How Local Culture Shapes Maternal Decision-Making During the First 1,000 Days of Life ?: A Phenomenological Study in West Aceh, Indonesia

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ABSTRACT

Introduction: Childhood stunting remains a major public health challenge in Indonesia. Although cultural factors influence maternal and child health behaviours, limited evidence explains how cultural norms, local traditions, and community beliefs interact to shape maternal decision-making during the first 1,000 days of life. This study explored how local culture shapes maternal decision-making related to childhood stunting during the first 1,000 days of life in West Aceh Regency, Indonesia **Methods**: A qualitative phenomenological study was conducted involving 14 purposively selected participants, including mothers, village midwives, ma'blien (traditional birth attendants), grandmothers, and Posyandu cadres. Data were collected through semi structured in-depth interviews and analyzed using thematic analysis. Trustworthiness was enhanced through triangulation, member checking, peer debriefing, and reflexive documentation. **Results**: Three interrelated themes emerged: cultural norms, local traditions, and community beliefs. Cultural norms influenced maternal diet and behaviour during pregnancy and the postpartum period. Local traditions, including the role of ma'blien, shaped maternal and newborn care. Community beliefs influenced breastfeeding, complementary feeding, healthcare-seeking, and childcare through intergenerational knowledge transmission. Together, these dimensions constituted an interconnected sociocultural system that shaped maternal decision-making. **Conclusion**: Maternal decision-making related to childhood stunting is embedded within an interconnected sociocultural system rather than isolated cultural practices. Effective stunting prevention strategies should integrate culturally sensitive interventions while engaging influential community members. These findings

provide a conceptual framework for culturally responsive maternal and child health programmes.

.**Keywords :** Stunting; Decision Making; Maternal Health; Midwifery; Infant Nutrition

1. Introduction

Stunting remains one of the most important public health challenges worldwide because it has long-term consequences for children's physical growth, cognitive development, educational attainment, and future productivity.[1,2] According to joint estimates from United Nations Children's Fund (UNICEF), the World Health Organization (WHO), and the World Bank, the number of children under five years of age affected by stunting declined from 203.6 million in 2000 to 148.1 million (22.3%) in 2022. Despite this progress, the global burden remains substantial, with more than half of all affected children living in Asia and approximately two-fifths in Africa.[3] Indonesia continues to be among the countries with the highest prevalence of stunting in the Southeast Asia Region, making stunting reduction a major public health priority.[4]

Indonesia has implemented various multisectoral strategies to reduce stunting, resulting in a gradual decline in national prevalence. The 2022 Indonesian Nutritional Status Survey reported that the prevalence of stunting had decreased to 21.5%, although it remained above the WHO threshold of 20%.[5] Consequently, stunting prevention has become one of the national development priorities through integrated interventions involving the health sector, local governments, and village communities.[6,7] However, improvements have not been equally achieved across all regions.[5] Aceh Province remains one of the provinces contributing substantially to the national stunting burden.[5] Although the provincial prevalence declined from 33.2% in 2021 to 29.4% in 2023, West Aceh Regency showed a contrasting pattern, with the prevalence increasing from 27.4% in 2021 to 30.4% in 2022 and reaching 33.4% in 2023.[5,8] This trend suggests that contextual factors beyond existing health interventions may continue to influence childhood stunting in this setting.

Stunting is a multifactorial condition resulting from the interaction of biological, environmental, behavioral, and social determinants. Previous studies have identified inadequate dietary intake, inappropriate infant feeding practices, recurrent infectious diseases, poor sanitation, and limited access to health services as important determinants of impaired child growth.[9,10] Beyond these immediate determinants, broader social factors, including education, household economy, food systems, and cultural environments, also influence maternal and child health behaviours associated with nutritional status.[11,12] These findings indicate that stunting cannot be adequately understood without considering the social and cultural context in which maternal decisions are made.[13] . In many Indonesian communities, cultural values continue to shape maternal behaviours during pregnancy, childbirth, the postpartum period, breastfeeding, and complementary feeding.[14] In West Aceh, traditional beliefs and customs remain closely integrated into maternal and child health practices. Anthropological evidence shows that the *ma'blien* continues to be a highly respected traditional birth attendant who provides care throughout pregnancy and the postpartum period.[14] Cultural practices such as *peunulang*, which symbolises the family's trust in the *ma'blien*, and *madeung*, a postpartum period characterised by dietary regulations and behavioural restrictions, remain widely practised.[15] These traditions may influence maternal nutrition, infant feeding practices, and decisions regarding the use of formal health services during the first 1,000 days of life, a

critical period for preventing childhood stunting.[15,16]

Previous studies have consistently demonstrated that cultural beliefs, food taboos, and traditional childcare practices are associated with maternal and child nutrition.[16,17] However, most studies have examined these cultural practices individually, focusing on specific beliefs or behaviours.[18] As a result, there is still limited understanding of how different cultural dimensions, including norms, traditions, and community beliefs, interact to shape maternal decision-making throughout the first 1,000 days of life.[19,20] Exploring these interactions is important because maternal decisions are rarely influenced by a single cultural practice but rather by multiple sociocultural factors operating simultaneously within families and communities. Such understanding is needed to support the development of culturally appropriate public health interventions for stunting prevention.[18]

Therefore, this phenomenological study aimed to explore how local cultural norms, traditions, and beliefs shape maternal decision-making during the first 1,000 days of life and how these sociocultural processes contribute to the risk of childhood stunting in West Aceh Regency, Indonesia. By examining the lived experiences of mothers, traditional birth attendants, health workers, community health volunteers, and family members, this study provides evidence to support more culturally responsive strategies for stunting prevention and maternal and child health programmes.

2. Methodology

Design

This qualitative study employed a phenomenological approach to explore how local culture shapes maternal decision-making related to childhood stunting during the first 1,000 days of life in West Aceh Regency, Aceh Province, Indonesia.

Participants

Participants were recruited using purposive sampling to obtain information-rich cases with direct experience and knowledge of local cultural practices related to maternal and child health. Snowball sampling was subsequently used to identify additional *ma'blien* (traditional birth attendants) recognized by community members as key cultural informants.

Setting

The study was conducted from January to May 2026 and is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guideline.

Study population

Sample size

A total of 14 participants were included, comprising six mothers of children aged 12–59 months, two village midwives, two ma'blien, two grandmothers, and two Posyandu cadres. Maximum variation sampling was applied to obtain diverse perspectives regarding maternal and child health practices within the local cultural context. Recruitment continued until data saturation was achieved, indicated by the absence of new codes or themes during subsequent interviews. All participants voluntarily provided written informed consent before participation. Detailed inclusion criteria for each participant group are presented in Table 1.

Table 1. Characteristics and inclusion criteria of study participants (n=14)

Participant group	Inclusion criteria	n
Primary informants (Mothers)	Mothers of children aged 12–59 months with and without stunting, residing in West Aceh Regency, having experience raising children within the local cultural environment, willing to participate, and providing written informed consent	6

Key informants (Village midwives)	Village midwives with at least five years of experience in maternal and child health services in the study area	2
Key informants (*Ma'blien*)	Traditional birth attendants recognized by the community for their roles in pregnancy, childbirth, and postpartum care	2
Supporting informants (Grandmothers)	Grandmothers actively involved in caring for their grandchildren	2
Supporting informants (*Posyandu* cadres)	Active *Posyandu* cadres involved in growth monitoring and community nutrition activities	2

Data collection

Data were collected through face-to-face semi-structured in-depth interviews using an interview guide developed from the literature and study objectives. The guide explored participants' experiences and perspectives regarding cultural norms, traditions, beliefs, maternal nutrition, breastfeeding, complementary feeding, childcare practices, and healthcare-seeking behaviors during the first 1,000 days of life.

All interviews were conducted by the first author, who had prior training and experience in qualitative interviewing. Before each interview, participants received information about the study objectives and voluntary nature of participation. No prior personal or professional relationship existed between the interviewer and participants. Interviews were conducted in locations selected by participants, including their homes, community health facilities, and village meeting places, to ensure privacy and comfort. Each interview lasted approximately 45–90 minutes and was audio-recorded with participants' permission. Field notes were maintained to document contextual observations and non-verbal expressions. Data collection and preliminary analysis were undertaken concurrently to allow emerging findings to guide subsequent interviews.

Ethical considerations

Ethical approval was obtained from the Health Research Ethics Committee of Universitas Syiah Kuala (No. 011/EA/FK/2026). Written informed consent was obtained from all participants before data collection. Participants were informed about the study objectives, voluntary participation, confidentiality, and their right to withdraw at any stage without consequences. Personal identifiers were removed from transcripts to ensure anonymity, and all procedures were conducted in accordance with the principles of the Declaration of Helsinki.

Data analysis

Interview recordings were transcribed verbatim immediately after each interview. The transcripts were read repeatedly to achieve familiarity with the data before coding. Data were analyzed using thematic analysis guided by the interactive model of Miles and Huberman, consisting of data reduction, data display, and conclusion drawing and verification. Meaningful units related to sociocultural beliefs, traditions, and maternal decision-making were assigned initial codes, which were iteratively compared and grouped into categories before being synthesized into overarching themes. Data displays, including matrices and thematic summaries, were used to compare perspectives across participant groups and identify relationships among emerging themes. Throughout the analytical process, conclusions were continuously verified by revisiting the original transcripts to ensure consistency with participants' narratives. NVivo version 12 Pro (QSR International, Melbourne, Australia) was used to facilitate data organization and coding.

Data trustworthiness

Trustworthiness was established according to Lincoln and Guba's criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through triangulation of data from mothers, village midwives, ma'blien, grandmothers, and Posyandu cadres, prolonged engagement during data collection, and member checking with selected participants. Dependability was supported through detailed documentation of interview procedures, field notes, coding decisions, and analytic processes. Confirmability was strengthened by maintaining an audit trail and conducting regular discussions among the research team to minimize researcher bias. Transferability was enhanced through purposive maximum variation sampling and detailed descriptions of the study setting, participants, and research procedures.

3. Results

Characteristics of Participants

A total of 14 informants participated in this study, comprising six primary informants (mothers of children with and without stunting), four key informants (two village midwives and two *ma'blien*), and four supporting informants (two grandmothers and two Posyandu cadres). Participants ranged in age from 23 to 63 years and represented diverse educational backgrounds and caregiving roles, providing a broad range of perspectives on maternal and child health practices within the local cultural context (Table 2).

Table 2. Characteristics of study participants

Informant	Gender	Age (Years)	Last Education	Status
Mother of Toddler 1	Female	32	College	Mother of Toddler Not Stunted
Mother of Toddler 2	Female	28	High School	Mother of Toddler Stunted
Mother of Toddler 3	Female	34	Junior High School	Mother of Toddler Stunted
Mother of Toddler 4	Female	30	High School	Mother of Toddler Stunted
Mother of Toddler 5	Female	27	College	Mother of Toddler Not Stunted
Mother of Toddler 6	Female	23	High School	Mother of Toddler Not Stunted
Midwife 1	Female	42	College	Midwife
Midwife 2	Female	39	College	Midwife
Ma'blien 1	Female	56	Did Not Finish Elementary School	*Ma'blien* (Traditional Birth Attendants)
Ma'blien 2	Female	63	Did Not Finish Elementary School	*Ma'blien* (Traditional Birth Attendants)

Informant	Gender	Age (Years)	Last Education	Status
Grandmother 1	Female	52	Junior High School	Grandmother of toddler with Not Stunted
Grandmother 2	Female	61	Elementary School	Grandmother of toddler with Stunted
Posyandu Cadre 1	Female	32	High School	Posyandu Cadre
Posyandu Cadre 2	Female	35	College	Posyandu Cadre

Themes and Subthemes Identified from the Interviews

Qualitative analysis identified three major themes and twelve subthemes describing how local culture shapes maternal decision-making during the first 1,000 days of life and contributes to childhood stunting risk in West Aceh Regency (Table 3).

Table 3. Themes and subthemes identified from the interviews

Theme	Subthemes
Cultural norms	Food taboos during pregnancy
	Behavioral restrictions during pregnancy
	Postpartum dietary restrictions
Local traditions	*Jok bu bidan*
	Role of *ma'blien*
	Umbilical cord care
	Peucicap ceremony
	Postpartum care practices
Community beliefs	Colostrum beliefs
	Honey or formula feeding before breast milk
	Traditional medicine
	Beliefs regarding healthy children and stunting

Theme 1. Cultural Norms Regulating Maternal and Child Health Practices

Participants consistently described cultural norms as important factors influencing maternal behaviours during pregnancy and the postpartum period. These norms primarily consisted of food

taboos and restrictions on daily activities that were believed to protect mothers and unborn children from miscarriage, difficult labour, and postpartum complications. Although healthcare workers provided nutritional counselling, participants reported that advice from older family members remained highly influential in daily decision-making.

Food taboos during pregnancy

Food restrictions were widely practiced throughout pregnancy. Several foods, including pineapple, durian, and jengkol, were avoided because they were believed to increase the risk of miscarriage, poisoning, or pregnancy complications.

"*Pineapple is rarely consumed, and durian is also prohibited. Like jengkol, it is also prohibited because of the fear of getting drunk or poisoned, or of miscarriage.*" (Mother of Toddler 2)

Behavioral and postpartum restrictions

Participants also described restrictions on certain behaviours and foods during pregnancy and after childbirth. These practices were intended to facilitate delivery and accelerate maternal recovery.

"*Eating rice crusts is prohibited. In the past, people said it was feared that the placenta would stick to the uterine wall.*" (Mother of Toddler 4)

These findings indicate that cultural norms continue to shape maternal dietary and behavioural practices during critical periods of pregnancy and postpartum care.

Theme 2. Local Traditions Supporting Maternal and Newborn Care

Participants reported that several traditional practices remain integral to maternal and newborn care in West Aceh. These traditions were viewed not only as cultural heritage but also as expressions of family responsibility, community support, and protection for mothers and infants.

Jok bu bidan and the role of ma'blien

One of the most frequently described traditions was jok bu bidan, a customary practice in which families formally entrust pregnant women to the care of a ma'blien by providing food and symbolic gifts. Participants perceived this practice as ensuring continuous assistance throughout pregnancy, childbirth, and the postpartum period.

"*At seven months of pregnancy, there is a tradition called jok bu bidan, which means bringing rice to the village midwife. The purpose is to entrust the mother to the village midwife from seven months of pregnancy until delivery*." (Mother of Toddler 3)

Another participant explained:

"*The food given to the village midwife is called jok bu bidan. After that, the mother and baby become the responsibility of the ma'blien, who takes care of them until 44 days after childbirth*." (Grandmother 1)

Postpartum rituals

Participants also described postpartum practices, including umbilical cord care and peucicap, as traditions intended to promote the health, protection, and well-being of newborns. Overall, these traditions illustrate the continuing influence of customary practices on maternal and infant care within the community.

Theme 3. Community Beliefs Influencing Maternal Decision-Making

Participants described various community beliefs that influenced decisions regarding breastfeeding, infant feeding, treatment seeking, and perceptions of child health. These beliefs were generally transmitted across generations and were often regarded as trustworthy sources of knowledge.

Beliefs regarding colostrum and infant feeding

Some participants believed that colostrum should not be given to newborns because it was considered unsuitable for infants. Instead, honey

or infant formula was sometimes introduced before breastfeeding was established.

"*The first breast milk is discarded and not given directly to the baby because people believe the milk becomes good only after massage*." (Mother of Toddler 2)

Traditional medicine

Traditional herbal remedies remained widely used for common childhood illnesses before seeking formal healthcare.

"*For diarrhea, I use fern leaves and gambier and place them on the stomach. It has been very effective*." (Ma'blien 1)

Beliefs regarding healthy children and stunting

Participants also reported community beliefs regarding the characteristics of healthy children and the causes of stunting. These perceptions influenced family decisions related to feeding practices, healthcare utilization, and child growth monitoring.

Overall, participants described community beliefs as influencing maternal decisions regarding infant feeding, treatment-seeking, and child care during the first 1,000 days of life.

4. Discussion

This study demonstrates that maternal decision-making during the first 1,000 days of life is shaped by an interconnected sociocultural system consisting of cultural norms, local traditions, and community beliefs. Rather than operating independently, these dimensions interact across pregnancy, childbirth, postpartum care, and early childcare, collectively influencing maternal nutrition, breastfeeding, complementary feeding, healthcare-seeking behaviour, and childcare practices. These findings indicate that maternal decision-making is socially embedded rather than individually determined, as mothers continuously negotiate their decisions within culturally shared values, family relationships, and traditional authority. Consequently, childhood stunting should not be understood solely as a nutritional or biomedical problem but also as a consequence of the sociocultural environment in which maternal decisions are made.[11,12]

The interaction among cultural norms, local traditions, and community beliefs indicates that maternal decision-making is embedded within family relationships and community expectations rather than being based solely on individual knowledge.[21,22] Although health workers routinely provide nutrition education, mothers frequently described relying on advice from grandmothers, *ma'blien*, and other respected community members when making decisions related to pregnancy, infant feeding, and childcare.[23] From a sociocultural perspective, these influential family and community members function as informal health decision-makers whose recommendations often carry greater legitimacy than professional health advice because they are rooted in shared cultural values and long-standing community trust.[24] Consequently, maternal behaviours are socially negotiated rather than individually determined, reflecting collective cultural expectations instead of personal preferences alone.[25,26] This finding reinforces previous evidence that maternal health behaviours are socially negotiated and influenced by broader cultural environments rather than being determined solely by individual knowledge or access to health information.

One manifestation of this sociocultural system was the persistence of cultural norms regulating maternal diet and behaviour during pregnancy and the postpartum period.[21,27] Food taboos and behavioural restrictions were maintained because they were collectively perceived as protective practices rather than nutritional risks. Similar observations have been reported in other low- and middle-income countries, where culturally transmitted food taboos continue to influence maternal dietary diversity despite improved access to health information.[16,17] Previous studies have likewise shown that family expectations often outweigh individual knowledge in shaping maternal decisions.[28,29] These findings suggest that nutritional

counselling alone may be insufficient when culturally rooted beliefs remain influential within families and communities. Therefore, nurses, midwives, and other healthcare providers should adopt culturally responsive communication strategies that acknowledge local values while promoting evidence-based nutritional practices through respectful engagement with influential family members.[30,31]

Beyond cultural norms, local traditions functioned as mechanisms through which cultural authority was maintained within the community.[32,33] Practices such as *jok bu bidan*, postpartum rituals, umbilical cord care, and the continuing involvement of the *ma'blien* reflected not only the preservation of cultural heritage but also socially legitimate pathwaysthrough which maternal advice was accepted and implemented within families. Participants consistently described the *ma'blien* as trusted cultural authorities whose recommendations influenced maternal diet, breastfeeding practices, newborn care, and family decision-making. These findings suggest that the influence of the *ma'blien* extends beyond providing traditional care to shaping maternal health behaviours through culturally established trust and social legitimacy. Therefore, rather than being viewed as barriers to modern healthcare, *ma'blien* should be strategically engaged as community partners in culturally responsive maternal and child health programmes.

Community beliefs further reinforced maternal decision-making by providing culturally accepted explanations regarding breastfeeding, infant feeding, treatment-seeking, and perceptions of healthy child growth. These beliefs were transmitted across generations and consequently acquired social legitimacy within families.[34,35] Similar misconceptions regarding breastfeeding and infant feeding have been documented in various cultural settings and are associated with delayed breastfeeding initiation and inappropriate feeding practices.[34,36] However, the present study suggests that these beliefs persisted not merely because of limited knowledge but because they were continually reinforced by older family members and respected community figures who were regarded as trusted sources of advice. Consequently, maternal decisions reflected collective cultural expectations rather than purely individual preferences. These findings highlight the importance of family-centred health education, in which nurses and midwives engage influential family members alongside mothers to promote culturally acceptable breastfeeding and child-feeding practices.[37]

Collectively, these findings indicate that local culture functions as an interconnected sociocultural system rather than a collection of isolated practices. Cultural norms establish expectations for maternal behaviour, local traditions provide socially legitimate mechanisms through which these norms are enacted, and community beliefs reinforce them through theintergenerational transmission of knowledge. As illustrated in the conceptual framework (Figure 1),

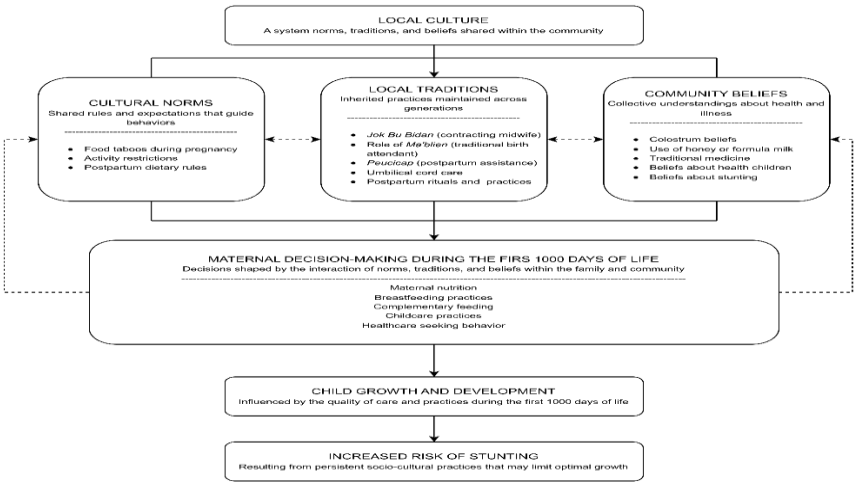

Figure 1. Conceptual framework illustrating the interaction between local cultural dimensions and maternal decision-making related to childhood stunting in West Aceh Regency

these cultural dimensions continuously interact and mutually reinforce one another to shape maternal decision-making throughout the first 1,000 days of life. Unlike previous qualitative studies that have primarily examined food taboos, traditional birth attendants, or breastfeeding beliefs as separate cultural phenomena, the present study demonstrates how these dimensions operate as an integrated sociocultural system influencing maternal health behaviours across pregnancy, childbirth, the postpartum period, and early childcare.[16,17] This systems perspective extends current understanding by highlighting that effective stunting prevention requires interventions that address the broader sociocultural context in which maternal decisions are negotiated, rather than focusing solely on individual behaviours or isolated cultural practices.

Public Health Implications

Because maternal decision-making emerged as a socially negotiated process rather than an individual behaviour, these findings have important implications for nursing, midwifery, and community-based stunting prevention programmes. For nursing and midwifery practice, culturally responsive counselling should be integrated into antenatal care, postnatal care, breastfeeding support, and child health services. Nurses and midwives should actively engage *ma'blien*, grandmothers, Posyandu cadres, and other influential family members when providing health education, as these individuals play a central role in shaping maternal decisions. At the community level, health promotion programmes should strengthen collaboration between healthcare providers and respected community leaders to improve the cultural acceptability of maternal and child health interventions. At the policy level, local governments should support culturally appropriate partnerships between formal healthcare services and traditional community networks to enhance the sustainability and effectiveness of evidence-based stunting prevention strategies.

Strengths and Limitations

This study has several strengths. First, the inclusion of mothers, village midwives, *ma'blien*, grandmothers, and Posyandu cadres enabled triangulation across multiple perspectives, providing a comprehensive understanding of local cultural influences on maternal decision-making related to childhood stunting. Second, the phenomenological approach facilitated an in-depth exploration of participants' lived experiences and resulted in a conceptual framework illustrating how cultural norms, local traditions, and community beliefs interact to

shape maternal decision-making during the first 1,000 days of life. These methodological strengths enhance the credibility and contextual richness of the findings.

Nevertheless, several limitations should be acknowledged. Because this study was conducted in a single district in Aceh Province, the findings may not be directly transferable to communities with different sociocultural characteristics. In addition, as with all qualitative research, the findings are intended to provide contextual understanding rather than statistical generalizability. Future multicentre qualitative studies or mixed-methods research conducted across diverse cultural settings are warranted to examine the transferability of the proposed conceptual framework and to further inform culturally responsive maternal and child health interventions.

5. Conclusions

This study demonstrates that maternal decision-making related to childhood stunting during the first 1,000 days of life in West Aceh Regency is shaped by an interconnected sociocultural system comprising cultural norms, local traditions, and community beliefs. Rather than acting as isolated influences, these cultural dimensions interact through family relationships, traditional authority, and the intergenerational transmission of knowledge to influence maternal nutrition, breastfeeding, complementary feeding, healthcare-seekingbehaviour, and childcare practices. By conceptualising local culture as an integrated sociocultural system, this study provides a broader understanding of how cultural factors collectively shape maternal decision-making during the first 1,000 days of life. Consequently, stunting prevention strategies should extend beyond conventional nutrition education by integrating culturally responsive approaches and actively engaging influential community members, including *ma'blien*, village midwives, grandmothers, and Posyandu cadres. These findings offer practical guidance for nurses, midwives, and public health practitioners in designing culturally appropriate maternal and child health interventions in communities with similar sociocultural contexts.

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Competing interests

The authors declare that they have no competing interests.

Abbreviations

COREQ: Consolidated Criteria for Reporting Qualitative Research; WHO: World Health Organization; UNICEF: United Nations Children's Fund

Authors' contributions

F: Conceptualization, Investigation, Data curation, Formal analysis, Visualization, Writing – original draft. MS**:** Conceptualization, Methodology, Project administration, Resources, Supervision, Validation, Writing – review & editing. DS: Methodology, Supervision, Validation, Writing – review & editing. N: Methodology, Data curation, Formal analysis, Validation, Visualization, Writing – review & editing. All authors have read and approved the final version of the manuscript.

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Availability of data and materials

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request. Interview transcripts are not publicly available

because they contain information that could compromise participant confidentiality.

Ethics approval and consent to participate

This study was approved by the Health Research Ethics Committee of the Faculty of Medicine, Universitas Syiah Kuala (Ethics Approval No. 011/EA/FK/2026). Written informed consent was obtained from all participants prior to data collection.

Consent for publication

By submitting this manuscript, all authors consent to the publication of the final accepted version of the manuscript.

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