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QUALITATIVE STUDIES

Cultural dynamics, social capital, and clinical challenges in stunting reduction in Indonesia: A qualitative study of pediatric nursingReni Mareta¹ , Adi Prayitno², Retno Setyowati³, Dwiningtyas Padmaningrum⁴**Author information**¹ Department of Nursing, Universitas Muhammadiyah Magelang Indonesia; School of Graduate Studies, Doctoral Program in Development Extension and Community Empowerment, Universitas Sebelas Maret, Indonesia² Study Program of the Development Extension and Community Empowerment, Universitas Sebelas Maret, Indonesia^{3,4} Faculty of Agriculture, Universitas Sebelas Maret, Indonesia renimareta@unimma.ac.id <https://doi.org/10.31603/jhns.v13i2.17245>**Abstract**

The high incidence of stunting in Indonesia is influenced by cultural dynamics, local social capital, and clinical challenges. Exploring these factors is of paramount importance, yet limited qualitative studies have focused on the population residing in areas within Magelang Regency that are categorized as disaster-prone regions. Therefore, this study aims to examine the experiences of healthcare professionals and community health volunteers in navigating the dynamics of implementing child growth and development monitoring. The study employed a qualitative approach to achieve its objectives. This study was conducted at the Muntilan 2 and Mertoyudan 2 Public Health Centers, which were selected for their extensive experience in supporting families and children with stunting in mountainous areas. Data collection was conducted between September and December 2025. Purposive sampling was employed to select participants based on predefined inclusion and exclusion criteria, resulting in a total of four key informants. Data collection instruments such as interview guides, were developed then validated by experts prior to the study. Data were gathered through in-depth interviews with key informants, including village midwives, nutritionists, community health volunteers, and community health centre nurse. Data analysis was conducted using the Miles and Huberman model, which involves three main stages: data reduction, data display, and drawing conclusions. The study identified five key themes: education and delivery of the 1000 first day of life, challenges of cultural barriers and resistance, multi-sector collaboration and local policies, specific interventions, monitoring and sustainability, and integration of disaster preparedness. The research findings indicate that program acceleration becomes more adaptive through the strategic utilization of social capital, flexibility in village fund allocation, and service innovations within integrated health post (*Posyandu* in Indonesia term). This study recommends policies that integrate intergenerational health education with community nurses acting as key educators to strengthen health promotion and accelerate stunting reduction.

Keywords: Local wisdom, paediatric nursing, qualitative study, social capital, stunting**Introduction**

Stunting or linear growth failure in toddlers is a clinical manifestation of chronic malnutrition and exposure to repeated infections that occurs from conception until the child is two years old (Suratri et al., 2025). Stunting inflicts profound and irreversible harm on a child's development (de Sanctis et al., 2021). Its consequences encompass permanent alterations to brain architecture, impaired cognitive capacity, and motor delays (Sideropoulos et al., 2025). Moreover, stunting elevates the long-term risk of degenerative diseases and severely compromises economic productivity in adulthood (Dewey & Begum, 2011; de Onis & Branca, 2016; Wulandari et al., 2025). At the global level, addressing stunting is a critical priority for safeguarding the quality of future human resources (Jalaludin et al., 2025). Data from the World Health Organization (WHO) in 2024 indicates a global stunting prevalence of 23.2%, affecting approximately 150.2 million children under the age of five (World Health Organization, 2025). The Asian region—specifically Southeast Asia and South Asia—bears a disproportionate burden, accounting for over half of the global share of childhood stunting (Azriani et al., 2024). Although Indonesia's national stunting prevalence has decreased to 19.8%, the government has established an ambitious priority policy aiming to further accelerate this reduction to reach a target of 14% (Humas BKKP [Badan

Kebijakan Pembangunan Kesehatan], 2025). Central Java Province exhibits fluctuating progress in its stunting reduction efforts; while provincial metrics dropped to 17.1%, aggregate prevalence rates across specific regions—such as Magelang Regency at 19.3%—remain high enough to warrant urgent administrative and clinical intervention (Susanti et al., 2024; Rachma, 2025).

The high prevalence of stunting in Indonesia is compounded by cultural barriers. Key obstacles include limited nutritional literacy alongside traditional dietary restrictions. In certain indigenous or local communities, strict cultural taboos prohibit the rearing and slaughtering of specific livestock. This restricts access to essential animal-source proteins and compromises childhood nutritional intake (Adi et al., 2026). Beyond dietary taboos, maternal health literacy, intra-familial power dynamics, and local customs serve as critical determinants of program success. Furthermore, the presence and mobilization (living in the mountainous area) of community social capital shapes the efficacy of stunting interventions (Sunarsih et al., 2026). Social capital is crucial for the success of a program. Community participation can be involved in various activities to prevent stunting, from antenatal classes to integrated health post (*Posyandu*) activities (Puspitasari et al., 2025). Based on Robert Putnam's social capital theory, social networks, collective norms and levels of mutual trust within a community can strengthen family resilience to deal with economic limitations and health access (Eriksson, 2011). In Indonesia, stunting management will be more effective if there is an integrated understanding of three main pillars such as cultural dynamics, the existence of social capital, and clinical challenges. This dominance of intergenerational parenting often keeps myths alive, such as the provision of complementary foods before the age of 6 months and the normalization of thin toddlers (Ramadhani et al., 2023). This can lead to social compliance bias (pseudo compliance), where people appear to comply in front of health workers but do not apply it in their home environment (Gusman et al., 2025). Furthermore, social networks of trust, the still-dominant role of integrated health post cadres, and varying village financial support across regions also impact the success of stunting management. The uneven distribution of village finances across regions, which support this program, could be a barrier to the planned program.

The prevention of stunting is focused on the golden period known as the first 1000 days of life (Suri et al., 2025). This period is widely recognized by the medical community as a critical window during which vital organs and the central nervous system develop rapidly (Likhar & Patil, 2022; Foláyan et al., 2025). Failure to meet nutritional needs during this phase can have irreversible consequences. To address this issue, the Indonesian government implemented the National Strategy for Stunting Acceleration, which incorporates multisectoral interventions. These interventions include supplementary feeding, weekly iron-folic acid supplementation for adolescent girls, mandatory integrated antenatal care, family assistance teams, and the revitalization of integrated health posts to strengthen education and promote optimal health during the first 1,000 days of life. The Asian region has developed several programs to combat stunting. In India, the Indian government has updated its national program to a national nutrition mission, focusing on multi-sectoral convergence between the ministries of health, women's health, and child development (PIB Delhi, 2026; Rajpal et al., 2020). Vietnam and Bangladesh improved nutrition by training community health workers to counsel families during home visits and clinic appointments (Kim et al., 2018; Kim et al., 2019). Although specific intervention clinical protocols have been developed, the assessment of lived experience of healthcare professional taking care stunting program is important and even limited. Most previous studies on stunting have focused on a single variable or isolated socioeconomic factors. Qualitative studies that assess the dynamics of culture, social capital, and clinical challenges interact, particularly among healthcare professional who delivering care in patient living in mountainous area are still very limited. Therefore, this study uses a qualitative phenomenological approach to explore the lived experiences and meaning constructions of health practitioners. Furthermore, delivering care in mountainous areas requires health workers to constantly navigate local traditions and community resistance. Nurses work within an interconnected system building trust with families, local leaders, and community health volunteers who often rely on traditional practices. Centering the voices of frontline healthcare workers is important for promoting adaptive health governance and nurse-led policy innovation. Documenting these lived experiences allows policy makers to identify nursing innovations, refine professional training programs, and create supportive clinical environments.

Method

This study employs a qualitative design to explore in-depth lived experiences, unravel the underlying complexity of the phenomenon, and capture the strategic insights of healthcare providers regarding stunting reduction. Assessing the lived experiences of healthcare professionals in the community is important since they operate at the critical intersection of formal clinical protocols and complex condition. Hence, exploring their firsthand accounts reveals the subtle operational barriers, resource deficits, and localized dynamics that quantitative metrics frequently miss regarding stunting. The study conducted in the Muntilan 2 and Mertoyudan 2 Public Health Centers. This study was located in Magelang Regency, a

site selected due to its complex disaster risk profile. According to the 2024–2028 Disaster Risk Study, the region faces significant hydrometeorological threats, including extreme weather, flooding, landslides, and droughts (Badan Pemeriksa Keuangan Republik Indonesia [BPK RI], 2025). Furthermore, the area is highly vulnerable to geological hazards, specifically earthquakes and volcanic eruptions. These environmental vulnerabilities directly impact the region's ecological stability, triggering both nutritional deficits and childhood stunting.

The study employed a purposive sampling method, selecting participants based on strict inclusion and exclusion criteria. The inclusion criteria required participants—regardless of gender—to be healthcare workers, village midwives, nutrition officers, or integrated health post cadres actively involved in the stunting program. Eligible participants also had to possess direct experience managing childhood stunting and treating patients from mountainous regions. Conversely, the exclusion criteria omitted healthcare workers unaligned with the stunting program and those who declined to participate due to heavy clinical workloads. A total of four participants were sampled for this study. This sample size was deemed sufficient given that qualitative research prioritizes depth of information and data saturation over statistical representation. Data saturation was achieved through prolonged individual in-depth interviews, iterative probing, and source triangulation across four participants until no new codes or conceptual themes emerged. This study included only four participants due to limitations in access to potential participants, as well as constraints related to their competence and willingness to participate in the research. The data collection yielded comprehensive insights through source triangulation, securing representation from key informants across different levels of care: one village midwife, one nutrition officer, one integrated health post cadre, and one community health center worker. Together, this combination provided a complementary perspective spanning clinical practice, program management, and direct community engagement.

Participants' demographic characteristics were collected using a structured questionnaire covering age, professional designation, educational attainment, years of clinical or community-based experience in stunting management, and work location. The following is the questions used for data collection: how do you explain the concept of the first 1000 days of life to pregnant women and families with toddlers? What strategies do you use to provide information and education to the public regarding the first 1000 days of life? What are the obstacles you often face in implementing health promotion programs for pregnant women, breastfeeding mothers, and toddlers during the first 1000 days of life? How does collaboration between health workers, community leaders and other parties optimize child growth and development during the first 1000 days of Life? Are there any specific interventions you undertake to address the problem of malnutrition or undernutrition in children in the first 1000 days of life? How do you monitor or assess the success of programs implemented to support the optimization of child growth and development during the first 1000 days of life? What do you think are the important factors in supporting the success of health promotion programs for mothers and children in the first 1000 days of life? What is your role in involving mothers and families in decisions related to maternal and child health during the first 1000 days of life? Do you feel that current programs are sufficient to increase public understanding of the first 1000 days of life? What do you think needs improvement? How does the stunting eradication program work in disaster-prone areas? Data was collected through in-depth interviews using an interview guide between September and December 2025. The average interview duration was 45 minutes for each participant. To accommodate participants' different professional roles and work schedules, individual interviews were conducted at mutually agreed-upon times and in private locations. The healthcare professionals (midwife, nutritionist, and nurse) were interviewed in private rooms at their respective health centres, while the community health cadre was interviewed at the village office. These arrangements ensured confidentiality, minimized disruptions to routine work, and encouraged participants to share their experiences openly. The interview guide was reviewed and validated by three experts with complementary areas of expertise: pediatric and community nursing, qualitative research methodology, and applied linguistics. Validation process was computed using the Item-Content Validity Index (I-CVI) on a 4-point relevance scale. Expert ratings yielded I-CVI scores ranging from 0.83 to 1.00 across items, resulting in an overall Scale-CVI/Average (S-CVI/Ave) of 0.92, demonstrating robust content validity. The instrument focused on assessing participants' conceptual understanding of the First 1,000 Days of Life, field-level obstacles, financial flexibility, local innovations, and the integration of disaster management into nutrition programming.

Data analysis was conducted using inductive thematic analysis to evaluate the interview transcripts. This approach allowed patterns and insights to emerge directly from the raw data without the constraints of a preexisting theoretical framework. Verbatim quotations were coded, transitioning from initial open codes to broader categories, and synthesized into cross-sectoral themes that capture the intersection of cultural dynamics, social capital, and clinical challenges in stunting reduction. To ensure analytical rigor, the coding process followed the six-phase thematic analysis framework (Braun & Clarke, 2006). The research team engaged in iterative cycles of data immersion, regular debriefing,

and consensus-building to resolve coding discrepancies. This collaborative verification process ensured that the final themes accurately reflect both the realities of pediatric nursing and the complex community structures influencing childhood stunting in Magelang Regency.

To establish rigor and trustworthiness in this study, the methodology strictly adheres to Lincoln and Guba's evaluative framework, ensuring credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Hamilton, 2020; Cypress, 2017). Credibility (internal validity) was achieved through source triangulation by interviewing participants which captures a multi-layered perspective on pediatric nursing and stunting. Furthermore, the interview guide underwent rigorous expert validation to eliminate instrument bias. Transferability was maintained by providing a description of the research setting in Magelang Regency, detailing how its unique geographical vulnerabilities and disaster-prone environment intersect with nutritional health. This allows future researchers to determine if the findings apply to similar disaster-exposed communities. Dependability and confirmability were ensured through a clear audit trail documenting the purposive sampling rationale, specific inclusion/exclusion criteria, and the realization of data saturation. The researcher adopted a neutral stance to preserve the integrity of the data. The final analysis reflects genuine cultural dynamics and clinical realities rather than researcher preconceptions by grounding all insights directly in the participants' narratives. This study received ethical approval from the Institutional Review Board (IRB) of the Faculty of Health Sciences at Universitas Muhammadiyah Magelang under protocol number II.3.AU/F/2025.

Results

This study comprised four participants, including a village midwife, a nutritionist, a community health worker, and an integrated health post cadre. All participants possessed over five years of professional experience in managing childhood stunting, with specific expertise in treating populations residing across mountainous terrains (**Table 1**).

Table 1. Participants characteristics.

ID	Age (years old)	Profession	Experiences (years)
P1	49	Village midwife	< 5
P2	41	Nutritionists	< 5
P3	50	Health workers	< 5
P4	37	Health cadres	< 5

Thematic analysis of the in-depth interviews yielded five major themes that illustrate the complexity of implementing the first day of life program in the field (**Table 2**).

Table 2. Themes and sub-themes.

No	Themes	Sub-themes
1	Education and delivery of the 1000 first day of life	The meaning of the golden period Local language strategies and community classes
2	Challenges of cultural barriers and resistance	Dependency behavior Patriarchal parenting and grandparents' intervention The financial perception that nutrition is expensive Chronic infectious comorbidities
3	Multi-sector collaboration and local policies	Village budget flexibility Emotional capital and the core role of community cadres
4	Specific interventions, monitoring and sustainability	Local food innovation and specialized medical formula processing The innovation of a "two-session integrated health post" Upstream intervention of adolescent girls
5	Integration of disaster preparedness	Synchronization of the Maternal and Child Health (KIA) handbook with disaster risk reduction protocols

The structure of the themes, subthemes, and representation of informant statements are presented in detail in the following description.

Theme 1: Education and delivery of the 1000 first day of life

The theme of education and the delivery of the 1000 first day of life concept emerged from two supporting sub-themes: the meaning of the golden period and local language strategies and community classes. The researcher raised this because one of the informants had a solid theoretical understanding of the irreversibility dimension of the 1000 first day of life. The focus of communication was directed at the functional development of the brain and heart.

"...starting from conception until the age of 2 years..., so we explain to the community of course in the local language to optimize brain development" (P1).

The second sub-theme is supported by findings in the field in the form of obstacles to community education (average junior high school) which were addressed by adapting local languages through integrated Ante Natal Care (ANC), maternity classes and toddler classes.

"This causes us cadres to have to adjust our explanations to languages that are easy to understand..., their average education is junior high school" (P4).

Theme 2: Challenges of cultural barriers and resistance

This theme comprises four distinct sub-themes, the first of which is dependency behavior. This sub-theme emerged from a major social barrier identified in the field: a mentality of dependence on Supplementary Food Assistance. Consequently, improvements in childhood nutritional deficits declined immediately once the program was suspended.

"...the impression is that when it's given, it's okay, when it's not given, it's okay, there are also those who think it's the government's job..." (P1).

The second sub-theme is patriarchal parenting and grandparents' intervention. This theme emerged from findings indicating that childcare practices are heavily dominated by traditional myths passed down by grandmothers and grandfathers, compounded by a distinct absence of paternal involvement.

"...the grandmother still uses the old parenting style, saying her simbah is healthy...young mothers are still heavily influenced by interventions from their in-laws or mothers..." (P2, P4).

The third sub-theme is the financial perception that nutrition is expensive. This sub-theme was raised due to the discovery of the emergence of misconceptions that nutrition must be expensive

"... they do not understand that eggs, chicken, tofu and tempeh can also be given..." (P4).

The final sub-theme focuses on chronic infectious comorbidities, specifically tuberculosis (TB) and urinary tract infections (UTIs). Field findings revealed that persistent weight faltering among toddlers was frequently triggered by chronic UTIs resulting from the prolonged, improper use of disposable diapers.

"...frequently triggered by chronic UTIs resulting from the prolonged, improper use of disposable diapers. Many toddlers experience persistent weight faltering not merely due to food scarcity, but because of undetected chronic UTIs from wearing diapers all day without timely changes, alongside pediatric TB cases that halt growth progress" (P2, P3).

Theme 3: Multi-sector collaboration and local policies

The theme of multi-sector collaboration and local policy comprises two sub-themes, the first of which is village budget flexibility. This sub-theme is supported by field observations demonstrating political and financial commitment at the village level, manifested through the strategic reallocation of village funds to secure supplementary feeding and distribute specialized medical milk. The village would provide a budget to support the existing health center program using village funds, and not all village governments could implement this.

"...when there was a problem... the discussion became more comfortable... there was no basic budget before, but the village could just relax" (P1).

The second sub-theme centers on emotional capital and the core role of community cadres. Strong relational dynamics and mutual trust between local military personnel and health cadres catalyzed maximum volunteerism, prompting cadres to selflessly cook supplementary meals on a daily basis without financial compensation.

"...my relationship with the cadres has become almost like a family relationship...in the end, the cadres are the ones who cook for me every day, you know, and there are no cooking services..." (P1).

Theme 4: Specific interventions, monitoring and sustainability

The fourth theme—encompassing specific interventions, monitoring, and sustainability—comprises three distinct sub-themes. The first is local food innovation and specialized medical formula processing. This sub-theme emerged from key field observations, most a strategic shift from generic factory-made biscuits to protein initiatives, such as community egg partnerships. Additionally, this intervention incorporated the targeted distribution of foods for special medical purposes managed through screening protocols. This is done by the village midwife in collaboration with cadres to improve nutritional intake for toddlers.

"... milk is milk provided specifically by health workers... we get it directly from the egg farmers in our village" (P1).

The second sub-theme highlights the innovation of a "two-session integrated health post". This sub-theme emerged from the distinct adaptation implemented by local cadres, who introduced split morning and afternoon sessions to accommodate the schedules of working mothers. In contrast, standard protocols across neighboring community health center catchment areas adhered strictly to a single-session format.

"There are even some places that have all arrivals open two times in the morning and afternoon to bridge so that everyone can go to integrated health post" (P1).

The third sub-theme addresses upstream interventions targeting adolescent girls. This sub-theme highlights an upstream preventative initiative operationalized through a mass movement, where young women collectively take iron supplements every Friday. This approach ensures direct compliance monitoring, reducing the risk of menstrual anemia and safeguarding future maternal health.

"We implement taking iron tablets together at school every Friday" (P1).

Theme 5: Integration of disaster preparedness

The final theme, integrated disaster preparedness in the Merapi-prone region, comprises a single sub-theme: the synchronization of the Maternal and Child Health handbook with disaster risk reduction protocols. Given Magelang Regency's geographic vulnerability as a high-risk Mount Merapi disaster zone, field findings revealed that the protection of vulnerable demographics—specifically pregnant women and toddlers—is operationalized by optimizing the disaster-readiness guidelines embedded within the handbook. Furthermore, disaster preparedness training has been integrated into routine toddler health classes through multi-sector efforts.

".. just want to link this disaster awareness to pregnant women because in the KIA book there is disaster preparation... from FPRB will collaborate with BPBD to enter the toddler class" (P1).

Discussion

This study documents that efforts to disseminate the concept of the first 1000 days of life in Magelang Regency face barriers such as the community's low levels of formal education, which is dominated by junior high school graduates. This educational profile correlates with limited health literacy specifically undermining an individual's capacity to obtain, process, and comprehend basic health information required to make informed medical decisions (Coughlin et al., 2020). This is in line with research results which state that the success of breastfeeding still depends heavily on personal experience (literacy) and social networks (Boss et al., 2021). To bridge this cognitive gap, local healthcare practitioners formulated a communication strategy, deconstructing complex scientific paradigms into accessible vernacular. This adaptation proved highly effective; rather than using dense medical terminology to explain organ growth, practitioners utilized relatable analogies drawn from the daily lives of the rural community. Furthermore, empirical findings

demonstrated that coupling health education with structured, hands-on activities significantly maximized intervention efficacy specifically resulting in a twofold increase in the likelihood of exclusive breastfeeding compared to standard didactic education alone (Srivastava et al., 2024). A study emphasized that the effectiveness of public health interventions is highly dependent on responsive communicative adaptation to the literacy level of the local population in order to avoid barriers to understanding (Niederdeppe et al., 2024). In this study, to ensure long-term sustainability, these communication channels are integrated into community education. This is operationalized through regularly scheduled pregnant women's classes and mothers-to-toddlers' classes, which are jointly financed by community health center operational assistance and village budget contributions. Inadequate nutritional literacy in pregnant women is an indirect risk factor for giving birth to stunted children, as they often struggle to prepare balanced meals (Siswati et al., 2022). Additionally, this lack of knowledge leaves mothers less prepared to monitor pregnancy danger signs or track their toddler's growth using the handbook. Success in preventing stunting depends not only on education and the "1000 First Days of Life" concept, but also on fundamental determinants like higher parental education and better environmental sanitation (Vaivada et al., 2020). Furthermore, it requires increased access to maternal health services, including optimal antenatal care and delivery in health facilities.

The study highlighted that unequal sociocultural power relations are the biggest obstacle to achieving proper nutritional intake at the household level. The dominant patriarchal cultural structure limits the role of childcare and nutritional fulfillment as if it were solely the mother's responsibility, while the husband's role is limited solely to that of a financial provider. A lack of active father involvement in child health decisions limits both moral support and the household budget needed for nutrient-dense foods like eggs and milk. A study supported that active husband involvement in nutrition planning and regular health care visits increases children's dietary diversity and reduces the risk of stunting (Nguyen et al., 2018). This situation is complicated by the hegemony of parenting by the older generation, especially the role of grandparents or in-laws who live together (Hadi et al., 2025). In Indonesia, young mothers are often caught in a difficult position, unable to resist traditional practices that contradict modern health science. Out of social pressure or habit, they frequently enforce ancient maternal myths. For example, they may prohibit pregnant women from eating scaly fish due to fears of causing itching or a fishy odor in the fetus, or refuse to feed newborns colostrum because its yellowish color is mistakenly viewed as stale or dirty milk. Furthermore, mothers often give premature complementary foods such as mashed banana, honey, or rice water to babies under six months old, claiming it will keep the baby from fussing. This action damages the baby's immature intestinal mucosa and eliminates the biological protection of exclusive breastfeeding (Ardianah et al., 2025). Sociological analysis shows that grandmothers' permissive parenting styles, based on traditional traditions without scientific basis, are correlated with high stunting rates (Ramadhani et al., 2023). When aid programs are pushed from the top down without full integration, households become dependent on the handouts rather than adopting healthy habits. Without proper community awareness, families only pretend to comply to receive benefits, leading them to stop all nutritious practices the moment the assistance stop. In this study, the research setting implemented a transition from factory-made biscuits to locally sourced food. Through a direct partnership program with local farmers, each toddler targeted for stunting is guaranteed a daily supply of one fresh egg. The use of local food has been proven to be more effective because it teaches families that the fulfillment of essential nutrients can be accessed from the surrounding environment without having to rely on industrial products from outside the region. Consistent allocation of village budget utilization for the purchase of local agricultural products stimulates microeconomic circulation at the village level (Nazarudin et al., 2023).

Stunting prevention have shifted from generic factory-made biscuits to locally sourced fresh foods. Conventional supplementary feeding programs in Indonesia have relied on the distribution of biscuits (Kemenkes RI, 2023). Though biscuits helped gain an average of 1.0 kg in three months, giving them out in programs made communities overly dependent on aid and inclined to say what program organizers wanted to hear (Gusman et al., 2025). Furthermore, key accessibility innovations were observed as implementing two-session activities to accommodate working mothers. The interventions also targeted adolescent female students through weekly supervised iron supplementation. Similar school-based Weekly Iron and Folic Acid Supplementation (WIFS) initiatives in India and Vietnam have demonstrated significant reductions in adolescent anemia rates and enhanced compliance through structured peer support (Sethi et al., 2025; Liep et al., 2025). To ensure high healthcare coverage for children, primary care services must adjust their scheduling and costs to fit changing demographics, particularly the growing number of working women (Kruk et al., 2018). Stunting does not always correlate linearly with food poverty or a lack of pure calorie intake (Patriota et al., 2024). Field data shows that toddlers continue to experience severe growth retardation despite being in a sufficient economic status and receiving adequate nutrition (Govender et al., 2021). This demonstrates the dominant role of comorbid chronic infectious diseases as major nutrition blockers (Făcă et al., 2025; Ozer & Gundogan, 2024). The high prevalence of UTIs among

toddlers in Magelang Regency is closely linked to a sociocultural shift in modern parenting—specifically, the widespread misuse of disposable diapers for convenience. Many mothers leave their children in the same diaper for extended periods, well exceeding the safe limit of 4 to 6 hours, and change them fewer than four times a day. Nurses play a key role in addressing these practices through health education that emphasizes appropriate diaper-changing frequency, proper perineal hygiene, and early recognition of UTIs symptoms in toddlers. Furthermore, community nurses can collaborate with cadres to conduct regular parenting education and home visits, helping mothers adopt evidence-based diaper hygiene practices and reduce the risk of infections. Children with chronic UTIs often do not exhibit typical painful urination symptoms, but instead manifest as intermittent, mild fever, nausea, vomiting, and decreased appetite, leading to weight loss (weight faltering) (Daniel et al., 2023).

The research area is highly vulnerable to disasters; therefore, protecting vulnerable groups, such as pregnant women and infants, is crucial—particularly concerning environmental factors that may drive stunting. In emergency response situations for natural disasters, vulnerable groups such as pregnant women, breastfeeding mothers, and toddlers face a double threat in the form of physical and nutritional vulnerability. Emergency evacuations are often not friendly to fulfilling the nutritional needs due to damaged environmental sanitation, scarcity of clean water, and limited supplies of non-instant baby food. Currently, the integration of disaster mitigation within the 1000 first days of life framework is still in its early stages. Recent initiatives include synchronizing maternal and child health records with the Local Disaster Risk Reduction Forum and coordinating with the Disaster Management Agency to institutionalize safety protocols in pediatric clinics. Integrating disaster mitigation into maternal and child health services aligns with research findings that the national disaster preparedness framework often neglects the nutritional needs of mothers and children (Kim-Herrera et al., 2025). Therefore, an integrated safety protocol is needed between disaster management agencies and primary health facilities to prevent a spike in acute malnutrition rates in disaster-prone areas. For instance, people in research setting lies in the successful activation of community social capital to cover the structural limitations of primary health care facilities. The interpersonal relationship between village midwives and health cadres at the hamlet level is no longer just a formal bureaucratic relationship, but has transformed into a very deep emotional family bond. This situation has triggered the emergence of extraordinary "emotional capital," with volunteers willingly dedicating hours each day without pay to prepare complementary food. Driven entirely by volunteerism, they receive no wages or food services for themselves, yet they continue to process these ingredients to ensure that stunted toddlers receive optimal nutritional intake. The close collaboration involves the active participation of other community groups, creating strong social cohesion that has been proven to be able to reduce stunting (Putri, 2024).

The activation of social capital received legal and tactical financial backing from the village government through flexible Village Fund allocations (Ekadinata et al., 2023). Within the context of local governance, this highlights a unique administrative agility—the bureaucratic capacity to quickly and legally refocus village budgets to address pressing field issues. For example, when there was a delay in the food distribution children with stunting, the village government immediately allocated Village Funds to buy food. In situations involving delays in intervention, pediatric and community health nurses act as clinical advocates by promptly identifying nutritional faltering and communicating urgent needs to local authorities. Meanwhile, village governments serve as institutional facilitators by reallocating local funds to address these needs, demonstrating the importance of collaboration between clinical nursing vigilance and responsive local governance. The finding of this study carries significant international relevance across global health, nursing research, health policy, and medical sociology. Its key global contributions center first on serving as a valuable model for Low- and Middle-Income Country (LMIC) health policy. Because childhood stunting remains a critical global health indicator targeted by the UN Sustainable Development Goals, Indonesia's multisectoral stunting-reduction initiative serves as a major case study. With analyzing how cultural dynamics and social capital impact policy execution, this study offers practical blueprints for other Global South nations in South Asia and Sub-Saharan Africa facing similar child malnutrition challenges.

Furthermore, the publication advances international nursing frameworks by standardizing competent pediatric care and expanding implementation science. The study shifts the international dialogue from purely clinical or nutritional fixes to community-based solutions. In doing so, it highlights the unique dual role of pediatric nurses as both clinical care providers and socio-cultural navigators who leverage trust networks to overcome traditional dietary practices and caregiving stigmas. Integrating sociological concepts like social capital into pediatric practice demonstrates how community networks directly enhance clinical compliance and outcomes. By detailing frontline clinical challenges such as workforce shortages and caregiver resistance, the research provides evidence for global organizations like the WHO and UNICEF (United Nations Children's Fund) on bridging the gap between top-down public health mandates and ground-level operational realities.

Conclusion

Accelerating stunting reduction during the critical first 1000 days of Life in Indonesia requires more than just meeting clinical nutritional needs. Program success depends heavily on integrating community social capital, maintaining flexibility in village budget management, and addressing local cultural and geographical challenges. Key drivers of successful implementation include operating two-session integrated health post services for working mothers, enabling flexible village fund allocations, transitioning toward food and nutritional supplementation, and integrating Mount Merapi disaster preparedness into the toddler class curriculum. Disaster preparedness is directly linked to stunting prevention because disaster displacements disrupt food security, clean water, and sanitation, which increases acute malnutrition and infection risks if not proactively managed. To build on these findings, policy makers and researchers should focus on four strategic priorities: reconstructing community health education models, incorporating chronic infection screening into workflows, formalizing village budget flexibility for health initiatives, and actively engaging fathers in childcare.

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AI statements

During the preparation of this work, the author used Grammarly to improve the grammar, syntax, and overall readability of the text. The final content was thoroughly reviewed, verified, and approved by the author, who takes full responsibility for the accuracy and integrity of the final output.

Author's declaration

Reni Mareta conceived and designed the study, conducted field data collection, and drafted the original manuscript. Adi Prayitno provided overall conceptual guidance and supervised the qualitative thematic analysis. Retno Setyowati analyzed policy and multi-sectoral collaboration data and refined the manuscript structure. Dwiningtyas Padmaningrum evaluated the methodological framework, contributed to data interpretation, and edited the final manuscript. All authors reviewed and approved the final version.

Availability of data and materials

All data and materials generated from this study are presented within this manuscript. Any additional details or inquiries can be requested by contacting the corresponding author.

Competing interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethical clearance

This study received ethical approval from the Ethics Committee of the Faculty of Health Sciences, Universitas Muhammadiyah Magelang (Approval No. II.3.AU/F/2025).

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Publishers and journal's note

This study contributes novel empirical qualitative evidence regarding the role of pediatric nurses in mitigating stunting within high-altitude rural populations. This article provides insights for nurse-led health promotion, community engagement, and maternal-child health policy in developing healthcare systems with evaluating the strategic deployment of social capital and intersectoral collaboration.

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Authors' insight

Key points

- Stunting reduction in Indonesia is not purely a medical issue; it requires navigating a complex interplay between local traditions, community relationships, and healthcare systems.
- Nurses serve as a bridge between formal clinical healthcare and local community structures, playing an active role as educators, advocates, and care coordinators in rural environments.
- Stunting prevention requires local community networks and clinical interventions to fit the unique contexts of specific geographic populations (such as mountain-dwelling communities).

Emerging nursing avenues

- How can pediatric nurses effectively address traditional beliefs or dietary taboos without compromising clinical standards in stunting prevention?
- What specific strategies allow healthcare workers to best mobilize community networks to maintain long-term stunting monitoring?
- What is the main resource or infrastructural barriers pediatric nurses face when delivering specialized child care in remote or mountainous areas?

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