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Development of Health Promotion Model and Theory of Reasoned Action Regarding Preventive Behavior Stunting Through Training of Youth Health Cadres in Stunting Locus Village Magetan District

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ABSTRACT

Stunting is a condition of failure to grow in children due to chronic malnutrition, especially in the first thousand days of birth. Reducing stunting requires integrated interventions including specific nutritional interventions, integrated prenatal care, monitoring pregnant women's nutrition, monitoring anemia, monitoring child growth and development, providing exclusive breastfeeding, providing MP-ASI that is nutritionally adequate, empowering families to monitor the administration of Fe tablets to pregnant women, vitamins. A Toddlers, PHBS, use of iodized salt, monitoring consumption of sidewalk snacks/manufactured snacks rich in MSG. The prevalence of malnutrition among children under five in Magetan district in 2018 was 0.96%. The aim of this research is to develop the Health Promotion Model (HPM), and the Theory of Reasoned Action (TRA) to influence the behavior of adolescent health cadres in preventing stunting.The type of research is cross sectional analytical. This research develops the Health Promotion Model and Theory of Reasoned Action in increasing the participation of adolescent health cadres in preventing stunting. The research location is the stunting locus village, Magetan Regency. The research population was all adolescent health cadres in Magetan Regency. The quantitative research sample was 400 cadres. The sampling technique is proportional stratified random sampling and simple random sampling. Exogenous variables are Prior Related behavior, personal factors. Endogenous variables are Perceived benefit of action, Perceived barrier of action, Perceived self efficacy, Activity related affect, Interpersonal influences (family, peers, providers, norms, support, model), Situation influences (option demand, aesthetic characteristics), Immediates competing demands (low control) and preferences (High control), Commitment to a plan of action, Health promoting behavior and community empowerment (adolescent health cadres). Data analysis using Regresi linier.The research results show the influence of Perceived benefit of action, Perceived barrier of action, Perceived self efficacy, Activity related affect, Interpersonal influences (family, peers, providers, norms, support, model), Situation influences (option demand, aesthetic characteristics), Immediates competing demands (low control) and preferences (High control), Commitment to a plan of action, Health promoting behavior towards community empowerment (adolescent health cadres). Conclusion: The development of the Health Promotion Model (HPM) and the Theory of Reasoned Action (TRA) influence the behavior of adolescent health cadres in preventing stunting.

Keywords: Health Promotion Model_Theory of Reasoned Action_Adolescent health cadres _Prevention of stunting

INTRODUCTION

Stunting is a condition where a toddler has less length or height compared to age. This condition is measured by body length or height that is more than minus two standard deviations from the median of

WHO child growth standards. Stunting is caused by insufficient nutritional intake over a long period of time due to providing food that is not in accordance with nutritional needs (1). Stunting can occur when the fetus is still in the womb and only appears when the child is two years old. Stunting is a condition of failure to thrive in children under five due to chronic malnutrition, especially those under 1,000 HPK. The condition of failure to thrive in children under five is caused by a lack of nutritional intake for a long time and the occurrence of recurrent infections, and these two causal factors are influenced by inadequate parenting patterns, especially in the 1,000 HPK (2). Children are classified as stunted if their length or height according to their age is lower than the applicable national standards. The standards in question are contained in the Maternal and Child Health book and several other documents. Riskesdas in 2018 found that 30.8% of children experienced stunting. Even though the prevalence of stunting has decreased from 37.2% in 2020, the stunting rate remains high and there are still 2 (two) provinces with a prevalence above 40% (3). In accordance with Magetan Regent's Decree Number 188/132/Kept/403.013/2022 concerning Determining priority village locations for Accelerating stunting prevention in 2023. In Magetan Regency there are still 27 stunting locus villages spread across 8 sub-districts (4).

The direct cause of nutritional problems in children, including stunting, is low nutritional intake and health status. Reducing stunting focuses on addressing the causes of nutritional problems, namely factors related to food security, especially access to nutritious food, the social environment related to the practice of feeding babies and children, access to health services for prevention and treatment, and environmental health which includes the availability of facilities. clean water and sanitation (5). These four factors influence the nutritional intake and health status of mothers and children. Interventions on these four factors are expected to prevent nutritional problems, both undernutrition and excess nutrition (6).

The problem of stunting at an early age will have an impact on the quality of Human Resources. Stunting causes the body's organs to not grow and develop optimally. Stunted toddlers contribute to 1.5 million (15%) deaths of children under five in the world and cause 55 million Disability-Adjusted Life Years, namely the loss of healthy life span every year (7). In the short term, stunting causes failure to grow, obstacles to cognitive and motor development, and suboptimal physical body size and metabolic disorders. In the long term, stunting causes a decrease in intellectual capacity. Disorders of the structure and function of nerves and brain cells that are permanent and cause a decrease in the ability to absorb lessons at school age which will affect productivity as an adult. Apart from that, malnutrition also causes growth disorders (short and/or thin) (8). Adolescent Health Cadres are adolescents who are selected/voluntarily volunteered to take part in carrying out health service efforts for themselves, friends, family and the community (9).

Research objective: Developing a Health Promotion Model and Theory of Reasoned Action that influences stunting prevention behavior through training of village adolescent health cadres at the stunting locus in Magetan Regency.

Research urgency: increasing community empowerment in efforts to detect early and prevent stunting through training adolescent health cadres.

RESEARCH METHOD

This type of research is analytical with a cross sectional design. In this research, we examined and developed the Health Promotion Model (HPM) and Theory of Reasoned Action (TRA) variables in an effort to increase the participation of adolescent health cadres in

preventing stunting (34). The research location is the stunting locus village, Magetan Regency. The research was carried out from January 2024 to December 2024.

The research population was all 3,525 adolescent health cadres in Magetan Regency, spread across 28 sub-districts and 207 villages in Magetan Regency. The quantitative research sample used the Rule of Thumb formula of 400 people. The sampling technique for this research was proportional stratified random sampling with sampling using simple random sampling based on adolescent health cadres in each village. The exogenous variables in this research are Prior Related behavior, personal factors (35).

The endogenous variables of the research are Perceived benefit of action, Perceived barrier of action, Perceived self efficacy, Activity related affect, Interpersonal influences (family, peers, providers, norms, support, model), Situation influences (option demand, aesthetic characteristics), Immediates competing demands (low control) and preferences (High control), Commitment to a plan of action, Health promoting behavior and Behavior beliefs, Outcomes evaluation, Normatives beliefs, Motivational beliefs, Attitudes, subjective norms, Behavioral intention. The dependent variable is community empowerment (adolescent health cadres) regarding stunting prevention (36).

Data processing in research;The collected data will be processed in the following stages: editing, coding, tabulating and cleaning. Data analysis is done by: Descriptive analysis; Inferential analysis: to analyze the influence of exogenous variables in this research are exogenous variables including Prior Related behavior, personal factors. Endogenous variables in this research are Perceived benefit of action, Perceived barrier of action, Perceived self efficacy, Activity related affect, Interpersonal influences (family, peers, providers, norms, support, model), Situation influences (option demand, aesthetic characteristics), Immediates competing demands (low control) and preferences (High control), Commitment to a plan of action, Health promoting behavior (Stunting prevention) using regresi linier (37)

RESULT AND DISCUSSION

Overview of Research Location Frequency

The Magetan Regency Government is targeting to be free of stunting by 2024. This was conveyed directly by the Head of the Magetan Regency Health Service, during the Makcling Festival at Pendapa Surya Graha Magetan, Monday (25/07). Stunting cases in Magetan Regency in 2021 were recorded at 10.15% or around 2,504 toddlers out of a total of 24,657 toddlers. Until now, the number of stunting cases in Magetan Regency is still stable. Magetan Regency is one of the districts in East Java Province. Magetan Regency consists of 18 sub-districts and 22 health centers. Based on the Magetan Regent's Decree Number: 188/132/Kept/403.013/2022, dated 28 April 2022, concerning the list of priority villages for accelerating stunting prevention in 2023.

Table 1. Frequency distribution of characteristics of research respondents

No	Cadre Age (Years)	Frequency	Percentage
1	15	46	11.5
2	16	85	21.3
3	17	117	29.3
4	18	123	30.8
5	19	29	7.3
No	**Religion**	**Frequency**	**Percentage**
1	Islam	363	90.8
2	Kristen	21	5.3
3	Katholik	16	4.0
4	Hindu	0	0
5	Budha	0	0
No	**Education**	**Frequency**	**Percentage**

1	basic education (SD-SMP)	62	15.5
2	Secondary Education (SMA-Sederajat)	307	76.8
3	Higher education (D3-S1, S2, S3)	31	7.8
No	**Work**	**Frequency**	**Percentage**
1	Student/Students	122	70.0
2	Farmers/farm laborers	77	16.0
3	Private/entrepreneur	201	50.3

In Table 1, the frequency distribution of the characteristics of research respondents shows that the majority were 18 years old, 30.8%, the majority of research respondents were Muslim, 90.8%. Most of the research respondents had secondary education (high school equivalent) as much as 76.8%. Most research respondents work as students, 70%.

Mean Frequency Distribution and Standard Deviation of Health Promotion Model (HPM) Variables

Table 2. Mean frequency distribution and standard deviation of health promotion model variables

No	Variabel	Frekuensi	Persentase
1	Prior related behavior (PRB)		
	3	30	7.5
	4	46	11.5
	5	324	81.5
2	Personal factors (PF)		
	3	39	9.8
	4	53	13.3
	5	308	77.0
3	Perceived benefit of action (PBA)		
	3	46	11.5
	4	45	11.3
	5	309	77.3
4	Perceived self efficacy (PSE)		
	3	30	7.5
	4	30	7.5
	5	340	85.0
5	Activity related affect (ARA)		
	3	16	4.0
	4	60	15.0
	5	324	81.0
6	Interpersonal influences (family, peers, providers, norms, support, model) (II)		
	3	46	11.5
	4	15	3.8
	5	339	84.8
7	Situation influences (option demand, characteristic aesthetic) (SI)		
	3	30	7.5
	4	76	19.0
	5	294	73.5
8	Immediates competing demands (low control) and preferences (High control) (ICD)		
	2	16	4.0
	3	15	3.8
	4	60	15.0
	5	309	77.3
9	Comittment to a plan of action (Pencegahan stunting), Health promoting behavior (CPA)		
	3	30	7.5
	4	46	11.5
	5	324	81.0

	Variabel Penelitian	*Mean*	*Standard Deviation*
1	Prior related behavior (PRB)	4.67	0.661
2	Personal factors (PF)	4.67	0.645
3	Perceived benefit of action (PBA)	4.66	0.676
4	Perceived self efficacy (PSE)	4.78	0.570
5	Activity related affect (ARA)	4.77	0.508
6	Interpersonal influences (family, peers, providers, norms, support, model) (II)	4.73	0.653
7	Situation influences (option demand, characteristic aesthetic) (SI)	4.66	0.613
8	Immediates competing demands (low control) and preferences (High control) (ICD)	4.66	0.736
9	Comittment to a plan of action (Pencegahan stunting), Health promoting behavior (CPA)	4.74	0.588

In Table 2, the frequency distribution of health promotion model variables shows the results: Prior related behavior (PRB) regarding stunting prevention mostly gets a score of 5, 81.5%. Most of the personal factors (PF) regarding stunting prevention received a score of 5 with a score of 77.0%. Most of the perceived benefits of action (PBA) regarding stunting prevention received a score of 5, 77.3%. Perceived self efficacy (PSE) regarding stunting prevention mostly got a score of 5 with 85.0%. Activity related affect (ARA) stunting prevention mostly got a score of 5 as much as 81.0%, Interpersonal influences (family, peers, providers, norms, support, models) (II) stunting prevention mostly got a score of 5 as much as 84.4%, Situation influences (option demand, characteristic aesthetic) (SI) stunting prevention mostly got a score of 5 as much as 73.5%, Immediates competing demands (low control) and preferences (High control) (ICD) stunting prevention mostly got a score of 5 as much as 77.3% and Commitment to a plan of action (prevention of stunting), Health promoting behavior (CPA) in preventing stunting mostly got a score of 5 as much as 81.0%.

The mean of the Health promoting behavior variable ranges between 4.66-4.78, while the Standard Deviation of the health promotion model variable ranges between 0.508-0.736.

Table 3. Mean frequency distribution and standard deviation of theory of planned behavior variables

No	Variabel	Frekuensi	Persentase
1	Behavior beliefs (BB).		
	3	40	10.0
	4	57	14.3
	5	303	75.8
2	Outcomes evaluation (OE)		
	3	47	11.8
	4	47	11.8
	5	306	76.5
3	Normatives beliefs (NB)		
	3	33	8.3
	4	33	8.3
	5	334	83.5
4	Motivation beliefs (MB)		
	3	15	3.8
	4	64	16.0
	5	321	80.3
5	Attitudes (A)		
	3	41	10.3
	4	56	14.0

	5	303	75.8
6	Subjective norm (SN)		
	3	47	11.8
	4	47	11.8
	5	306	76.5
7	Behavioral intention (BI)		
	3	31	7.8
	4	34	8.5
	5	335	83.8

No	Variabel Penelitian	*Mean*	*Standard Deviation*
1	Behavior beliefs (BB)	4.66	0.653
2	Outcomes evaluation (OE)	4.65	0.681
3	Normatives beliefs (NB)	4.75	0.593
4	Motivation beliefs (MB)	4.77	0.505
5	Attitudes (A)	4.66	0.657
6	Subjective norm (SN)	4.65	0.681
7	Behavioral intention (BI)	4.76	0.582

In Table 3, the frequency distribution of the Theory of Reasoned Action (TRA) variable shows that: Behavior beliefs (BB) in preventing stunting mostly get a score of 5, 75.8%. Outcomes evaluation (OE) of stunting prevention mostly got a score of 5, 76.5%. Normative beliefs (NB) in preventing stunting mostly got a score of 5 as much as 83.5%. Motivational beliefs (MB) in preventing stunting. the majority got a score of 5 as much as 80.3%. Attitudes (A) in preventing stunting mostly got a score of 5 as much as 75.8%. Subjective norm (SN) in preventing stunting. the majority got a score of 5 as much as 76.5% and Behavioral intention (BI) in preventing stunting mostly got a score of 12 as much as 83.8%.

The mean of the theory of planned behavior variable ranges between 4.65-4.77, while the Standard Deviation of the theory of planned behavior variable ranges between 0.505-0.681.

Table 4. Regression Analysis of research variables

Variable	Unstandardized Coefficients		*t*	*sign*	Information
	B	Std. Error			
PRB	0.264	0.015	17.574	0.001	*Signifikan*
PF	-0.087	0.014	-6.032	0.001	*Signifikan*
PBA	1.160	0.025	46.911	0.001	*Signifikan*
PSE	0.145	0.019	7.572	0.001	*Signifikan*
ARA	-1.096	0.035	-31.095	0.001	*Signifikan*
II	-0.080	0.023	-3.552	0.001	*Signifikan*
SI	-0.108	0.037	-2.921	0.001	*Signifikan*
ICD	0.326	0.018	17.933	0.001	*Signifikan*
BB	0.075	0.013	5.957	0.001	*Signifikan*
OE	0.056	0.019	2.996	0.001	*Signifikan*
NB	-0.064	0.015	-4.409	0.001	*Signifikan*
MB	0.276	0.028	9.699	0.001	*Signifikan*
A	-0.078	0.013	-5.874	0.001	*Signifikan*
SN	0.132	0.015	8.717	0.001	*Signifikan*
BI	0.004	0.013	.316	0.752	*No Signifikan*

Dependent Variable: CPA

Frequency distribution of health promotion model variables. Results were obtained: Prior related behavior (PRB) regarding stunting prevention mostly got a score of 5, 81.5%. Most of the personal factors (PF) regarding stunting prevention received a score of 5 with a score of 77.0%. Most of the perceived benefits of action

(PBA) regarding stunting prevention received a score of 5, 77.3%. Perceived self efficacy (PSE) regarding stunting prevention mostly got a score of 5 with 85.0%. Activity related affect (ARA) stunting prevention mostly got a score of 5 as much as 81.0%, Interpersonal influences (family, peers, providers, norms, support, models) (II) stunting prevention mostly got a score of 5 as much as 84.4%, Situation influences (option demand, characteristic aesthetic) (SI) stunting prevention mostly got a score of 5 as much as 73.5%, Immediates competing demands (low control) and preferences (High control) (ICD) stunting prevention mostly got a score of 5 as much as 77.3% and Commitment to a plan of action (prevention of stunting), Health promoting behavior (CPA) in preventing stunting mostly got a score of 5 as much as 81.0%. The mean of the Health promoting behavior variable ranges between 4.66-4.78, while the Standard Deviation of the health promotion model variable ranges between 0.508-0.736. This paradigm shift places nurses in a key position in their roles and functions. Almost all health promotion and disease prevention services, both in hospitals and other health care settings, are carried out by nurses. This change in the paradigm of health services from curative to promotive and preventive has been responded to by nursing theorist Pender by producing work on the Health Promotion Model or health promotion model. This model combines 2 theories, namely expectancy value theory and social cognitive theory which is consistent with all theories that view the importance of health promotion and disease prevention as something logical and economical (2). The Health Promotion Model is designed to be a “complementary counterpart to the health protection model.” This model was developed to incorporate behaviors to improve health and is applicable across the life span. The aim is to help nurses know and understand the main determinants of health behavior as a basis for behavioral counseling to improve well-being and healthy lifestyles. Pender's health promotion model defines health as "a positive dynamic state, not simply the absence of disease." Health promotion is aimed at increasing the client's level of well-being. This model describes the multidimensional nature of humans as they interact in the environment to achieve health. This model focuses on the following three areas: individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcomes (3)(4). This theory suggests that humans have basic abilities: a. Symbolization is the process and transformation of experience as a guide for future action; b. Thinking ahead, anticipating events that will arise and planning actions to achieve quality goals; c. Learn from other people's experiences. Establishing rules for generations and regulating behavior through observation without the need for trial and error; d. Self-regulation uses internal standards and self-evaluation reactions to motivate and regulate behavior, regulates the external environment to create motivation to act; e. Self-reflection, thinking about one's thought processes and actively modifying them (5). The health proposition model propositions include: a. Previous behavior and acquired characteristics influence health-promoting beliefs and behaviors; b. Humans make behavioral changes where they expect valuable benefits for themselves; c. Perceived obstacles can be an obstacle to the ability to take action, a mediator of behavior as well as actual behavior (6); d. Promotion or use of oneself will increase the ability to take action; e. The positive influence on behavior resulting from good use of oneself can add to positive outcomes; f. When positive emotions or affect are associated with behavior, it is likely to increase commitment to action (7); g. Humans prefer to carry out health promotion when the behavior model is attractive, the behavior is expected to occur and can support existing behavior; h. Families, groups and health care providers are

important interpersonal resources that influence, increase or decrease the desire for health-promoting behavior; i. Situational influences on the external environment can increase or decrease the desire to participate in health-promoting behaviors (8); j. The greatest commitment to a specific activity plan is more likely to sustain health-promoting behavior over the long term; k. Commitment to activity plans is less likely to show the desired behavior if a person has low control and the desired needs are not available; l. A person can modify cognition, influencing interpersonal and physical environments that encourage health actions (9).

Frequency distribution of the Theory of Reasoned Action (TRA) variable. Results obtained: Behavior beliefs (BB) in preventing stunting mostly got a score of 5 as much as 75.8%. Outcomes evaluation (OE) of stunting prevention mostly got a score of 5, 76.5%. Normative beliefs (NB) in preventing stunting mostly got a score of 5 as much as 83.5%. Motivational beliefs (MB) in preventing stunting. the majority got a score of 5 as much as 80.3%. Attitudes (A) in preventing stunting mostly got a score of 5 as much as 75.8%. Subjective norm (SN) in preventing stunting. the majority got a score of 5 as much as 76.5% and Behavioral intention (BI) in preventing stunting mostly got a score of 12 as much as 83.8%. The mean of the theory of planned behavior variable ranges between 4.65-4.77, while the Standard Deviation of the theory of planned behavior variable ranges between 0.505-0.681. Theory of Reasoned Action (TRA) explains that behavior changes based on the results of behavioral intentions, and behavioral intentions are influenced by social norms and individual attitudes towards behavior (Eagle, Dahl, Hill, Bird, Spotswood, & Tapp, 2013, p. 123). Subjective norms describe individual beliefs regarding normal and acceptable behavior in society, while individual attitudes towards behavior are based on individual beliefs about that behavior. The theory of reason action, developed by Ajzen and Fishbein, states that the best prediction of someone's behavior is based on that person's interests. Behavioral interest is based on 2 main factors, namely: the individual's belief in the results of the behavior carried out and the individual's perception of the views of those closest to the individual regarding the behavior carried out (10). Attitudes will influence behavior through a careful and reasoned decision-making process and will have a limited impact on three things, namely: The attitude towards behavior is based on attention to the results that occur when the behavior is carried out. Behavior carried out by an individual is not only based on views or perceptions that the individual considers correct, but also pays attention to the views or perceptions of other people who are close or related to the individual. The attitudes that emerge are based on the individual's views and perceptions, and paying attention to other people's views or perceptions of the behavior will give rise to behavioral intentions which can become behavior (11). The Theory of Reasoned Action has four main terms: Beliefs, Attitudes, Subjective Norms, and Intentions: Beliefs; Belief is the probability that an object has some attribute. Typically, it is used to mean that a person has a belief that an action or behavior will result in consequences. For example, if someone says, “I think I will get lung cancer if I smoke every day,” then he or she has a belief about smoking. People can have different beliefs. For example, a person may believe that exercise can improve health with a high degree of certainty, but that exercise can cause injury with a lower degree of certainty (12). Attitude; Attitude is our assessment of a particular behavior, whether positive or negative regardless of whether a person considers the behavior to be a good or bad idea or whether the behavior will lead to an outcome they personally value. The main point of this model is that attitudes are a function of beliefs. Attitude is equivalent to the sum of the strength of beliefs multiplied

by the outcome evaluation for each person's beliefs (13). For example, if a behavioral scientist wanted to predict a person's intention to exercise, that person's attitude toward exercise would be a function of all their beliefs about whether exercise will produce the results they desire. If someone thinks that exercise will produce desired results, they will have a positive attitude towards it. Meanwhile, someone who thinks that exercise will bring unexpected results will have a negative attitude (14). Fishbein and Ajzen (1975) define attitude as "the tendency to respond positively or negatively to a psychological object. For example, someone who believes that smoking every day is not good for their health will have an attitude towards smoking. Subjective Norms; Subjective norms are the sum of all the important people in a person's life and whether they think those people would want them to do that behavior. For example, a person might wonder whether their partner, doctor, or mother would want them to exercise. Overall, intentions are a function of attitudes and subjective norms. Psychologists define two types of subjective norms: command norms and descriptive norms (15). Command norms describe what people think others should do. A person who feels the urge to perform an action, such as eating a bowl of acai, does so because they think other people think they should eat it. Meanwhile, descriptive norms are someone's perception of what other people think they should do, even though the truth may be different. For example, consider someone who is considering whether or not to wear a surgical mask (16). The norm they advocate may be that they believe that most experts want them to wear masks, as do their doctors and family members. However, descriptive norms describe a person's beliefs about what other people actually do. If someone believes that not many people wear masks, the descriptive norm that few people wear masks influences their decision about whether they should do so (17). Perceived benefit of action, Perceived barrier to action, Perceived self efficacy, Activity related affect, Interpersonal influences (family, peers, providers, norms, support, model), Situation influences (option demand, characteristic aesthetic), Immediates competing demands (low control) and preferences (High control), Commitment to a plan of action, Health promoting behavior towards community empowerment (adolescent health cadres) in preventing stunting. In order to improve the quality of life of the community and its human resources, Indonesia is still facing worrying nutritional problems, one of which is stunting. Stunting is a condition where a child's length or height is below the median of two standard deviations (-2SD) of child growth and development set by the World Health Organization (WHO, 2015). This condition can cause increased morbidity and mortality rates, disrupted physical growth, and decreased motor and cognitive development functions in children, which leads to an increased risk of chronic diseases in adulthood. In the long term, stunting can also affect children's productivity in the future. The decline in learning achievement caused by stunting conditions disrupts the child's learning process which of course will affect the quality of the child in adulthood (18)(19). In addition, the condition of children who experience stunting as children affects their height when they grow up, which has an impact on reproductive health, economic productivity and damage to development in the long term. Many factors cause children to experience stunting. Determinant factors that cause children to experience stunting in Indonesia include the mother's height and education, premature birth and length at birth, exclusive breastfeeding for 6 months, and household socio-economic status (20). In line with this research, the determinant factors that influence stunting in children aged 0 – 59 months in several Southeast Asian countries include low household income, lack of maternal education, inappropriate feeding practices for babies

and young children, water sanitation. and inadequate hygiene, and infectious diseases suffered by both family members and the baby (21). Summarized from the Indonesian Ministry of Health's Data and Data Center, children are vulnerable to stunting due to maternal knowledge and nutrition during pregnancy, parenting and feeding patterns for babies, family socio-economic conditions, poor environmental conditions such as access to sanitation and clean water, and low access to health services. . Looking at the factors above, prevention is needed which includes sensitive and specific nutritional interventions that target target groups in priority locations as the key to successful improvement in child nutrition and growth and development (22)(23). One effort that can be made to overcome the problem of malnutrition in the toddler age group is the provision of 3 Supplemental Sriwijaya University Food (PMT). In 2011, the Ministry of Health of the Republic of Indonesia provided a budget for PMT Recovery and PMT Extension activities through the Health Operational Assistance Fund (BOK) in each community health center for children aged 6-59 months. PMT Recovery can be factory and local. PMT Recovery manufacturer is an additional food biscuit that contains 10 vitamins and 7 minerals. These additional food biscuits are given once a day for 90 consecutive days or for 3 months (24)(25). Through the planned behavior approach (theory of planned behavior) developed by Ajzen. This model is a development of the previous model theory known as the Theory of Reasoned Action by Ajzen and Fishbein. In the modification, the theory of planned behavior adds one variable, namely perceived behavioral control. Both theoretical models state that desire or intention is seen as the best predicator of behavior. According to Ajzen, the central factor of individual behavior is influenced by the individual's intention towards certain behavior. Intention to behave is influenced by three components, namely attitudes, subjective norms and perceived behavioral control, including intentions to prevent stunting (26)(27).

CONCLUSION

The development of the Health Promotion Model (HPM) and Theory of Reasoned Action (TRA) has an influence on empowering adolescent health cadres in efforts to prevent stunting.

REFERENCES

1. Journal CD, Angriani Y, Banyumulek D, Kediri K, Barat KL, Safety F, et al. Peningkatan Pengetahuan Food Safety , Hygiene Personal Dan Sanitasi Pada Ibu Rumah Tangga Untuk. 2024;5(2):3987–92.
2. Putri SN, Sudiyat R. Pengmbangan E-Book Anti Stunting (EBAS) Bagi Kader Kesehatan Mengenai Pencegahan Stunting Development of E-Book Anti Stunting (EBAS) for Health Prevention Cadres Stunting. J Kesehat Siliwangi. 2021;2(1):267.
3. Kementerian Kesehatan RI Badan Penelitian dan Pengembangan. Hasil Utama Riset Kesehatan Dasar. Kementrian Kesehat Republik Indones [Internet]. 2018;1–100. Available from: http://www.depkes.go.id/resources/download/info-terkini/hasil-riskesdas-2018.pdf
4. Magetan B. SK Bupati Lokus stunting MGT.pdf. Pemkab Magetan; 2022.
5. Dwi Astuti D, Benya Adriani R, Widyastuti Handayani T, Keperawatan J, Kemenkes Surakarta P. Pemberdayaan Masyarakat Dalam Rangka Stop Generasi Stunting. JMM (Jurnal Masy Mandiri). 2020;4(2):156–62.
6. Fabrizio CS, van Liere M, Pelto G. Identifying determinants of effective complementary feeding behaviour change interventions in developing countries. Matern Child Nutr.

2014;10(4):575–92.
7. Tedla M, Malede A, Berhan Z. Prevalence and associated factors of malnutrition among under-five children living in slum areas of Bahir Dar Town, Ethiopia. Pan Afr Med J. 2024;47.
8. Antonio Suarez Weise. WHO Global Nutrition Target : Stunting Policy Brief. Stunting Policy Br. 2014;1–21.
9. Purbowati MR, Ningrom IC, Febriyanti RW. Gerakan Bersama Kenali, Cegah, dan Atasi Stunting Melalui Edukasi Bagi Masyarakat di Desa Padamara Kabupaten Purbalingga. AS-SYIFA J Pengabdi dan Pemberdaya Kesehat Masy. 2021;2(1):15.
10. Gottwald M. Health Promotion Models. Rehabil Use Theor Model Pract. 2006;131–46.
11. Nasution A, Parinduri SK, Asnifatima A, Saci MAA. Peluang dan Tantangan Promosi Kesehatan Kader Kesehatan Remaja Kota Bogor. J Ilmu Kesehat Masy. 2021;10(01):46–54.
12. Manggala T, Suminar JR, Hafiar H. Faktor-Faktor Keberhasilan Program Promosi Kesehatan "Gempur Stunting" Dalam Penanganan Stunting di Puskesmas Rancakalong Sumedang. Cover J Strateg Commun. 2021;11(2):91–102.
13. Tiwari R, Ausman LM, Agho KE. Determinants of stunting and severe stunting among under-fives: Evidence from the 2011 Nepal Demographic and Health Survey. BMC Pediatr. 2014;14(1):1–15.
14. Pender N. The Health Promotion Model. Curr Nurs Theor [Internet]. 2011;3rd:51–75. Available from: http://nursing.umich.edu/faculty-staff/nola-j-pender%0Ahttp://nursing.umich.edu/faculty-staff/nola-j-pender%0Ahttp://currentnursing.com/nursing_theory/health_promotion_model.html
15. Khan FR. Private sector participation for women nutrition. J Nutr Food Sci. 2018;08(2):165–74.
16. Aty YMVB, Herwanti E, Mochsen R. Simultaneous Factors Affecting Toddler Nutritional Status. J Info Kesehat. 2021;19(1):64–76.
17. Liem S, Marta RF, Panggabean H, Ajisukmo CR. Comparative Review Between COVID-19 and Stunting: Communication Framework Toward Risk-Mitigating Behavior. Bul Psikol. 2020;28(2):113.
18. Handayani TE, Suharto A, Rahayu TP. Development of Social Capital Based on Health Promotion Model to Improve Behavior for Taking VIA Test. Heal Notions [Internet]. 2019;3(6). Available from: http://heanoti.com/index.php/hnhttp://heanoti.com/index.php/hn/article/view/hn30602
19. Hall C, Bennett C, Crookston B, Dearden K, Hasan M, Linehan M, et al. Maternal Knowledge of Stunting in Rural Indonesia. Int J Child Heal Nutr. 2018;7:139–45.
20. Srof BJ, Velsor-Friedrich B. Health promotion in adolescents: A review of Pender's health promotion model. Nurs Sci Q. 2006;19(4):366–73.
21. Heydari A, Khorashadizadeh F. Pender's health promotion model in medical research. J Pak Med Assoc. 2014;64(9):1067–74.
22. Purnamasari I, Nasrullah D, Choliq I, Hasanah U. Factors Relating to Stunting Prevention Behavior Based on Health Promotion Model (HPM) Theory in Tanah Kali Kedinding Community Health Center Surabaya [Internet]. Atlantis Press SARL; 2024. Available from: http://dx.doi.org/10.2991/978-2-38476-273-6_62
23. Madden TJ, Ellen PS, Ajzen I. A Comparison of the Theory of Planned Behavior and the Theory of Reasoned Action. Personal Soc Psychol Bull. 1992;18(1):3–9.

24. Trafimow D. The Theory of Reasoned Action. Vol. 19, Theory & Psychology. 2009. p. 501–18.
25. Mahyarni M. Theory Of Reasoned Action Dan Theory Of Planned Behavior (Sebuah Kajian Historis tentang Perilaku). J EL-RIYASAH. 2013;4(1):13.
26. Shimp TA, Kavas A. The Theory of Reasoned Action Applied to Coupon Usage. J Consum Res. 1984;11(3):795.
27. Vallerand RJ, Deshaies P, Cuerrier JP, Pelletier LG, Mongeau C. Ajzen and Fishbein's Theory of Reasoned Action as Applied to Moral Behavior: A Confirmatory Analysis. J Pers Soc Psychol. 1992;62(1):98–109.
28. Wijanarka A, Fadhilah D, Kesehatan P, Kesehatan K. Development of Local Foodstuff-Based Complementary Food Porridge MP-ASI "SITOLE" Products as an Effort to Manage Stunting. 2023;21:295–307.
29. Newman JE, Garces A, Mazariegos M, Michael Hambidge K, Manasyan A, Tshefu A, et al. Theory-driven process evaluation of a complementary feeding trial in four countries. Health Educ Res. 2014;29(2):297–305.
30. Pradana PH FK, Sriatmi A, Kartini A. The CIPP Model of Stunting Management Program During Covid-19 Pandemic in Semarang City. J Gizi Indones (The Indones J Nutr. 2022;10(2):150–60.
31. Nazli R, Erlinda E. Pemodelan Aplikasi Pendukung Keputusan Makanan Pendamping Air Susu Ibu (Mpasi) Berbasis Android. J Teknol Dan Open Source. 2020;3(2):272–83.
32. Nina N, Supriyatna R. Determinan Efektivitas Program Kader Kesehatan Remaja di SMAN 01 Dramaga Bogor. J Ilmu Kesehat Masy. 2021;10(02):123–32.
33. Kesehatan K, Di R, Pandemi M. 1 , 2* , 3 3. 2022;1790–7.
34. Nursalam 2014. Konsep-Dan-Penerapan-Metodologi-Penelitian-Ilmu-Keperawatan-Ed-2_Library-Stikes-Pekajangan-2014.Pdf. 2014.
35. Suharto, Agung, Heru Santoso Wn Bjs. Metode Penelitian Dan Statistika Dasar Suatu Pendekatan Praktis. CV. Media Sains Indonesia. 2022. 151 p.
36. Nursalam. Metodologi Penelitian09162019.pdf [Internet]. 2016. Available from: http://eprints.ners.unair.ac.id/982/1/METODOLOGI PENELITIAN09162019.pdf
37. Almomani RZQ, Al-Ghdabi RR, Hamdan KM. Patients' satisfaction of health service quality in public hospitals: A PubHosQual analysis. Manag Sci Lett. 2020;10(8):1803–12.