Jurnal Ilmiah Kesehatan
(Journal of Health Science)
Fakultas Keperawatan dan Kebidanan | Universitas Nahdlatul Ulama Surabaya
ISSN 1978-6743
E-ISSN 2477-3948

Maternal Psychosocial Determinants and Child Stunting in a Socioeconomically Vulnerable Region of Eastern Indonesia

Elzina Dina De Fretes[1], Isra Nur Utari S. Potabuga[2]

[1,2] *Department of Nursing, Health Polytechnic, Ministry of Health, Sorong, Southwest Papua, Indonesia*

ARTICLE INFORMATION

Received: April 3, 2026
Revised: April 12, 2026
Available online: May 2026

KEYWORDS

Stunting; Maternal self-efficacy; Social support; Feeding practices; Structural determinants

CORRESPONDENCE

E-mail: defreteselsye@gmail.com

A B S T R A C T

Stunting remains a persistent public health challenge in socioeconomically vulnerable regions, where behavioral and structural determinants interact to influence child growth outcomes. The contribution of maternal psychosocial factors within structurally constrained settings remains insufficiently understood. This study examined the structural relationships between maternal self-efficacy, maternal social support, child feeding practices, and child stunting in a stunting-prone area of Eastern Indonesia. An analytic cross-sectional study was conducted among 233 mother–child dyads at a Public Health Center (PHC) using consecutive sampling. Maternal self-efficacy, social support, and child feeding practices were assessed using validated Likert-scale instruments. Stunting was defined as a height-for-age Z-score below -2 standard deviations, according to the WHO 2006 Child Growth Standards. Data were analyzed using Partial Least Squares Structural Equation Modeling. Results showed that maternal self-efficacy and social support demonstrated limited explanatory power in predicting child feeding practices and stunting. Structural relationships were weak ($\beta < 0.20$), and effect sizes were small to trivial ($f^2 < 0.03$). In conclusion, maternal psychosocial determinants alone may not substantially influence the prediction of child feeding practices and stunting in socioeconomically vulnerable populations. Behavioral constructs appear constrained by socioeconomic conditions. Effective stunting reduction strategies should integrate maternal-level interventions with systemic improvements in food security, sanitation, and social protection.

INTRODUCTION

Stunting remains a critical global public health challenge, disproportionately affecting children in low and middle income countries and reflecting deep structural inequalities in early life conditions. Impaired linear growth during the first five years of life is associated with long term consequences, including compromised cognitive development, lower educational attainment, reduced economic productivity, and increased risk of chronic diseases in adulthood (Mulyani et al., 2025). Recent global reports indicate that progress in reducing stunting has slowed, particularly in socioeconomically vulnerable regions where poverty, food insecurity, and limited access to basic services persist (Jalaludin et al., 2025a). In Indonesia, substantial regional disparities remain evident, with Eastern provinces experiencing consistently higher prevalence rates than national averages. These patterns suggest that stunting cannot be understood solely as a nutritional deficit but must be situated within broader structural and social determinants of health.

Behavioural science frameworks have increasingly been used to explain maternal influences on child nutrition. Social Cognitive Theory posits that self-efficacy shapes behaviour through perceived capability to perform specific actions (Egele et al., 2025), while the Theory of Planned Behaviour emphasizes perceived behavioural control and social norms as determinants of intention and practice (Hagger &

https://doi.org/10.33086/jhs.v19i02.8758

Hamilton, 2024). Empirical evidence suggests that maternal self-efficacy and social support are positively associated with improved feeding practices and dietary diversity (Brani et al., 2024a; Zambetti et al., 2025). However, recent reviews highlight inconsistencies in translating psychosocial improvements into measurable anthropometric gains, particularly in low resource environments where structural barriers may constrain behavioural agency (Arqam et al., 2026). This inconsistency raises important theoretical questions regarding the boundary conditions of behavioural models in structurally constrained settings.

The Social Ecological Model proposes that child growth emerges from dynamic interactions across individual, interpersonal, community, and systemic levels (Oudat et al., 2025). Despite this multilevel understanding, most empirical studies either examine psychosocial predictors of feeding practices or analyse socioeconomic determinants of stunting independently. Few studies have tested an integrated structural framework that simultaneously links maternal self-efficacy, maternal social support, feeding practices, and child stunting within high risk populations. Evidence from Eastern Indonesia remains particularly limited, restricting insight into whether behavioural constructs derived from dominant health theories retain explanatory relevance in regions characterized by structural vulnerability. Addressing this gap is essential to avoid overreliance on behaviour cantered interventions in contexts where structural determinants may predominate.

This study addresses that gap by examining the structural relationships between maternal self-efficacy, maternal social support, child feeding practices, and stunting among mother child dyads in a stunting prone district of Eastern Indonesia using structural equation modelling. By empirically testing the boundary conditions of behavioural constructs within a socioeconomically vulnerable setting, this research contributes to the refinement of theory application in child nutrition. The findings aim to clarify the relative contribution of maternal level determinants within a broader ecological system and to inform the development of more context sensitive, multilevel strategies for stunting prevention.

METHOD

Study Design and Setting

This study employed an analytic cross-sectional design to examine the structural relationships between maternal self-efficacy, maternal social support, child feeding practices, and stunting in a stunting-prone area of Eastern Indonesia. A cross-sectional approach was considered appropriate for assessing associations among psychosocial constructs, behavioral practices, and anthropometric outcomes within a defined population at a single point in time. The study was conducted at Fakfak City Health Care Centre, Fakfak District, West Papua Province, a district characterized by persistent stunting prevalence and socioeconomic vulnerability.

Participants and Sampling

The study population consisted of biological mothers with children aged 0–59 months residing within the working area of Fakfak City Health Care Centre. Participants were recruited using consecutive sampling, whereby all eligible mother–child dyads attending maternal and child health services during the data collection period were invited to participate until the required sample size was achieved. This approach was selected to enhance representativeness within routine service settings while maintaining feasibility in a community-based context. Sample size estimation was conducted using G*Power software based on structural model testing parameters, assuming a small effect size, statistical power of 0.80, and alpha level of 0.05. The minimum required sample size was met, and the final analytic sample included 233 respondents. This sample size was also consistent with recommendations for Partial Least Squares Structural Equation Modeling (PLS-SEM), which accommodates small to medium samples depending on model complexity. Inclusion criteria were: (1) mothers aged 18 years or older; (2) having a child aged 0–59 months; (3) residing in the study area for at least six months; and (4) providing written informed consent. Exclusion criteria included: (1) children with congenital anomalies or chronic conditions affecting growth; (2) mothers with documented cognitive impairment limiting comprehension of the questionnaire; and (3) incomplete anthropometric or questionnaire data.

Measures and Instruments

Maternal Self-Efficacy

Maternal self-efficacy was measured using a structured questionnaire developed based on feeding self-efficacy and balanced nutrition principles. The instrument assessed mothers' confidence in selecting nutritious foods, preparing diverse menus, managing feeding difficulties, ensuring hygiene and food safety, and maintaining appropriate feeding frequency. Items were rated on a five-point Likert scale ranging from 1 indicating strongly disagree or not confident to 5 indicating strongly agree or very confident. Higher scores reflected greater perceived self-efficacy.

Maternal Social Support

Maternal social support was assessed using a multidimensional instrument capturing emotional, instrumental, informational, and appraisal support. The questionnaire measured perceived support from spouses, extended family members, and healthcare workers or community health cadres. All items were rated on a five-point Likert scale, with higher scores indicating stronger perceived support.

Child Feeding Practices

Child feeding practices were evaluated using indicators reflecting dietary diversity, feeding frequency, responsive feeding behavior, and feeding difficulty management. Dietary diversity assessment was aligned with WHO Infant and Young Child Feeding guidelines and included consumption across seven

food groups within the reference period. Behavioral dimensions were measured using Likert-scale items adapted from established feeding practice frameworks.

Stunting Measurement

Child height was measured by trained health personnel using standardized anthropometric procedures. Height-for-age Z-scores were calculated according to the WHO Child Growth Standards 2006 reference. Stunting was defined as height-for-age Z-score below minus two standard deviations. Anthropometric measurements followed WHO protocols to ensure measurement reliability and standardization.

Data Collection Procedure

Data collection was conducted during routine maternal and child health service sessions at Fakfak City Health Care Centre. After obtaining written informed consent, mothers completed structured questionnaires under supervision of trained enumerators to minimize missing responses and clarify item comprehension. Anthropometric measurements were obtained during the same visit using calibrated equipment. All research assistants underwent standardized training prior to data collection to ensure consistency in interview administration and measurement procedures.

Statistical Analysis

Data were analysed using SmartPLS version 4.1.1.6. A two-step PLS-SEM approach was applied, consisting of evaluation of the measurement model followed by assessment of the structural model.

PLS-SEM was selected due to its suitability for exploratory structural modeling, its robustness with small to medium sample sizes, and its prediction-oriented focus when theory testing occurs in relatively underexplored settings. Unlike covariance-based SEM, PLS-SEM does not require multivariate normality assumptions and is appropriate for complex models with latent constructs measured by multiple indicators. Measurement model evaluation included assessment of indicator reliability through outer loadings, internal consistency reliability using Cronbach’s alpha and composite reliability, and convergent validity using Average Variance Extracted. Threshold values of 0.70 for reliability coefficients and 0.50 for Average Variance Extracted were considered acceptable. Discriminant validity was assessed using the Heterotrait-Monotrait ratio criterion. Structural model evaluation included examination of standardized path coefficients, coefficients of determination, effect sizes, collinearity diagnostics using Variance Inflation Factor, and model fit using Standardized Root Mean Square Residual. Statistical significance was determined through bootstrapping with 5,000 resamples to generate robust standard errors and confidence intervals.

Ethical Considerations

This study received ethical approval from the Health Research Ethics Committee of Politeknik Kesehatan Kementerian Kesehatan Sorong. Number DP.04.03/F.LIII.13.a./393/2026 on 17 January 2026. Written informed consent was obtained from all participants prior to data collection. Confidentiality of personal

information was strictly maintained, and participation was voluntary. Respondents were informed that they could withdraw from the study at any time without affecting their access to health services.

RESULT

Sample Characteristics

A total of 233 mother–child dyads were included in this investigation. The mean maternal age was 29.8 ± 6.4 years, with the majority aged 20–35 years (69.5%). Most mothers had completed secondary education (30.5%) and were not formally employed (67.0%). Over half of the respondents had two to three children (67.0%) and identified as indigenous Papuan (63.5%). Children had a mean age of 26.7 ± 15.2 months, with the largest proportion aged 12–36 months (40.3%). The prevalence of low birth weight (<2500 g) was 12.4%, while 72.1% had received complete basic immunization. More than half of households reported income below the regional minimum wage (57.9%) and had more than 4 household members (57.9%). Access to improved sanitation remained suboptimal, with nearly one-fifth lacking a private sanitary latrine (Table 1).

Table 1. Socio-Demographic Characteristics of Mothers, Children, and Households

Variable	n	%
Maternal Characteristics		
Maternal Age, Mean ± SD (years)	29.8 ± 6.4	
< 20 years	18	7.7
20–35 years	162	69.5
> 35 years	53	22.8
Educational Attainment		
No formal education / Did not complete primary school	21	9.0
Primary school or equivalent	48	20.6
Junior secondary school or equivalent	63	27.0
Senior secondary school or equivalent	71	30.5
Diploma / Bachelor’s degree	30	12.9
Employment Status		
Homemaker	156	67.0
Civil servant / Military / Police	18	7.7
Private sector employee / Contract worker	32	13.7
Self-employed / Trader	19	8.2
Farmer / Fisher	8	3.4
Parity		
1 child	74	31.8
2–3 children	121	51.9
≥ 4 children	38	16.3
Ethnicity		
Indigenous Papuan	148	63.5
Non-Indigenous Papuan	85	36.5
Child Characteristics		
Child Age, Mean ± SD (months)	26.7 ± 15.2	
0–11 months	76	32.6
12–36 months	94	40.3
37–59 months	63	27.1
Sex		
Male	121	51.9
Female	112	48.1
Birth Weight		

https://doi.org/10.33086/jhs.v19i02.8758

< 2500 g (Low Birth Weight)	29	12.4
≥ 2500 g	204	87.6
Basic Immunization Status		
Complete	168	72.1
Incomplete	49	21.0
Never immunized	16	6.9
Household Characteristics		
Household Income		
Below Fakfak District Minimum Wage	137	58.8
At or above Fakfak District Minimum Wage	96	41.2
Household Size		
≤ 4 members	98	42.1
> 4 members	135	57.9
Primary Source of Drinking Water		
Piped water supply (municipal)	64	27.5
Protected well / Borehole	88	37.8
Protected spring	41	17.6
Rainwater / River / Other sources	40	17.1
Sanitation Facility		
Private household latrine (septic tank)	112	48.1
Shared / Public latrine	76	32.6
No improved sanitation facility	45	19.3

Note: SD = standard deviation; Low Birth Weight defined as < 2500 g.

The structural model demonstrated limited explanatory power. The R^2 values indicated weak predictive capacity for child feeding practices (0.010), maternal self-efficacy (0.009), and child stunting (0.036). Model fit evaluation showed an SRMR of 0.102, exceeding the recommended threshold of 0.08, suggesting suboptimal model fit. Collinearity diagnostics revealed no multicollinearity concerns (VIF range: 1.000–1.054). The standardized path coefficients and corresponding effect sizes are summarized in Table 2. Overall, structural relationships were weak ($\beta < 0.20$), and effect sizes were small to trivial ($f^2 < 0.03$).

Table 2. Structural Model Summary

Structural Path	β	f^2	R^2
Mothers' Self-Efficacy → Feeding Practices	-0.030	0.001	0.010
Maternal Social Support → Feeding Practices	0.093	0.009	0.010
Mothers' Self-Efficacy → Stunting	0.047	0.002	0.036
Maternal Social Support → Stunting	0.070	0.005	0.036
Feeding Practices → Stunting	0.167	0.029	0.036
Maternal Social Support → Mothers' Self-Efficacy	-0.096	0.009	0.009
Model Fit Indices: SRMR = 0.102; NFI = -1.838; Chi-square = 148.771			
Collinearity: VIF range = 1.000–1.054			

Note: β = standardized path coefficient; f^2 = effect size (0.02 small, 0.15 medium, 0.35 large); $R^2 < 0.25$ indicates weak explanatory power.

Furthermore, Figure 1 describes the final structural model of maternal self-efficacy, maternal social support, child feeding practices, and child stunting.

https://doi.org/10.33086/jhs.v19i02.8758

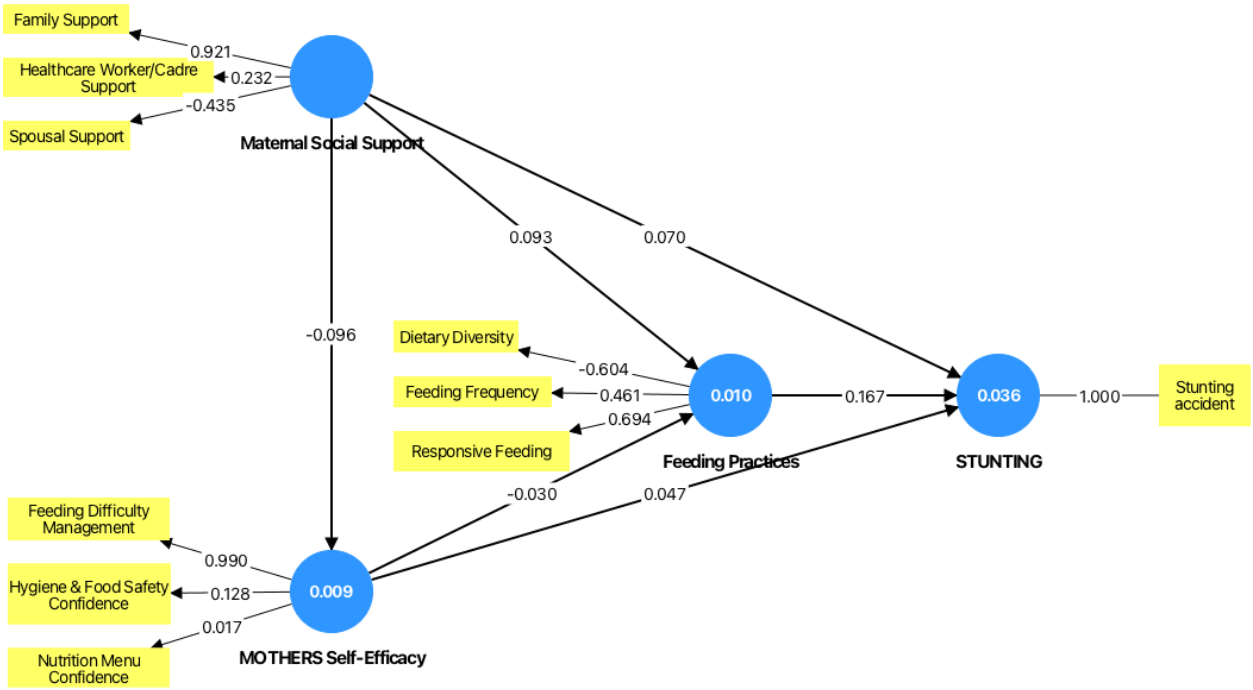

Figure 1. Final Structural Model of Maternal Self-Efficacy, Social Support, Feeding Practices, and Stunting

DISCUSSION

The findings indicated that psychosocial determinants demonstrated limited explanatory power in predicting child stunting (Table 2). These results suggest that individual-level behavioral constructs do not necessarily translate into measurable anthropometric improvements in environments characterized by socioeconomic vulnerability. Global evidence consistently identifies stunting as a multidimensional phenomenon shaped by complex interactions among biological, environmental, and structural determinants (Arief et al., 2025; Astuti et al., 2025). This paper extends this understanding by highlighting the constrained influence of maternal psychosocial factors within structurally disadvantaged settings.

Social Cognitive Theory posits that self-efficacy influences behavior through perceived capability to execute actions required to achieve desired outcomes (Egele et al., 2025). In child nutrition, higher maternal self-efficacy is theoretically associated with improved feeding practices and healthier growth trajectories. However, the current findings indicate that confidence alone may be insufficient to produce meaningful changes in child growth indicators. Empirical evidence suggests that the behavioral impact of self-efficacy becomes more pronounced when individuals operate within enabling environments that provide adequate resources and institutional support (Hendra et al., 2025; Xiao & Zheng, 2025; Yang et al., 2025). In structurally constrained contexts marked by poverty, food insecurity, and inadequate sanitation, cognitive determinants may be overshadowed by material limitations that restrict behavioral agency.

The Social Ecological Model provides a useful framework for interpreting these results. This model conceptualizes child health outcomes as products of dynamic interactions across multiple levels, including individual, interpersonal, community, and structural domains (Kong et al., 2025). The limited explanatory capacity observed in this study reinforces the argument that models focusing predominantly on individual-level predictors may inadequately capture the complexity of stunting in high-risk populations. Structural determinants such as household food insecurity, poor sanitation, limited economic resilience, and restricted access to quality health services have been consistently identified as major contributors to growth faltering (Cameron et al., 2021; Jalaludin et al., 2025b). By empirically examining psychosocial constructs within a structurally vulnerable population, this study contributes to testing the boundary conditions of behavioral theories in real-world settings.

The Theory of Planned Behavior further posits that behavioral performance is shaped by intention, subjective norms, and perceived behavioral control (Ajzen, 1991). Social support is expected to reinforce normative expectations and enhance maternal motivation to adopt recommended feeding practices. Prior studies have demonstrated positive associations between spousal or family support and improved child feeding behaviors (Douglas et al., 2023; Hu et al., 2025). However, the present findings indicate that perceived social support alone may not sufficiently offset structural barriers that constrain household decision-making. When economic pressures and environmental limitations dominate daily life, normative reinforcement and internal motivation may exert limited influence on child growth outcomes.

Differences between the present findings and prior studies reporting significant associations between maternal self-efficacy and feeding practices (Brani et al., 2024b; Özdemir & Ercan-Şahin, 2025) may reflect variation in contextual vulnerability. In settings with relatively stronger infrastructure and economic stability, psychosocial determinants may play a more decisive role in shaping nutritional outcomes. In contrast, in structurally disadvantaged environments, biological risks and material deprivation may exert stronger effects on linear growth. These findings underscore the importance of contextualizing behavioral models within broader socioeconomic realities rather than assuming universal applicability.

From a policy perspective in Indonesia, these findings carry important implications. National stunting reduction strategies have emphasized behavioral change communication and maternal education as central pillars of intervention. The present study suggests that such approaches should be systematically integrated with structural interventions targeting household food security, social protection, sanitation infrastructure, and strengthening of primary healthcare services. Fragmented interventions that prioritize behavioral modification without addressing structural constraints may yield limited impact in high-risk regions.

Conceptually, these findings support a reframing of intervention paradigms from behavior-centered models toward integrated structural reform approaches that situate individual agency within broader systems of opportunity and constraint. Addressing stunting in socioeconomically vulnerable regions requires multilevel strategies that combine psychosocial strengthening with systemic improvements in living conditions. Behavioral determinants remain relevant, but their effectiveness depends on the structural environments in which mothers attempt to exercise agency.

This study has several limitations. The cross-sectional design precludes causal inference. Self-reported measures may introduce social desirability bias. The structural model did not incorporate additional determinants such as household food insecurity, maternal nutritional status, or infection exposure, which may further explain variation in child growth outcomes. Future research should employ longitudinal and multilevel designs to examine cross-level interactions and refine explanatory models of stunting within structurally vulnerable populations.

Overall, this study demonstrates that maternal self-efficacy and social support exert limited influence on stunting outcomes in settings characterized by structural disadvantage. Integrating Social Cognitive Theory, the Theory of Planned Behavior, and the Social Ecological Model provides a comprehensive conceptual lens for understanding these findings and reinforces the necessity of systemic, multilevel approaches to sustainable stunting reduction.

CONCLUSION

Maternal psychosocial determinants alone may not substantially influence the prediction of child feeding practices and stunting in socioeconomically vulnerable populations. This study contributes to the literature by empirically showing that behavioral constructs derived from Social Cognitive Theory and the Theory of Planned Behavior do not operate independently from broader ecological constraints. By integrating behavioral and ecological perspectives within a single structural framework, this research provides evidence that maternal-level interventions alone may be insufficient to substantially reduce child stunting in high-risk regions. In addition, from a theoretical perspective, this investigation underscores the need to situate behavioral determinants within multilevel models that explicitly account for socioeconomic and environmental influences. Furthermore, from a practical standpoint, stunting prevention strategies should combine behavioral strengthening approaches with structural improvements in food security, sanitation, and economic resilience. However, this study was limited by its cross-sectional design and reliance on self-reported measures, which restrict causal interpretation. Future research should employ longitudinal and multilevel approaches to clarify dynamic pathways between psychosocial factors and child growth outcomes in vulnerable settings. Addressing stunting in high-risk regions requires a paradigm shift from isolated behavioral interventions toward systemic transformation of social determinants.

https://doi.org/10.33086/jhs.v19i02.8758

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