that the theoretical discussion directly informs the study's analysis of how early marriage conditions influence stunting prevention practices at the household level.

Levels of Prevention: The Leavell and Clark Framework

The Leavell and Clark framework conceptualizes prevention as a staged process from health maintenance to rehabilitation, making it suitable for systematically examining stunting prevention behaviors in families formed through early marriage (Leavell and Clark, 1967).

Primary prevention aims to control risk factors before health problems occur through health promotion, improved nutrition, immunization, and sanitation (Leavell and Clark, 1967). In stunting prevention, primary prevention is most critical before pregnancy, during pregnancy, and in early

childhood, particularly within the first 1,000 days of life. Key actions include adequate maternal nutrition, anemia prevention, exclusive breastfeeding, appropriate complementary feeding, and infection prevention through hygiene and sanitation (WHO, 2020; WHO, 2013). Among early married families, primary prevention is also closely linked to caregiving readiness and the capacity to make independent health decisions, which are often not yet stable.

Secondary prevention focuses on early detection and prompt response to prevent deterioration (Leavell and Clark, 1967). In the stunting context, this includes growth monitoring, identification of inadequate weight gain, early detection of wasting and underweight, and timely management of recurrent infections that reinforce the malnutrition infection cycle (WHO, 2013). Families formed through early marriage may face barriers at this stage due to limited health literacy, domestic workload, and inconsistent access to services.

Tertiary prevention emphasizes rehabilitation and prevention of further adverse outcomes once problems have occurred (Leavell and Clark, 1967). For stunting and related nutritional problems, this involves referral, nutritional recovery, family support, and changes in caregiving practices to prevent recurrence and reduce the risk of subsequent developmental delays (WHO, 2013). Among young families, tertiary prevention often requires cross sector support that integrates health and social services because the underlying constraints are rarely purely medical. This framework strengthens the study by enabling a structured mapping of what behaviors occur at each stage, which factors shape them, and which barriers limit their consistent implementation (Leavell and Clark, 1967).

Stunting Determinants Most Relevant to Families Formed Through
Early Marriage

Stunting is a key indicator of child health and is linked to cognitive development, learning capacity, and long term productivity, and it may reinforce intergenerational cycles of poverty (WHO, 2013). In this study, determinants are narrowed to those most directly relevant to families formed through early marriage to maintain analytic focus.

First, poverty and household welfare are structural determinants that increase vulnerability to stunting through limited purchasing power for nutritious foods, constrained access to health services, and poor housing and sanitation conditions (UNICEF, 2013). Evidence from Indonesia indicates a positive relationship between the proportion of people living in poverty and stunting prevalence, underscoring stunting as a health problem embedded in socioeconomic vulnerability (Laksono and Wulandari, 2021). Among early married families, poverty not only reflects circumstances but also restricts behavioral options, including food choices, antenatal care attendance, and access to clean water.

Second, maternal education, health literacy, and caregiving practices are closely related. Education supports health literacy and the ability to translate information into practice (Notoatmodjo, 2007). Higher female education tends to be protective because it increases health service utilization and improves child care quality (Boyle et al., 2006, cited in Hazarika, 2010). In early marriage contexts, schooling is often interrupted, increasing vulnerability to misinformation about nutrition and childcare, including myths and food taboos.

Third, the residential environment, sanitation, and recurrent infections operate through biological and environmental pathways. Sanitation, safe water, crowding, and disease risk affect nutrient absorption and strengthen

the malnutrition infection cycle (WHO, 2013). Dense urban settlements and limited infrastructure contribute to infection exposure, particularly diarrhea and environmentally mediated diseases that adversely affect nutritional status (Soemirat, 2010). Therefore, stunting prevention behavior must also be examined as hygiene, sanitation, and health seeking behavior.

Fourth, sociocultural factors and health perceptions operate through normative pathways. Food taboos, normalization of short stature, or fatalistic views of stunting may reduce the perceived urgency of prevention and hinder service utilization (WHO, 2013). This dimension helps explain why families do not always respond to risk through a purely biomedical logic; caregiving decisions often reflect negotiation between knowledge, norms, and social pressures.

Early Marriage as a Triggering Condition for Prevention Vulnerability

Early marriage is defined as marriage below 19 years of age (Law Number 16 of 2019). In this study, early marriage is conceptualized as a context of vulnerability rather than merely an age variable. It may influence stunting prevention behaviors through several mechanisms.

First, biological and reproductive readiness matters, as adolescent pregnancy increases risks of complications and conditions that may affect fetal and infant health. Second, psychosocial readiness for parenting is often limited at younger ages, including emotional regulation, problem solving capacity, and stable decision making under caregiving demands. Third, educational and economic constraints are common, as early marriage is frequently associated with school discontinuation and economic dependence, reducing control over food choices and service access (Bappenas et al., 2020). Fourth, household power relations and decision making autonomy may constrain

young mothers, whose health decisions may be determined by spouses or extended family, limiting maternal control over prevention behaviors (Ajzen, 1991; Rohmat, 2010).

Empirically, a study using IFLS data suggests that age at first marriage is an early indicator of pregnancy and birth related risk and that child marriage should be a policy priority in stunting prevention (Demsa and Frensi, 2024). Meta synthesis evidence also indicates that economic pressures and the social environment are strong determinants of child marriage, implying that interventions should integrate economic empowerment with expanded access to education (Pourtaher et al., 2024). Early marriage is therefore structurally embedded and shapes conditions that make consistent stunting prevention behaviors more difficult to sustain.

Family Systems and Family Health Functions as the Arena of Behavior

The family is a primary social unit responsible for value socialization, emotional support, and economic support, and therefore constitutes a central arena for shaping health behaviors (Arsini, 2014; Rohmat, 2010). Within family systems theory, health behaviors are not located solely at the individual level but are shaped by relational patterns, communication, and family rules (Minuchin, 1974; Bowen, 1978). This is particularly relevant for families formed through early marriage, where caregiving decisions often involve young spouses and extended family members, making prevention behavior a negotiated outcome within the family system.

To operationalize family functioning in the health context, this study draws on a family health task framework that includes recognizing health problems, making decisions, providing care, modifying the environment, and utilizing health facilities (Bailon and Maglaya, 1978, cited in Efendi and Makhfudli, 2009). This framework helps explain

barriers commonly faced by early married families, such as failure to recognize risk signs due to low health literacy, limited autonomy in health decisions due to spousal or extended family dominance, delayed care seeking due to cost or access barriers, an unsupportive home environment due to inadequate sanitation and water, and irregular use of health services due to access constraints, norms, or stigma.

Social Work Perspective: Person in Environment and Integrated Intervention

Social work conceptualizes child related problems as cross cutting issues intersecting with poverty, education, family relations, violence, and service access (Ellya, 2020). The person in environment perspective emphasizes that change should not be directed only at individuals such as mothers and fathers but also at the social environment and service systems that shape family capacity (Gitterman, 2001). Because stunting in early married families often reflects a combination of economic constraints, norms, and service access barriers, prevention requires integrated social support rather than purely medical intervention (Siporin, cited in Huraerah, 2011).

Within this study, the most relevant social work roles include educator to strengthen literacy in nutrition, caregiving, and the first 1,000 days of life (Ife, 2002); broker to connect families with posyandu and primary health services, social assistance, and protection programs (Pujileksono and Wuryantari, 2017); enabler or empowerer to enhance young families' capacity to make and sustain healthy decisions (Pujileksono and Wuryantari, 2017); and advocate to promote equitable service access when families face structural barriers (Ife, 2002). This social work framework reinforces the study's position that stunting prevention among families formed through early marriage should be understood as a child health and wellbeing effort

that depends on supportive social systems (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 Puskesos 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 Puskesos, 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 disscusion

The first theme concerns limited physical and psychological readiness for parenthood among early marriage mothers. Most participants described feeling unprepared during early pregnancy and the transition to motherhood. Participant 1 reflected, "I was confused about what to do as a mother; everything felt new and overwhelming." This sense of psychosocial immaturity was accompanied by uneven foundational caregiving knowledge, particularly regarding infant care and fulfillment of basic needs. Across the majority of participants, early maternal adaptation was characterized by uncertainty and reliance on external guidance. Participant 2 identified the local midwife as her primary source of information, indicating that pregnancy and caregiving knowledge was largely accessed through nearby health services rather than through prior preparation.

The second theme reveals low and fragmented health literacy as a dominant pattern in the early period. Although awareness levels varied, most participants reported limited understanding of stunting beyond its visible manifestation as short stature. Participant 3 stated, "I didn't know what stunting was at that time," while Participant 1 expressed similar unawareness. Even among those who had heard the term, understanding was partial. Knowledge of iron supplementation illustrates this pattern: while most participants consumed iron tablets during pregnancy, several did so without understanding their function. Participant 3 explained, "I took the tablets because they were given to me, but I didn't know what they were for." This suggests that compliance did not necessarily reflect informed preventive behavior. Midwives and posyandu cadres were consistently identified as key information sources; however, explanations were not always fully comprehended. Participant 4 reported receiving guidance from a midwife but noted that the explanation was delivered quickly and she did not seek clarification, indicating passive information reception rather than active understanding.

The third theme concerns access to and utilization of health services. While nearly all participants described posyandu, primary health centers, and local midwives as geographically accessible, early utilization was inconsistent. This inconsistency appeared to stem not from physical barriers but from psychosocial and motivational factors, including limited perceived urgency, shyness, lack of confidence, and competing domestic responsibilities. Participant 1 reported not attending posyandu during the early period, while Participant 5 acknowledged that services were available but attended infrequently. In one case, Participant 4 received a home visit from a midwife after failing to attend postpartum services. Importantly, service utilization increased following encouragement and

follow-up from posyandu cadres, indicating that external cues to action played a significant role. Posyandu was also described as an informal learning space where mothers gained information about food and nutrition through cadre communication and peer interaction.

Overall, this theme suggests that health promotion within early marriage households is characterized less by structural inaccessibility and more by limited health literacy, psychosocial readiness, and proactive engagement. Preventive behavior during the early period depended heavily on external guidance rather than internalized understanding, highlighting the need for more dialogical and empowerment-oriented health communication strategies.

Specific Protection

The first finding concerns social and economic support. Participants described varied support from spouses and extended family. Participant 4 reported that her husband worked frequently and was rarely at home during pregnancy and after childbirth, requiring her to manage most activities independently. Participant 5 reported relying on parental assistance. Participants also described economic constraints that affected household needs.

The second finding concerns nutrition specific practices to support maternal nutrition during pregnancy. Participants reported that food consumption during pregnancy largely followed what was available in the household. Participant 5 described eating available foods without reporting any specific pregnancy nutrition. Participants also reported limited capacity to obtain certain 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

In secondary prevention, findings are organized into two domains, early diagnosis and timely management.

Early Diagnosis

The first finding indicates limited early recognition of stunting-related signs, a pattern observed among most participants rather than isolated cases. Across four of the five participants, child health assessment was primarily based on visual observation, such as smaller body size, lack of visible weight gain, or comparison with peers, rather than on growth monitoring indicators. Participant 4 described noticing that her child was thinner and smaller than other children of the same age; however, awareness of potential undernutrition risk only emerged after guidance from posyandu cadres.

More broadly, recognition of possible growth problems tended to occur reactively following weighing and height measurement at posyandu or after direct communication from cadres and health workers rather than through proactive parental monitoring. This pattern suggests that early detection relied heavily on external health surveillance mechanisms rather than on an internalized understanding of growth indicators within the household.

The second finding indicates that local health service actions occurred after problematic growth patterns were identified through posyandu monitoring or nutritional assessment. Participants described routine monitoring through weight and height measurement. Participant 1 reported learning about the child's condition after a

nutritional examination and reported that the child received assistance through the DASHAT program. Participants also described home visits by health personnel in certain cases. In addition, participants reported receiving supplementary foods such as mung bean porridge, biscuits, and eggs, which they associated with the PMT program. Participant 2 reported receiving DASHAT assistance and linked it to children identified as stunted or at risk of stunting.

Timely Management

Participants described management responses after receiving information from cadres or health workers, mainly involving increased food intake and milk supplementation. Most participants identified adding milk and "nutritious foods" as their primary strategy, while one mentioned including vegetables alongside milk. Although these actions reflect responsiveness, they suggest a simplified understanding of nutrition focused on increasing quantity or specific items rather than a comprehensive dietary strategy emphasizing balanced intake, dietary diversity, and age-appropriate feeding practices.

Family support, particularly reminders from parents or in-laws to attend posyandu, facilitated service utilization. Community programs such as PMT and DASHAT were perceived as helpful; however, their role appeared to reinforce supplementary feeding rather than strengthen deeper nutritional knowledge and caregiving skills. Overall, post-detection management was reactive and nutritionally narrow, 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

In tertiary prevention, the findings describe caregiving changes after indications of growth problems and reported outreach related to early marriage prevention and stunting prevention at the community level.

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.

Primary prevention among families formed through early marriage in Sukahaji Subdistrict operated through health promotion and specific protection, yet these components did not function as an integrated continuum. Coherence was weakened by two interrelated factors identified in the findings: low maternal health literacy and limited socioeconomic and familial support. As shown in the Results, several participants reported confusion during early motherhood, limited understanding of stunting, and uncertainty regarding the function of iron tablets, indicating that information delivery did not consolidate into functional knowledge.

In the domain of health promotion, education from midwives and posyandu cadres was available; however, participants' accounts suggest that communication was largely one-directional and not always fully understood. This interpretation is grounded in reports that explanations were delivered quickly, that some mothers did not ask for

clarification, and that awareness of stunting often emerged only after cadres highlighted growth concerns. Consequently, prevention tended to be reactive rather than anticipatory. The reported experiences of psychological unpreparedness and stress further illustrate how limited understanding intersected with caregiving challenges, as described by several participants in the early transition to motherhood.

Although physical access to services was available to all participants, inconsistent utilization was reported by most. Participants attributed this not to distance, but to embarrassment, limited spousal encouragement, and uncertainty about the importance of routine checks. Thus, the weakness of primary prevention was empirically grounded in participants' own explanations, while the conclusion that prevention functioned as "available but fragile" is an analytical synthesis of these patterns.

Specific protection was similarly constrained. Most participants described economic limitations, uneven spousal involvement, and reliance on extended family reminders. Maternal nutrition during pregnancy and child feeding practices were shaped by household capacity, indicating that risk reduction could not be separated from structural conditions. This pattern applied to the majority of participants, although the degree of constraint varied.

Interpreted through the UNICEF framework for stunting, these findings confirm that caregiving and nutrition are shaped by broader socio-economic determinants. This study extends that perspective by demonstrating that in early-marriage contexts, primary prevention is undermined not by service absence but by limited capacity to translate access and information into sustained preventive practice.

Transition to secondary prevention: when information does not become practice and services are used inconsistently, risks persist until growth problems are

identified after observable signs emerge, shifting the focus from risk reduction to early detection and response.

Secondary Prevention

The findings show that secondary prevention among families formed through early marriage in Sukahaji Subdistrict operated mainly through early diagnosis and impact limitation. However, as reflected in the Results section, mothers' awareness of growth problems generally emerged only after weighing sessions at posyandu or direct advice from cadres and midwives. Several participants reported that they recognized potential undernutrition only after cadres highlighted low weight or growth discrepancies. This empirical pattern supports the interpretation that household responses were largely reactive and strengthened following external prompting, rather than initiated through independent monitoring.

In early diagnosis, limited maternal understanding of stunting previously evidenced by unfamiliarity with its signs, causes, and prevention contributed to inconsistent growth monitoring at the household level. Some participants described interpreting smaller body size as hereditary or typical, indicating normalization of early signs. These accounts help explain delayed detection: families lacked an internal trigger to assess risk until external actors intervened.

In impact limitation, participants described increasing food intake, providing milk, or relying on supplementary foods after receiving guidance. As reported earlier, these responses focused on adding specific items rather than implementing diversified or age-appropriate feeding strategies. This supports the analytical conclusion that impact limitation occurred within a constrained knowledge framework. The issue was not the absence of effort mothers expressed willingness to respond but that

actions were shaped by limited health literacy and narrow nutritional understanding.

Social support patterns reported in the Results further contextualize this reactivity. Limited spousal involvement and uneven family encouragement affected mothers' capacity to sustain follow-up actions, while reminders from extended family facilitated service attendance. Thus, secondary prevention depended not only on knowledge but also on relational support structures described by participants.

Government programs such as PMT and DASHAT were reported as helpful in providing supplementary intake and encouraging attendance at posyandu. However, their effectiveness varied according to mothers' engagement and comprehension, as indicated by participants who did not always fully understand the guidance provided.

Taken together, these empirically grounded patterns indicate that secondary prevention tended to move from outside to inside triggered by cadres, midwives, or programs rather than emerging from routine household initiative. This conclusion is directly derived from participants' accounts of delayed recognition, external prompting, and simplified response strategies. By documenting this reactive configuration and linking it to limited literacy and constrained partner support, the study refines the application of the Leavell and Clark model and the UNICEF framework within the specific context of early-married families in an urban, vulnerable setting.

Transition to tertiary prevention: when secondary prevention remains externally triggered and inconsistently sustained, some families enter a prolonged recovery phase requiring stable behavioral adjustment, continued monitoring, and stronger caregiving capacity.

Tertiary prevention

The findings show that tertiary prevention, understood as rehabilitation, among families formed through early marriage in Sukahaji Subdistrict is characterized by three interrelated patterns observed across most participants. First, maternal behavior change tended to occur gradually and was commonly strengthened after external intervention. Second, outreach to adolescents related to early marriage prevention was described as limited in participants' experiences. Third, posyandu cadres played a vital role as information brokers and ongoing companions. Together, these patterns suggest that rehabilitation within early married families relied not only on maternal intention but also on active community actors and continued system support.

Behavioral change in response to children identified as at risk did not generally emerge spontaneously. Several participants described initially misinterpreting or normalizing signs such as perceiving short stature as hereditary or delayed development as typical before receiving clarification from cadres or health workers. Across most cases, more proactive actions (e.g., improving food provision, attending routine checkups, and monitoring development) intensified after external guidance. This indicates that rehabilitation frequently followed a trigger–response pattern in which the initial stimulus originated outside the household. However, the strength and sustainability of change varied among participants, particularly depending on the level of accompaniment received.

Rehabilitation was also shaped by practical constraints reported by many participants, including uncertainty in selecting affordable, nutritious foods, limited understanding of balanced diets, and uneven family support. These findings indicate that awareness alone was insufficient; practical skills and resources influenced

whether rehabilitative efforts could be maintained consistently.

Participants' accounts further suggest that exposure to structured adolescent reproductive health or life-skills education prior to marriage was limited. Rather than making a broad policy claim, this finding indicates that, within this sample, early marriage often occurred in contexts where preventive education was not strongly experienced. This upstream condition may help explain why families entered caregiving roles with constrained knowledge and readiness, as reflected in earlier primary and secondary prevention findings.

Posyandu cadres emerged consistently as central actors in tertiary prevention. Participants described cadres encouraging attendance, monitoring growth, providing explanations, and offering ongoing reminders. In this sense, cadres functioned as a proximal rehabilitation mechanism linking households to formal health services. The findings therefore suggest not universally, but in most cases that rehabilitation was more stable when cadre accompaniment was continuous.

In relation to the Leavell and Clark framework, these findings align with the emphasis on rehabilitation to improve functioning after risk is identified, while adding contextual nuance: in early married families, rehabilitation was gradual, externally reinforced, and shaped by structural constraints. Consistent with the UNICEF framework, outcomes were influenced by caregiving environments and socioeconomic conditions. Overall, this study highlights that tertiary prevention in this context was most effective when external support helped translate information into feasible daily caregiving practices.

Integrated Interpretation Across Prevention Levels

Overall, the discussion indicates that stunting prevention behaviors among families formed through

early marriage in Sukahaji Subdistrict constitute an interconnected process across prevention levels. In primary prevention, health promotion and specific protection were present through midwives, cadres, and service availability, yet did not translate into consistent practice due to low maternal health literacy, one direction communication, psychosocial barriers to service use, and weak socioeconomic and family support. Fragility at the primary level was followed by a secondary prevention pattern dominated by reactive responses.Maternal awareness and action typically emerged after external prompting from cadres or health workers, and responses remained limited and not fully grounded in comprehensive nutritional understanding, even though PMT and DASHAT functioned as important levers for early detection and initial management. In tertiary prevention, maternal behavior changes again occurred gradually and was externally triggered, while practical constraints, including uncertainty about affordable balanced menus and limited environmental support, limited rehabilitation sustainability. At the same time, weak upstream outreach to adolescents highlighted broader conditions that shaped vulnerability before families entered caregiving roles.

The novelty of this study lies in its detailed and integrated mapping of how the three Leavell and Clark prevention levels operate in practice within the UNICEF stunting framework for families formed through early marriage. The findings clarify that prevention success is not determined solely by the existence of programs or services, but by the mechanisms that translate programs into everyday practice. In this context, posyandu cadres emerge as a key bridging mechanism, functioning as information conduits, triggers of behavior change, and ongoing companions who help close gaps in health literacy

and enable meaningful access among this vulnerable group.

Conclusion

This study concludes that stunting prevention behaviors among families formed through early marriage in Sukahaji Subdistrict have not developed into strong and consistent practices across prevention levels, despite the availability of community-based services and programs. At the primary prevention level, health promotion and specific protection were provided through the roles of midwives and posyandu cadres, yet household uptake and implementation remained limited due to low health literacy, largely one direction information delivery, psychosocial barriers such as embarrassment and limited spousal support, and socioeconomic constraints that reduced families' capacity to meet nutrition and caregiving needs. At the secondary prevention level, household responses to stunting were predominantly reactive and tended to emerge after external prompting, while actions were not consistently grounded in comprehensive nutritional understanding. In this context, PMT and DASHAT functioned as important entry points for early detection, access to supplementary intake, and education, but their effectiveness still depended on maternal capacity and supportive environments. At the tertiary prevention level, maternal behavior change occurred gradually and was again activated by cadres and health workers, yet sustained rehabilitation at home was constrained by limited practical nutrition skills, economic barriers, and weak social support. In parallel, upstream preventive outreach to adolescents to reduce early marriage remained suboptimal.

The novelty of this study lies in its integrated mapping of how the three Leavell and Clark prevention levels operate in practice within families formed through early

marriage. The findings also demonstrate that community-based stunting responses, consistent with the UNICEF framework, are strongly shaped by local bridging mechanisms, particularly the role of posyandu cadres as information conduits, triggers of awareness, and ongoing companions for behavior change, as well as by structural factors, especially socioeconomic support, that directly influence families' ability to translate programs into sustainable caregiving and nutrition practices.

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