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Exploring the Role of Islamic Counselors in Premarital Stunting Prevention in Depok City, Indonesia: A Qualitative Descriptive Study Informed by the Theory of Planned Behavior

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ABSTRACT

Introduction: Islamic counsellors occupy a strategic position in premarital services and are increasingly expected to support stunting prevention by delivering early health and nutrition messages to prospective couples. However, their involvement remains constrained by limited training, time, resources, and coordination with health services.

Methods: This qualitative descriptive study explores the role of Islamic counsellors in stunting prevention for prospective couples using the Theory of Planned Behavior (TPB) as an analytical framework. In-depth interviews were conducted with 21 participants comprising 10 Islamic counsellors at the Office of Religious Affairs (KUA), 6 prospective couples, and 5 health workers in Depok City, West Java. Participants were selected through purposive sampling to capture diverse stakeholder perspectives across institutional roles and geographic sub-districts. Data were analysed using a hybrid deductive-inductive thematic approach informed by the TPB constructs of attitudes, subjective norms, and perceived behavioral control. Data saturation was reached after 18 interviews, with three additional confirmatory interviews conducted.

Results: Three principal themes emerged: (1) religious and moral responsibility as behavioral beliefs shaping counselors' positive attitudes toward integrating stunting prevention, consistent with the attitudinal component of TPB; (2) community trust and institutional expectations as normative influences reinforcing supportive subjective norms; and (3) training, time, and resource constraints affecting counselors' perceived behavioral control, which moderates their intentions and counseling practices. These themes demonstrate how TPB constructs explain the mechanisms through which Islamic counselors navigate their health communication role within structural limitations.

Conclusion: Islamic counsellors hold perceived potential to contribute to upstream stunting prevention through premarital counselling, though this potential is conditioned by structural constraints including limited training, restricted counseling duration, and variable institutional coordination. These findings represent perceptions and implementation experiences rather than demonstrated impact on stunting outcomes. Strengthening structured training, standardized premarital counselling modules, and sustained cross-sector collaboration between religious and health sectors is recommended to support counselors' capacity. Further research employing mixed-methods designs with outcome measurement is needed to evaluate the effectiveness and generalizability of these findings.

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INTRODUCTION

Stunting is a growth disorder in which a child is significantly shorter than peers of the same age as a result of chronic malnutrition that typically begins during pregnancy and continues throughout early childhood. The physical manifestations of stunting often become apparent after the age of two years (1). The causes of stunting are multifactorial, including inadequate nutritional intake, poor awareness of the importance of healthy preparation for pregnancy beginning in adolescence and during marriage, insufficient antenatal care, and nutritional deficiencies during the first 1,000 days of life. Recurrent infections within this critical period also contribute to increased risk. Children who experience stunting are more likely to suffer from delayed physical growth, impaired cognitive development, weakened immunity, and a greater likelihood of chronic diseases later in life (2). Beyond the individual level, stunting threatens the quality of future generations, which in turn hampers national progress (3). The risk factors for stunting originate well before pregnancy, encompassing adolescent malnutrition, anemia, inadequate birth spacing, and insufficient preconception health preparation. Targeting prospective couples before pregnancy is therefore a critical upstream strategy, as the first 1,000 days of life—from conception through the child's second birthday—represent the most important window for nutritional intervention

At the global level, stunting remains a serious public health concern, with 22.3% of children under five affected in 2022 according to the UNICEF-WHO-World Bank Joint Child Malnutrition Estimates, a figure that remains far from the Sustainable Development Goals (SDGs) 2030 target of 13.5% and reflects persistent inadequacies in early childhood nutrition and maternal health interventions worldwide (4,5). Within the Southeast Asian region, the prevalence reached 26.4% based on the same UNICEF/WHO estimates, with Indonesia recording the second highest rate at 31.06% according to the 2022 Indonesian Nutritional Status Survey (SSGI), following Timor Leste at 45.1%. This regional disparity underscores the need for contextually tailored prevention strategies that account for socio-cultural and institutional factors specific to each country (5). At the national level, the prevalence of stunting has decreased from 27.7% in 2019 to 21.5% in 2023 according to SSGI data, yet it remains above the national target. Regional data from the e-PPGBM (Community-Based Nutrition Recording and Reporting System) show disparities, with West Java reporting a decline from 6.08% in 2021 to 4.34% in 2023. It should be noted that the West Java figure is based on a different measurement system (e-PPGBM, which captures prevalence among children presenting at health facilities) and is therefore not directly comparable to the SSGI population-based survey estimates cited at the national level. However, in Depok City, West Java Province, an alarming increase was observed over two consecutive years, rising from 5.7% in 2021 to 12.6% in 2022 (6). The 2023 Depok Health Profile reported that the districts with the highest prevalence were Tapos (17.88%), Sawangan (13.89%) and Bojongsari (13.37%) (7,8).

Efforts to prevent stunting require integrated and multisectoral collaboration that extends from national policy to implementation at regional and village levels. This approach must actively involve not only the health sector but also education, community, and religious sectors. Strengthening resources and capacity building for all stakeholders is critical for sustainable success. The Government of Indonesia has implemented several upstream strategies, one of which involves targeting families at risk, particularly prospective brides and grooms, as a key entry point for early prevention (9). The Office of Religious Affairs plays a strategic role in this process because of its close engagement with couples prior to marriage (10).

The Office of Religious Affairs is an official institution under the Ministry of Religious Affairs of the Republic of Indonesia, responsible for delivering religious services and guidance to the Muslim community. Premarital education and counselling provided at the Office of Religious Affairs is facilitated by Islamic religious counselors (11). Considering that the majority of Indonesia's population is Muslim and that communities often place higher trust in religious leaders than in government officials, involving Islamic counselors in delivering health communication, especially related to stunting prevention, is a strategic approach (3,12).

The engagement of Islamic counselors in stunting prevention is supported by growing empirical evidence demonstrating the effectiveness of faith-based and community-driven approaches in influencing health behavior. Studies conducted in Indonesia have shown that integrating Islamic educational values—such as faith (*iman*), worship (*ibadah*), and moral responsibility (*akhlaq*)—into health programs can enhance community awareness and promote behavioral change by framing child nutrition and care as part of religious obligation (13). Religious leaders, including Islamic counselors and *ulema*, have been found to play a critical role as trusted social influencers who disseminate

health information through sermons, study groups, premarital counseling, and community engagement activities (14). These approaches have been associated with increased knowledge of balanced nutrition, improved parenting practices, and stronger community participation in stunting prevention efforts. However, existing evidence also highlights important challenges, including limited integration between religious and health systems, insufficient training of religious counselors on stunting-related issues, and the absence of structured policy support for faith-based interventions (15). Addressing these gaps is essential to optimize the potential of religious institutions as platforms for early prevention. From a theoretical perspective, this approach aligns with behavior change frameworks that emphasize the role of interpersonal influence, social norms, and culturally embedded communication in shaping health behaviors. In the Indonesian context, where religious leaders often serve as key opinion leaders, Islamic counselors are therefore strategically positioned to contribute to stunting prevention, particularly through premarital and preconception interventions. Furthermore, KUA is responsible for organizing Premarital Guidance (*Bimbingan Perkawinan/Bimwin*) for prospective couples, a mandatory program aimed at equipping couples with knowledge on building a harmonious family (*keluarga sakinah*), reproductive health, and the rights and obligations of husbands and wives. KUA serves as the frontline institution that provides direct access to prospective couples before marriage, making it a strategic channel for delivering preconception health messages and stunting prevention information.

Guided by the Theory of Planned Behavior (TPB), this study aims to explore the role of Islamic counselors in stunting prevention through premarital counseling, with particular attention to how counselors' attitudes, subjective norms, and perceived behavioral control shape their intentions and practices. By applying TPB as an analytical framework, this study addresses a gap in the empirical literature on the application of behavioral theory to faith-based premarital health interventions and contributes to understanding the mechanisms through which religious actors influence health-related intentions and practices. Specifically, the study examines how Islamic counselors at the Office of Religious Affairs (Kantor Urusan Agama/KUA) in Depok City, West Java, navigate their expanding health promotion role within the structural constraints of the premarital counseling system. It should be noted that the findings are primarily based on institutional and provider perspectives, with limited direct evidence from prospective couples.

METHOD

This study employs a qualitative descriptive design, which is appropriate for exploring roles, meanings, institutional practices, and implementation barriers as perceived by stakeholders (16). A qualitative approach was selected because the study does not assess prevalence, statistical associations, or intervention effectiveness, but rather seeks to understand the subjective experiences and perceptions of Islamic counselors and other stakeholders involved in premarital stunting prevention. The study is reported in alignment with the COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines (17).

Research Design

This study used a qualitative descriptive design to explore stunting prevention efforts targeting prospective couples. In-depth interviews were selected as the data collection method because they are appropriate for exploring roles, meanings, and institutional practices in depth, and they allow participants to describe their experiences and perspectives in their own terms. Data were collected using semi-structured interview guides consisting of open-ended questions and probing prompts to capture detailed experiences and contextual nuances among participants.

Informants

The interview guide was developed based on the TPB framework, a review of the stunting prevention and premarital counseling literature, and consultation with two public health experts. The guide comprised five main domains: (1) counselors' understanding of stunting and its prevention; (2) the integration of health messages into premarital counseling; (3) collaboration with health workers and institutions; (4) perceived barriers and facilitators; and (5) recommendations for program improvement. The guide was pilot-tested with two counselors and refined prior to data collection. Informants were selected using purposive sampling based on their knowledge and involvement in premarital counseling and stunting prevention programs. Inclusion criteria for Islamic counselors required a minimum of one year of experience in conducting premarital counseling and active involvement in the Bimwin program. For

prospective couples, inclusion required having attended at least one premarital counseling session at a KUA office. For health workers, inclusion required current employment at a Puskesmas involved in stunting prevention programs. Exclusion criteria included individuals in temporary or acting positions. A total of 21 participants were recruited, comprising 10 Islamic religious counsellors at KUA offices across multiple sub-districts (6 male, 4 female; age range 32–55 years; mean counseling experience 8.5 years), 6 prospective brides and grooms (3 couples; age range 22–35 years), and 5 health workers from community health centers (3 nutritionists, 2 midwives; mean health service experience 10.2 years). This distribution was designed to capture diverse stakeholder perspectives across institutional roles, gender, and geographic sub-districts within Depok City. No eligible participants refused participation.

Research Location and Period

The study was conducted across five KUA offices and their corresponding Puskesmas catchment areas in Depok City, West Java, including offices in high-prevalence sub-districts (Tapos, Sawangan, and Bojongsari) as identified in the 2023 Depok Health Profile. Data collection took place between August and September 2025.

Data Collection

In-depth interviews were conducted with several key informants, including the Head of the Depok City Health Office and the Head of the KUA office in Depok City, who provided institutional policy perspectives. Additional interviews were conducted with Islamic counselors (frontline providers) and health workers (frontline providers) involved in premarital counseling programs. All interviews were conducted by the first author, a female public health researcher with prior experience in qualitative interviewing. The interviewer had no professional or supervisory relationship with the participants, which helped minimize social desirability bias. Participants were informed that the research was independent and not linked to institutional evaluation.

Field notes and audio recordings were used to document the interviews with participants' informed consent. Interviews were conducted in private rooms at the participants' workplaces to ensure confidentiality and comfort. Each interview lasted approximately 30–60 minutes. The interviewer maintained a reflexive journal documenting observations, impressions, and potential biases after each interview.

Data Analysis

Data analysis was conducted simultaneously with data collection, and data saturation was reached after 18 interviews, with three additional interviews conducted to confirm saturation, yielding no new themes or categories. Interview recordings were transcribed verbatim and reviewed repeatedly to obtain a comprehensive understanding of the data. Meaning units were identified and coded. Codes with similar meanings were grouped into categories and further developed into themes reflecting patterns in the data.

Coding and thematic analysis employed a hybrid deductive-inductive approach informed by the Theory of Planned Behavior (TPB). Initial codes were derived deductively from TPB constructs (attitudes toward the behavior, subjective norms, and perceived behavioral control), and subsequent inductive coding allowed for the emergence of additional themes not captured by the theoretical framework, such as implementation barriers and intersectoral coordination (18). This hybrid approach ensured both theoretical sensitivity and openness to data-driven insights. An audit trail was maintained documenting all analytic decisions, code definitions, and theme development. Memo writing was used throughout the process to record analytic reflections. Coding was conducted manually using Microsoft Word, supported by mind-mapping tools to visualize relationships between categories, themes, and TPB constructs. A third researcher independently examined the coding process and theme development, resolving discrepancies through discussion and consensus, thereby enhancing analytical consistency and dependability (19).

Ethical Approval

This study obtained ethical approval from the Health Research Ethics Committee, Faculty of Public Health, Universitas Indonesia (No. KET-510/UN2.F10.D11/PPM.00.02/2025). All participants provided informed consent, and confidentiality and anonymity were maintained throughout the study. Audio recordings, transcripts, and field notes were stored on a password-protected device accessible only to the research team. Quotations were anonymized, and any identifying information was removed or modified to prevent identification, particularly given the single-city

study context where institutional roles may be identifiable. To enhance credibility, the study employed triangulation across multiple data sources (counselors, prospective couples, health workers, and institutional leaders), peer debriefing among the research team, and negative case analysis to identify divergent perspectives. Researcher reflexivity was maintained through reflexive journaling and regular team discussions to acknowledge and manage the researchers' prior assumptions about the role of religious institutions in health promotion.

RESULTS

The findings are organized into three principal themes corresponding to the core constructs of the Theory of Planned Behavior: (1) attitudes toward stunting prevention in premarital counseling, reflecting how counselors' religious and moral convictions shape positive evaluations of integrating health messages; (2) subjective norms influencing counseling practices, encompassing community trust, institutional expectations, and cross-sector support; and (3) perceived behavioral control and structural constraints, addressing how training, time, and resource limitations affect counselors' perceived capacity and moderate their intentions and practices (18–20). Each theme is supported by strategically selected empirical excerpts with role-based identification, followed by interpretive synthesis that explicitly maps findings onto TPB constructs. The perspectives of each participant group (Islamic counselors, prospective couples, health workers, and institutional leaders) are indicated for each theme.

Across these three themes, the analysis reveals both enabling factors and structural challenges in integrating stunting prevention into premarital guidance programs at the Office of Religious Affairs. The qualitative analysis of in-depth interviews with 21 participants (10 Islamic counselors, 6 prospective couples, and 5 health workers) in Depok City demonstrates that the interplay of attitudes, subjective norms, and perceived behavioral control shapes counselors' capacity to function as agents of health communication within the premarital counseling system. It should be noted that the findings predominantly reflect institutional and provider perspectives, with limited direct evidence from prospective couples.

The integration of stunting prevention messages into premarital counseling has expanded the role of Islamic counselors beyond religious guidance to include basic health education and behavior change communication. Islamic counselors are increasingly expected to convey information related to nutrition, reproductive health, and stunting prevention during premarital guidance sessions at the Office of Religious Affairs (KUA). This expanded role is shaped by their position as trusted community figures, which allows health messages to be delivered in a manner that is culturally and religiously acceptable to prospective couples. These perceptions reflect the attitudinal component of TPB, as counselors evaluate the integration of health messages as a positive and meaningful extension of their role. However, the implementation of this role is constrained by limited counseling time, dense materials, lack of supporting media, and uneven capacity among counselors due to insufficient training, reflecting limitations in perceived behavioral control.

In response to these challenges, Islamic counselors and health workers have adopted several adaptive practices, including integrating health messages into religious sermons, prioritizing key messages during short counseling sessions, and collaborating informally with trained peers and health professionals. These adaptive strategies represent counselors' efforts to maintain behavioral intention despite constraints on their perceived behavioral control, consistent with the TPB framework's prediction that perceived control moderates the intention-behavior relationship.

Table 1. Role of Islamic Counselors in Premarital Stunting Prevention

Role / Strategy	Description	Benefits	Challenges
Health Education Integration	Incorporating stunting, nutrition, and reproductive health messages into premarital counseling and religious guidance	Increases acceptance of health messages; reaches couples before pregnancy	Limited time during counseling sessions; materials not standardized
Religious-Based Communication	Delivering stunting prevention messages using religious values, moral	Enhances trust and message credibility; culturally appropriate	Counselors require adequate health knowledge to avoid misinformation

Role / Strategy	Description	Benefits	Challenges
	guidance, and Islamic teachings		
Informal Collaboration	Coordination with health workers, nutritionists, and trained peers during counseling activities	Extends reach of health services; supports knowledge transfer	Coordination is inconsistent; not all counselors are involved
Adaptive Counseling Practices	Prioritizing key messages, using simple language, and encouraging follow-up health checks	Improves participant engagement and understanding	Lack of audiovisual media and supporting facilities
Peer Knowledge Sharing	Sharing information among counselors who have attended training (BIMTEK) with those who have not	Helps bridge training gaps	Knowledge transfer is uneven and not formally monitored

Table 1 presents a qualitative thematic matrix that explicitly maps empirical findings onto the core constructs of the Theory of Planned Behavior. Each row identifies a counselor role or strategy, its corresponding TPB construct (attitudes, subjective norms, or perceived behavioral control), subthemes, supporting participant groups, illustrative quotations, and the implications for counseling intentions and practices. This mapping demonstrates that counselors' understanding of stunting prevention as a religious and moral responsibility reflects attitudes shaped by behavioral beliefs; institutional expectations, community trust, and support from KUA leadership and health authorities constitute normative influences reinforcing subjective norms; and constraints related to training, time, and resources inform perceived behavioral control, moderating counseling intentions and practices. It should be noted that this table represents a conceptual synthesis informed by the TPB framework rather than an empirically validated model of causal pathways. These relationships are further illustrated in Figure 1, which presents a TPB-informed conceptual synthesis of the mechanisms through which beliefs, norms, and perceived control relate to counseling intentions and stunting prevention practices in premarital counseling settings.

Islamic counselors play a strategic role in stunting prevention efforts, particularly through education and guidance provided to prospective brides and grooms. Counselors function not only as information providers but also as initiators of behavior change, moral guides, and bridges between government programs and the community in the domains of religion and health.

In practice, counselors conduct integrated counseling activities at the KUA, often in collaboration with health workers from community health centers (Puskesmas) to deliver information on nutrition, reproductive health, and family planning. In addition, Islamic counselors demonstrate a proactive attitude in conveying religious values that support family health, such as the importance of safeguarding the body as a trust, parental responsibility, and the obligation to ensure the well-being of future generations.

> *"As counselors, we must be able to link stunting issues with religious teachings so that prospective brides and grooms understand that protecting children's health is part of worship." (Informant A)*
>
> *"We usually provide material on marital readiness and reproductive health, including nutrition before pregnancy, in collaboration with the Puskesmas." (Informant M)*
>
> *"I often emphasize the importance of not smoking, and this must also be demonstrated by the counselor." (Informant Z)*
>
> *"Our role is not only to deliver information but also to ensure that they truly understand and are willing to change." (Informant H)*
>
> *"We also emphasize the value of parental responsibility so that future parents do not neglect their children's health." (Informant S)*

Coordination among stakeholders, particularly with Puskesmas and the Health Office, is a key factor in the implementation of stunting prevention programs for prospective brides and grooms. Islamic counselors act as intermediaries between prospective couples and health workers. They coordinate counseling schedules, premarital health examinations, and ensure that each prospective couple receives education and services in accordance with program requirements.

Some informants noted that coordination functions more effectively when there is direct support from the head of the KUA or when a formal memorandum of understanding (MoU) exists between institutions.

"We usually coordinate with the Puskesmas regarding counseling schedules for prospective brides and grooms." (Informant A)

"During cross-sector meetings, we share updates on counseling activities to avoid overlap." (Informant K)

"KUA serves as the main driver, but technical support from health workers is still needed for nutrition education and health examinations." (Informant H)

"Coordination works well when there is intensive communication, especially before premarital guidance sessions." (Informant Z)

Although stunting prevention programs for prospective brides and grooms have been implemented, various barriers persist. These include limited human resources, low awareness among prospective couples regarding stunting, limited counseling time, and inadequate facilities and infrastructure.

Several counselors reported that the number of counselors in the field is disproportionate to the number of prospective couples requiring guidance. Health worker availability is also limited, resulting in difficulties in delivering integrated counseling.

Cultural barriers were also identified, including resistance to premarital health examinations and low participation in face-to-face counseling due to difficulties in obtaining work leave to attend sessions.

"The challenge is that counseling sessions often coincide with other activities, so attendance is limited." (Informant M)

"Many prospective couples still see this as just an administrative requirement." (Informant S)

"We also lack counselors in several sub-districts, so not everyone can be reached." (Informant B)

"Some prospective couples refuse health examinations because they feel healthy, even though the examinations are important." (Informant K)

"Facilities such as counseling aids are still incomplete." (Informant A)

"It is quite difficult for them to obtain permission from their workplaces." (Informant Z)

Support for stunting prevention programs comes from both internal and external sources. Internally, support from the head of the KUA and fellow counselors plays an important role in sustaining program implementation. Support in the form of educational materials, training, and operational funding contributes to more effective counseling. In addition, community support and involvement of local religious leaders strengthen the acceptance of stunting prevention messages within the community.

Several informants noted that recognition of counselors' roles in health issues represents meaningful progress in cross-sector approaches, demonstrating that stunting prevention requires collaboration beyond the health sector.

"We are greatly helped by cooperation with the Puskesmas, making counseling more comprehensive." (Informant H)

"The head of the KUA fully supports the continuation of this activity." (Informant M)

"The Health Office often assists with materials and resource persons." (Informant Z)

"We also involve local religious leaders so that stunting prevention messages are more accepted by the community." (Informant A)

The findings indicate that an ideal collaboration model for stunting prevention among prospective brides and grooms is based on sustained cross-sector synergy involving KUA, Islamic counselors, health workers, and community leaders.

At the institutional level, KUA functions as the central coordinating body, while Puskesmas provides technical and medical support. Islamic counselors act as mediators who deliver health messages with religious values that resonate with the community.

"KUA is the center, but we always coordinate with the Puskesmas." (Informant B)
"There needs to be an MoU between institutions so the program can be sustained." (Informant S)
"The materials should be integrated between religious guidance and health education." (Informant K)
"Collaboration with community leaders makes counseling more acceptable." (Informant A)

The relationships among these actors and the mechanisms of collaboration identified in this study are illustrated in the conceptual model presented in Figure 1.

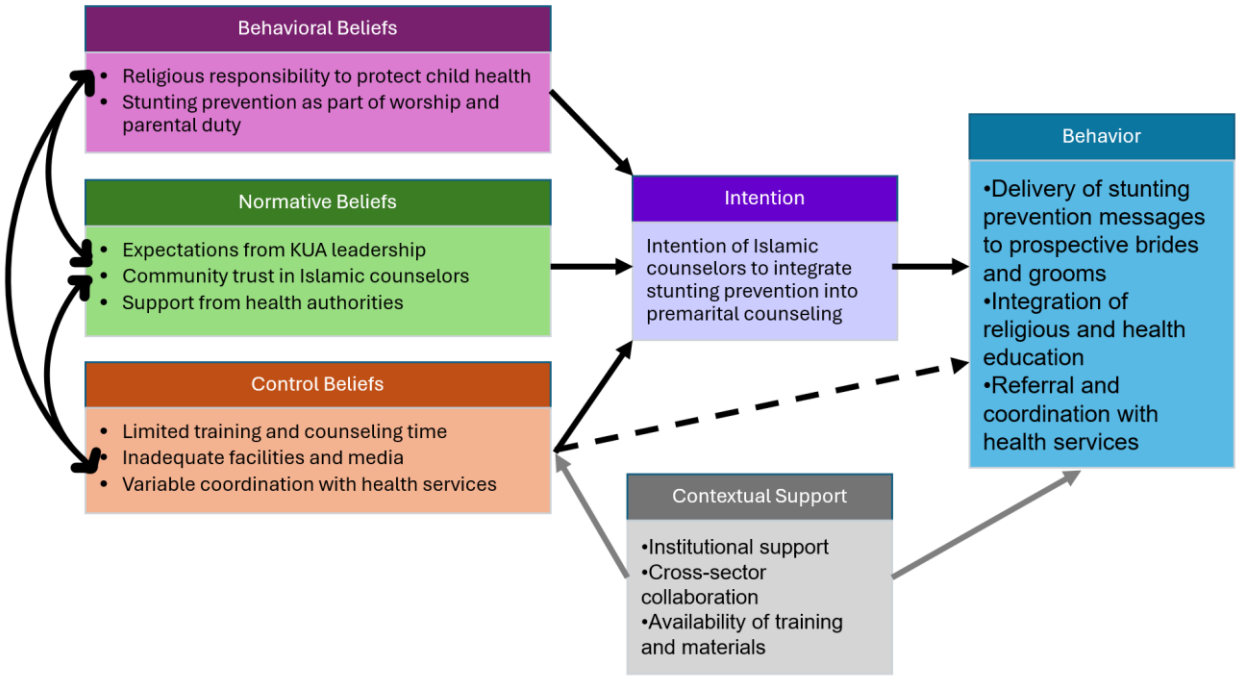

Figure 1. Conceptual model of Islamic counselors' role in premarital stunting prevention informed by the Theory of Planned Behavior

DISCUSSION

The findings of this study demonstrate that Islamic counselors play a strategic role in supporting stunting prevention efforts through education and premarital counseling for prospective brides and grooms. Their roles extend beyond providing religious instruction to include promoting health awareness, encouraging healthy behaviors, and facilitating access to health information related to reproductive health and nutrition. Counselors' attitudes and practices reflect a sense of social and religious responsibility to ensure that prospective couples are prepared to establish healthy families physically, mentally, and spiritually. The importance of counselors acting as role models for healthy behavior, such as avoiding smoking, also reflects broader family health considerations, as smoking has been identified as a family risk factor associated with stunting. Similar findings were reported by Rahmi et al. (2024), who showed that cultural norms in West Sumatra influenced couples' willingness to adopt early health practices .

In practice, Islamic counselors conduct integrated counseling activities at the Office of Religious Affairs (KUA), often in collaboration with health workers from community health centers (Puskesmas). Through this collaboration, counselors deliver information on nutrition, reproductive health, and family planning as part of premarital preparation. Some counselors also extend health messaging beyond formal counseling sessions by integrating it into sermons, religious study groups (majelis taklim), and other religious gatherings. Such contextual approaches help make stunting prevention messages more acceptable to the community by embedding them within religious and social activities. Previous studies have reported that premarital counseling significantly improves participants' knowledge regarding nutrition, reproductive health, and the risks of stunting (21,22). However, although knowledge levels increased, these improvements did not always translate into sustained behavioral change among participants.

The transformation of Islamic counselors' roles in this study reflects a broader shift in community-based health promotion approaches documented in international scholarship. Counselors increasingly incorporate religious values related to safeguarding the body as a trust (amanah), parental responsibility, and the fulfillment of children's rights to adequate nutrition and care. This shift aligns with findings from faith-based health intervention research in sub-Saharan Africa, where Zahrah et al. (2023) demonstrated that religious leaders who frame health behaviors as spiritual obligations achieve higher community adherence to nutrition and maternal health recommendations (23). Similarly, Nicol et al. (2022) found that the integration of health messaging within existing religious structures enhanced message acceptability and behavioral uptake among Muslim communities in northern Nigeria (24). These convergent findings suggest that the mechanism through which religious authority influences health behavior operates through the alignment of health practices with deeply held moral and spiritual beliefs, thereby transforming external recommendations into internally motivated obligations .

Effective coordination among stakeholders was also identified as a critical factor in implementing stunting prevention programs targeting prospective couples. Collaboration between KUA, the Health Office, and Puskesmas enables the integration of religious counseling with technical health education. Nevertheless, the study findings suggest that coordination mechanisms remain uneven across regions and often depend on informal communication rather than formal institutional arrangements. Similar challenges have been identified in previous studies, which reported that many facilitators lacked updated knowledge on stunting, nutrition, and maternal health and relied on outdated modules or verbal explanations during counseling sessions (25,26). Such inconsistencies may contribute to variations in the quality of counseling services provided to prospective couples.

In addition to coordination challenges, the study identified several structural and cultural barriers affecting the implementation of premarital stunting prevention programs. Limited human resources, insufficient counseling facilities, and restricted counseling time were frequently reported obstacles. Furthermore, some prospective couples perceived premarital counseling merely as an administrative requirement for marriage registration rather than an opportunity to obtain knowledge about family health preparation. These perceptions may reduce participant engagement and limit the effectiveness of counseling sessions. Providing educational materials, such as pocketbooks and printed information resources, has been shown to improve couples' access to reliable health information (27,28).

Resource limitations also affect the sustainability and implementation fidelity of premarital counseling programs. Several KUA offices lack sufficient funding, training resources, and educational materials to implement comprehensive counseling services. For example, Handayani . Similarly, in Jember Regency, only one-third of KUA offices conducted premarital classes because of limited budget allocations from the Ministry of Religious Affairs. These findings highlight the importance of strengthening institutional support to ensure that counseling programs can be implemented consistently across regions.

The study findings further suggest that strengthening cross-sector collaboration is essential for improving the effectiveness of stunting prevention programs targeting prospective couples. Collaboration between religious institutions and health offices has shown promising results in several regions. Muslihun et al. (2024) described how integrated programs in Lombok successfully combined religious teachings with health education, resulting in increased community engagement and awareness of healthy practices (29). In this context, Islamic counselors serve as mediators who translate technical health messages into religious values that resonate with community beliefs.

Community participation also plays a significant role in expanding the reach of stunting prevention programs. The involvement of religious leaders and majelis taklim groups enables health messages to be disseminated through existing religious and social networks. Embedding stunting prevention within these networks has been identified as an effective strategy for sustaining community-based health interventions (30). However, the need for stronger institutional arrangements remains evident. The absence of formal agreements between institutions may lead to program fragmentation and reduce continuity when personnel changes occur. Establishing formal memoranda of understanding (MoUs) between relevant institutions could therefore enhance accountability, coordination, and long-term program sustainability (31).

Overall, these findings highlight the importance of institutional and community-based collaboration in strengthening upstream stunting prevention through premarital services. Positioning the Office of Religious Affairs (KUA) as a central coordinating body, supported by technical input from Puskesmas, reflects an integrated service delivery model that aligns with current recommendations for multisectoral approaches to stunting prevention. The

role of Islamic counselors as mediators who translate health and nutrition messages into religious values reinforces their function as normative agents within the community. The application of the Theory of Planned Behavior in this study provides a structured framework for understanding how counselors' attitudes, subjective norms, and perceived behavioral control collectively shape their intentions and practices. The finding that perceived behavioral control—encompassing training adequacy, time availability, and resource sufficiency—moderates the intention-behavior relationship is consistent with the core TPB proposition and extends previous applications of behavioral theory in faith-based health contexts. However, many findings concerning training constraints, limited counseling time, inadequate resources, institutional coordination, and sustainability are implementation issues that may benefit from complementary frameworks. Concepts such as implementation fidelity, program reach, institutionalization, intersectoral coordination, and sustainability could provide additional explanatory depth.

However, limitations in training, counseling time, facilities, and cross-sector coordination constrain counselors' perceived behavioral control and thus their capacity to deliver effective health education. This study has several limitations. The qualitative design and single-city focus (Depok) limit transferability. The predominance of institutional and provider perspectives may introduce social desirability bias, and direct evidence from prospective couples is limited. The cross-sectional design precludes assessment of behavioral change over time. The study does not measure knowledge change, intention formation, service uptake, counseling fidelity, reproductive health behavior, nutrition behavior, pregnancy outcomes, or stunting outcomes. Future research should employ mixed-methods designs with larger and more geographically diverse samples, longitudinal approaches to assess sustained impact, and evaluative designs to measure changes in knowledge, intention, and health outcomes among prospective couples. Previous studies have shown that health messages delivered by respected religious and community leaders are more likely to be accepted and internalized, particularly in culturally cohesive settings.

CONCLUSION

This study suggests that Islamic counselors perceive a potential role in contributing to stunting prevention through premarital counseling for prospective couples. By applying the Theory of Planned Behavior as an analytical framework, this study extends behavioral theory into the domain of faith-based premarital health interventions, demonstrating how counselors' attitudes, subjective norms, and perceived behavioral control shape their intentions and practices. The findings represent perceptions and implementation experiences rather than demonstrated impact on stunting outcomes or behavioral change. The theoretical contribution lies in elucidating the mechanisms through which religious actors influence health-related intentions, specifically by framing health prevention as a religious obligation (attitudes), leveraging community trust as a normative resource (subjective norms), and navigating adaptive strategies within structural constraints (perceived behavioral control). Comparing implementation across districts and examining fidelity and sustainability of KUA-Puskesmas collaboration are also recommended. Practical recommendations include: the Ministry of Religious Affairs should develop standardized training modules for Islamic counselors on stunting prevention content; KUA offices should establish minimum counseling standards that allocate dedicated time for health education; formal referral mechanisms between KUA and Puskesmas should be established with clear protocols; and counselor competency indicators should be developed and monitored by the Health Office in collaboration with KUA leadership.

AUTHOR CONTRIBUTION STATEMENT

All authors contributed substantially to the conception and design of the study. The first author was responsible for data collection, data analysis, and drafting the initial manuscript. The second and third authors contributed to the development of the research framework, methodological guidance, and critical revision of the manuscript. The fourth and fifth authors contributed to data interpretation and provided important intellectual content related to maternal and child health perspectives. The sixth author supervised the overall research process, provided policy and public health perspectives, and critically reviewed the manuscript for important intellectual content. All authors have read and approved the final version of the manuscript.

CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest regarding the publication of this article. The authors have no financial or personal relationships with individuals or organizations that could inappropriately influence the research process, analysis, interpretation of data, or the conclusions presented in this study.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this manuscript, the authors used generative artificial intelligence (AI) tools to assist in language refinement, grammar checking, and improving the clarity of the manuscript. The authors carefully reviewed and edited all AI-assisted outputs and take full responsibility for the accuracy, integrity, and originality of the final content of the manuscript.

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BIBLIOGRAPHY

1. Scheffler C, Hermanussen M. What does stunting tell us? Human Biology and Public Health. 2023;3. Available from: https://doi.org/10.52905/hbph2022.3.36
2. Herbawani CK, Karima UQ, Syah Muh NH, Hidayati AN, Aprianto B. Analisis Determinan Kejadian Stunting di Wilayah Kerja Puskesmas Cinangka, Kota Depok. Ghidza: Jurnal Gizi dan Kesehatan. 2022;6(1):64–79. Available from: https://doi.org/10.22487/ghidza.v6i1.518
3. Noviansyah N, Romli K, Mukmin H, Wijayanto R. Strategy for Accelerating Stunting Prevention Through Religious Approach to Generate Qualified Generation. International Journal of Public Health Science (IJPHS). 2022;11(3):1058–1066. Available from: https://doi.org/10.11591/ijphs.v11i3.21383
4. UNICEF. Achieving the SDGs for Children in Indonesia: Emerging Findings for Reaching the Targets. Jakarta: UNICEF Indonesia; 2020.
5. World Health Organization (WHO). Joint Child Malnutrition Estimates (UNICEF-WHO-World Bank) [Internet]. 2024. Available from: https://www.who.int/data/gho/data/themes/topics/joint-child-malnutrition-estimates-unicef-who-wb
6. Munira SL. Hasil Survei Status Gizi Indonesia (SSGI) Tahun 2022. Presented at Policy Dissemination on Stunting Intervention; 2023 Feb 3. Jakarta: Badan Kebijakan Pembangunan Kesehatan, Kementerian Kesehatan RI.
7. Ministry of Health Indonesia. Indonesia Health Survey (SKI) 2023. Jakarta: Ministry of Health Indonesia; 2023.
8. Ministry of Health Indonesia. Survei Status Gizi Indonesia (SSGI) 2024. Jakarta: Ministry of Health Indonesia; 2024.
9. Badan Kependudukan dan Keluarga Berencana Nasional (BKKBN). Peraturan Badan Kependudukan dan Keluarga Berencana Nasional Nomor 12 Tahun 2021 tentang Rencana Aksi Nasional Percepatan Penurunan Angka Stunting Indonesia Tahun 2021–2024. Jakarta: BKKBN; 2021.

10. Saputri RA, Tumangger J. Upstream and Downstream Stunting Prevention in Indonesia. Journal of Political Issues. 2019;1(1):1–9.
11. Direktorat Jenderal Bimbingan Masyarakat Islam. Ruang Lingkup Kegiatan Jabatan Fungsional Penghulu dan Jabatan Fungsional Penyuluh Agama Islam. Jakarta: Kementerian Agama Republik Indonesia; 2024.
12. Ilham I. Peranan Penyuluh Agama Islam dalam Dakwah. Alhadharah: Jurnal Ilmu Dakwah. 2019;17(33):49–61. Available from: https://doi.org/10.18592/alhadharah.v17i33.2373
13. Marwan Z, Habiburrahim, Suyanta S, Silahuddin. Islamic Educational Values in the Prevention and Mitigation of Stunting in Subulussalam City. Tafkir: Interdisciplinary Journal of Islamic Education. 2025;7(1):203–218. Available from: https://doi.org/10.31538/tijie.v7i1.2485
14. Kholis N, Septiana D, Yusuf M, Rahmatullah MN. Cultural and Religious Authority in Public Health: The Role of Ulema and Traditional Leaders in Stunting Prevention in Kampar Regency, Indonesia. Fikri: Jurnal Kajian Agama, Sosial dan Budaya. 2025;9(2):444–453. Available from: https://doi.org/10.25217/jf.v9i2.4974
15. Noviansyah N, Romli K, Mukmin H, Wijayanto R. Strategy for Accelerating Stunting Prevention Through Religious Approach to Generate Qualified Generation. International Journal of Public Health Science (IJPHS). 2022;11(3):1058–1066. Available from: https://doi.org/10.11591/ijphs.v11i3.21383
16. Thorne S. Interpretive Description: Qualitative Research for Applied Practice. 3rd ed. New York: Routledge; 2025.
17. Dossett LA, Kaji AH, Cochran A. SRQR and COREQ Reporting Guidelines for Qualitative Studies. JAMA Surgery. 2021;156(9):875–876. Available from: https://doi.org/10.1001/jamasurg.2021.0525
18. Worthington AK. Theory of Planned Behavior. In: Persuasion Theory in Action: An Open Educational Resource. 2021.
19. Conner M. Theory of Planned Behavior. In: Handbook of Sport Psychology. 2020. p. 1–18.
20. Ajzen I. The Theory of Planned Behavior. Organizational Behavior and Human Decision Processes. 1991;50(2):179–211. Available from: https://doi.org/10.1016/0749-5978(91)90020-T
21. Rahmi A, Nur Islami B, Arrasyid MI, Al Fath INS, Haekal M, Sidiq A, et al. Bimbingan Perkawinan bagi Calon Pengantin Siap Cegah Stunting di Kantor Urusan Agama Kecamatan Haurgeulis, Indramayu. 2024 [cited 2026 Mar 6];1729–1741. Available from: https://altifani.org/index.php/altifani/article/view/663/335
22. Solihah E, Wahyudin U, Saepudin A. Overview of the Implementation of Pre-Marital Mentoring for Stunting Prevention by the Family Team (TPK). Media Penelitian dan Pengembangan Kesehatan. 2024;34(4):1044–1061. Available from: https://doi.org/10.34011/jmp2k.v34i4.2561
23. Zahrah SN, Damayanti NA. The Relationship Between Religious Leaders and the Knowledge of Mothers in Reducing Stunting: A Literature Review. Journal of Public Health in Africa. 2023;14(2):2622. Available from: https://doi.org/10.4081/jphia.2023.2622
24. Nicol JU, Iwu-Jaja CJ, Hendricks L, Nyasulu P, Young T. The Impact of Faith-Based Organizations on Maternal and Child Health Care Outcomes in Africa: Taking Stock of Research Evidence. Pan African Medical Journal. 2022; 43:168. Available from: https://doi.org/10.11604/pamj.2022.43.168.32983
25. Elsya V, Siregar NI. Strategi Komunikasi Bimbingan Perkawinan dalam Pencegahan Kasus Stunting di Kabupaten Temanggung. Jurnal Komunikasi Universitas Garut. 2023;9(2):241–255. Available from: https://doi.org/10.52434/jk.v9i2.3168
26. Kirana F. Konvergensi Penurunan Stunting Berbasis KUA di Provinsi Lampung. Jurnal Ilmiah Gema Perencana. 2023;2(1). Available from: https://doi.org/10.61860/jigp.v2i1.39
27. Iffah U, Safaringga M, Ridwan LH, Maharani P. The Influence of Media Leaflet on Increasing Knowledge of Reproductive Health of Brides-to-Be in Padang City. Jurnal Sosial Teknologi. 2024;4(5). Available from: https://doi.org/10.59188/jurnalsostech.v4i5.1228
28. Evrianasari N, Dwijayanti J. Pengaruh Buku Saku Kesehatan Reproduksi dan Seksual bagi Catin terhadap Pengetahuan Catin tentang Reproduksi dan Seksual di Kantor Urusan Agama (KUA) Tanjung Karang Pusat Tahun 2017. JKM (Jurnal Kebidanan Malahayati). 2017;3(4):211–216. Available from: https://doi.org/10.33024/JKM.V3I4.630

29. Muslihun M, Fahrurrozi F, Faizah F. Efektivitas Komunikasi Penyuluh Agama Islam dalam Penanganan Stunting di Kecamatan Sikur Lombok Timur. JIIP – Jurnal Ilmiah Ilmu Pendidikan. 2024;7(9):10872–10882. Available from: https://doi.org/10.54371/jiip.v7i9.6003
30. Susilawati S, Nokoe NS, Pusadan S, Nurman I. Office of Religious Affairs Banawa's Efforts in Minimizing Stunting Cases in Donggala Regency. Suloh: Jurnal Fakultas Hukum Universitas Malikussaleh. 2024;12(2):343–361.
31. My J, Rochmawati I, Juliana A. Implementation of Coordination in the Organization of One-Stop Integrated Services at the Office of Religious Affairs, Sintang District. Riwayat: Educational Journal of History and Humanities. 2024;7(1):262–279. Available from: https://doi.org/10.24815/jr.v7i1.37001