COGNITIVE CONSTRUCTION AND SHARIA RESPONSE: THEORETICAL FRAMEWORK OF PARENTAL REJECTION IN STUNTING DIAGNOSIS PHENOMENON

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Abstract
The prevalence of stunting in several regions of Indonesia, including Tulung District, Klaten, remains above the national target. One of the main obstacles in addressing this issue is the phenomenon of parental rejection of the stunting diagnosis given to their children. This study aimed to analyze in depth the factors underlying this rejection and to examine them through Peter L. Berger and Thomas Luckmann's social construction theory and the *Maqāṣid al-Syari'ah* framework. Using a qualitative method with in-depth interviews and participant observation, the study involved 4 inclusion informants (parents of children aged 6–59 months who rejected or ever rejected the stunting diagnosis) and 8 triangulation informants, including village midwives, nutrition officers, posyandu cadres, village officials, and religious leaders. The findings reveal that parents' rejection of the stunting diagnosis is constructed through a social process and reinterpreted according to everyday experience, cultural norms, and emotional meanings of parental success. In Berger's framework, this rejection represents a cycle of externalization of personal experience, objectivation through shared community beliefs, and internalization as social reality that resists medical authority. From the *Maqāṣid al-Syari'ah* perspective, this behavior reflects a contradicsm from the principles of *hifz al-nafs* (protection of life), *hifz al-'aql* (protection of reason), and *hifz al-nasl* (protection of offspring).
Keywords: *Maqāṣid al-Syari'ah*, Parental Rejection, Stunting, Social Construction,

Abstrak
Prevalensi stunting di beberapa wilayah Indonesia, termasuk Kecamatan Tulung, Kabupaten Klaten, masih berada di atas target nasional. Salah satu kendala utama dalam penanganan masalah ini adalah fenomena penolakan orang tua terhadap diagnosis stunting yang diberikan kepada anaknya. Penelitian ini bertujuan untuk menganalisis secara mendalam faktor-faktor yang melatarbelakangi penolakan tersebut serta meninjaunya melalui teori konstruksi sosial Peter L. Berger dan Thomas Luckmann serta kerangka Maqāṣid al-Syari'ah. Penelitian ini menggunakan metode kualitatif dengan teknik wawancara mendalam dan observasi partisipatif, melibatkan 4 informan inklusi (orang tua yang memiliki anak berusia 6–59 bulan dan menolak atau pernah menolak diagnosis stunting) serta 8 informan triangulasi yang terdiri dari bidan desa, petugas gizi, kader posyandu, perangkat desa, dan tokoh agama. Hasil penelitian menunjukkan bahwa penolakan orang tua terhadap diagnosis stunting terbentuk

melalui proses sosial dan direkonstruksi sesuai dengan pengalaman sehari-hari, norma budaya, dan makna emosional tentang keberhasilan pengasuhan. Dalam kerangka Berger, penolakan tersebut merupakan siklus eksternalisasi pengalaman pribadi, objektivasi melalui keyakinan bersama masyarakat, dan internalisasi sebagai realitas sosial yang menolak otoritas medis. Dari perspektif Maqāṣid al-Syari'ah, perilaku ini mencerminkan adanya ketidaksesuaian dengan prinsip hifz al-nafs (penjagaan jiwa), hifz al-'aql (penjagaan akal), dan hifz al-nasl (penjagaan keturunan).
Kata Kunci: *Maqāṣid al-Syari'ah, Stunting, Penolakan Orang Tua, Konstruksi Sosial*

A. INTRODUCTION

Stunting is a long-term and multifaceted health issue caused by various interrelated factors and can affect multiple generations. Its consequences go beyond physical growth delays in children, leading to serious long-term effects such as a higher risk of metabolic disorders in adulthood, reduced overall health quality, and diminished human resource potential, which in turn hinders economic progress.[1] Based on data released by the WHO, the global prevalence of stunting in children under five has reached 22.2%.[2] In Indonesia itself, the stunting trend shows a progressive decline, from 37% in early 2000 to around 24.4% in 2022.[3] The government, through the Ministry of Health, remains committed to reducing this figure to reach the target of 14% by 2024 through various cross-sectoral interventions packaged in the National Priority Program (PPN).[4]

However, addressing stunting cannot be viewed simply as a nutritional problem or the exclusive duty of the health sector. Social, cultural, and psychological aspects also play major roles in worsening or complicating efforts to manage and prevent this condition. In a psychosocial context, parents'

[1] Sukmawati Sukmawati et al., "Edukasi Pada Ibu Hamil, Keluarga Dan Kader Posyandu Tentang Pencegahan Stunting," Dharmakarya: Jurnal Aplikasi Ipteks Untuk Masyarakat 10, no. 4 (2021): 330–35; Afthon Yazid, "Relevansi Kebijakan Pemerintah Terkait Pemberian Makanan Tambahan (PMT) Untuk Pencegahan Stunting: Perfektif Saddu al-Dzariah," Fatayat Journal of Gender and Children Studies 1, no. 2 (2023): 50–62.

[2] WHO, Prevalence of Stunting in Children under 5 (%)., 2024, https://data.who.int/indicators/i/A5A7413/5F8A486.

[3] Riskesdas, Riset Kesehatan Dasar 2013 (Kementrian Kesehatan RI, 2013); Kemenkes, Membentengi Anak Dari Stunting, 2024.

[4] Dinkes Klaten, Rencana Kerja Dinas Kabupaten Klaten 2022 (2022).

emotional responses to a stunting diagnosis, such as disbelief, guilt, anxiety, and frustration, often become obstacles to the process of restoring a child's nutritional status.[5] Research findings in Kupang, East Nusa Tenggara, indicate that clinical indicators of malnutrition are not always explicitly apparent in the poorest community groups. In other finding, children from disadvantaged families exhibit better physical condition than those from more affluent families. In this context, maternal education and paternal involvement also give a substantial contribution to child development.[6] In contrast to previous studies that focused solely on nutritional factors or health education, this study integrates a social approach and *Maqāṣid al-Syari'ah* as an evaluative lens for parenting practices and diagnosis denial.

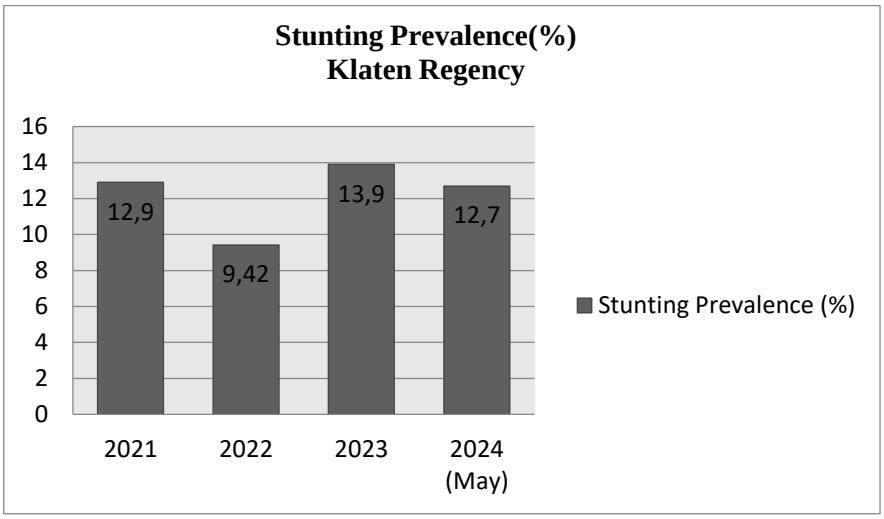
Klaten Regency Government issued Regent Regulation No. 93 of 2019 to support national policies for accelerating stunting reduction, which outlines various strategies and cross-sectoral interventions. These efforts demonstrate the region's commitment to implementing the national target for stunting reduction. Data from the Klaten Regency Health Office from 2021 to May 2024 shows that, in aggregate, stunting prevalence in the region has been successfully reduced to below the national threshold of 14%, targeted for 2024.[7]

[5] Ty Beal et al., "A Review of Child Stunting Determinants in Indonesia," Maternal & Child Nutrition 14, no. 4 (2018): e12617.

[6] Christiane Scheffler et al., "Stunting as a Synonym of Social Disadvantage and Poor Parental Education," International Journal of Environmental Research and Public Health 18, no. 3 (2021): 1350.

[7] Dinkes Klaten, Rencana Kerja Dinas Kabupaten Klaten 2024 (2024).

Figure. 1
Stunting Prevalence Graph in Klaten Regency



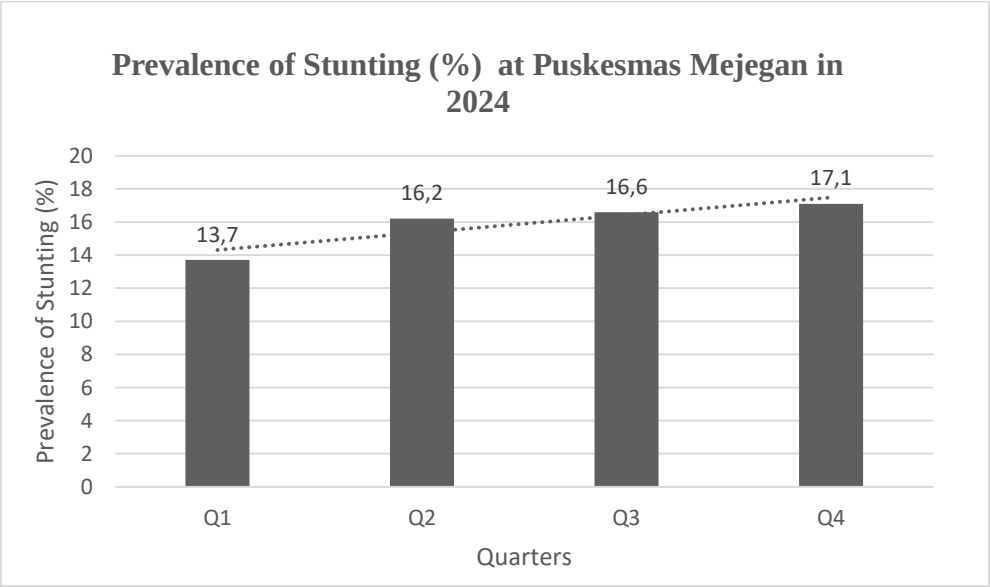
Despite these results generally showing substantial progress, equitable distribution of success remains a serious challenge. Not all administrative areas under the auspices of the Klaten Regency Health Office show the same trend. Some community health centers (Puskesmas) continue to record stunting prevalence rates exceeding safe limits. According to the 2024 fourth-quarter Medium-Term Development Plan (RPJM) Report, five community health centers had the highest stunting prevalence: Bayat and Kayumas Community Health Centers (Puskesmas) each with 19.5%, followed by Polanharjo (17.7%), Cawas I (17.3%), and Majegan (17.1%). Specifically, at Majegan Community Health Center, located in Tulung District, the prevalence rate showed a consistent increase every quarter throughout 2024. This is noteworthy considering that Majegan Community Health Center is located in the same district as Tulung Community Health Center, which recorded a lower rate of 13.2%. This difference indicates the presence of local variables that significantly influence the effectiveness of public health interventions at the community health center level.

A report submitted by health workers at the Majegan Community Health Center reveals that the high prevalence of stunting in the area is influenced not only by economic factors but also by parenting practices and parental resistance

to stunting diagnoses. Such resistance manifests as distrust toward medical assessments, reluctance to accept nutritional interventions and health services, and skepticism regarding the educational information provided by health staff.[8]

Figure. 2

Stunting Prevalence Graph at Majegan Community Health Center in 2024



Building on the observations mentioned earlier, this study aims to examine in depth the phenomenon of parental rejection of stunting diagnosis in children aged 6–59 months in the Majegan Community Health Center working area, Tulung District, Klaten Regency. The primary focus is to explore the social constructions that influence parents' perceptions and attitudes toward their children's health, while also examining the social, cultural, economic, and psychological dynamics that underlie their resistance to medical interventions.

In addition, this study also aims to examine this phenomenon from the perspective of *Maqāṣid al-Syari'ah*, by placing the issue of children's health within the framework of maintaining the five fundamental aspects of sharia, especiallyhifz al-nafs (mental health care), hifz al-'aql (mind care), and hifz al-nasl(offspring care). Through this theoretical approach, the research is expected to explain not only the socio-empirical dimensions of the rejection of a stunting diagnosis, but also provide normative reflection on parents' moral and religious

[8] Laporan ePPGBM, Laporan ePPGBM 2024 Puskesmas Majegan (2024).

responsibilities in fulfilling children's health rights as a form of sustainable welfare.

The main focus is directed toward the uncovering of the social constructions by which parents' perspectives and attitudes toward their children's health status are shaped, as well as toward the analysis of the social, cultural, economic, and psychological dynamics through which resistance to medical intervention is formed. This approach was chosen because it is able to capture the complexity of meanings, values, and subjective perceptions that exist in the daily experiences of informants. The research was conducted in the Majegan Community Health Center (Puskesmas) work area, Tulung, Klaten Regency, where there were reports of cases of parental rejection of a stunting diagnosis and interventions for their children. Data collection techniques were carried out through in-depth interviews and participant observation, which allowed researchers to explore social interactions, psychosocial dynamics, and cultural and religious responses that influence parental attitudes towards a stunting diagnosis. Informants were selected using the techniquepurposive samplingby establishing inclusion criteria, namely parents who have children aged 6–59 months who have been diagnosed with stunting but show rejection or have previously rejected the diagnosis or health interventions provided. Data collection was carried out on 4 mothers who have or are currently rejecting the diagnosis of stunting and the interventions provided, 2 village midwives, 2 nutrition officers, 2 posyandu cadres, 1 village official, and 1 religious leader. The research sample was categorized into 4 informants as inclusion factors or main informants and 8 informants as triangulation informants.

The data obtained were then analyzed using thematic analysis., which is adapted to the theoretical framework social construction Peter L. Berger & Thomas Luckmann as well as theory of *Maqāṣid al-Syari'ah*. Social construction theory helps in revealing how the reality of stunting is externalized, negotiated, and internalized by parents in their social structure, while the theory of *Maqāṣid al-Syari'ah* provides an ethical-normative lens to assess this attitude of rejection

within the framework of soul care (hifz al-nafs), reason (hifz al-'aql), and offspring (hifz al-naslData validity was maintained through triangulation of sources and methods, while continuous researcher reflexivity was employed to maintain objectivity in interpretation. With this approach, the research is expected to offer theoretical and practical contributions to the development of more effective and contextual health communication strategies.

B. FINDING AND DISCUSSION

1. Social System in Tulung, Klaten Community

Tulung is a district in Klaten Regency that borders Boyolali Regency. It is characterized as a rural area, with the majority of its residents working as farmers. Educational attainment levels vary; however, only a small proportion of the population is able to pursue higher education due to economic constraints. The social structure of the community is communal and family-oriented, where kinship ties still play a significant role in shaping social norms and influencing family decision-making. The local culture is strongly characterized by traditional practices such as *selametan* (communal thanksgiving rituals) and *kenduri* (feast gatherings). In addition, since the majority of the population adheres to Islam, Islamic religious practices coexist harmoniously with existing traditional values—for instance, memorial ceremonies for the deceased are commonly accompanied by the recitation of *tahlil* (Islamic prayers). In Tulung District, there are two community health centers (*puskesmas*) currently operating, namely Majegan Community Health Center and Tulung Community Health Center**.** The Majegan Health Center serves as a focal area of this study, as several cases of parental rejection of stunting diagnoses have been reported within its working area.[9]

[9] Anonim, "Profil Puskesmas Majegan 2024," Puskesmas Majegan, 2024.

2. The Cognitive Framework of Parents in Understanding Stunting Diagnosis

Based on the theoretical perspective of Berger and Luckmann's social constructionism[10] parents' understanding of a stunting diagnosis is inextricably linked to the primary and secondary socialization processes that shape their perspectives on child health.[11] Medical knowledge conveyed by health workers is not necessarily automatically internalized as truth by society, especially if it does not align with the framework of meaning that has been formed in their life experiences. In this context, a stunting diagnosis is not simply viewed as medical information, but as a symbolic representation that touches on self-esteem and identity as parents. The internalization process of this diagnosis will be greatly influenced by how parents understand the concepts of "health," "adequate care," and "parenting failure," all of which are socially constructed.[12]

This is clearly illustrated in an interview with a mother of a stunted child, who firmly rejected medical intervention, asserting that she had already done everything possible for her child. The mother stated,*"I've been feeding him well, giving him clean clothes, and giving him affection. My child isn't fussy or sick. How can he be called stunted? I can't accept it"*.[13] In this statement, it is clear that the mother's cognitive construction of "child health" is not determined by height indicators or growth curves, but rather by her subjective experience as the primary caregiver. Rejection of the stunting label is also a form of resistance to

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[10]. The social construction theory of Peter L. Berger and Thomas Luckmann explains that social reality is formed through an ongoing process of human interaction. Individuals create meaning through institutionalization, internalization, and objectification, making social reality appear as something "natural" or "given." Thus, social knowledge is not a biological inheritance but a constructed reality shaped and maintained by society. Peter Berger and Thomas Luckmann, "The Social Construction of Reality," in Social Theory Re-Wired (Routledge, 2016).

[11] Yusriadi Yusriadi et al., "Preventing Stunting in Rural Indonesia: A Community-Based Perspective," African Journal of Food, Agriculture, Nutrition and Development 24, no. 9 (2024): 24470–91; Willya Achmad, "Social Reality Stunting Prevention in Cianjur District," Jurnal EduHealth 13, no. 02 (2022): 467–77.

[12] Ari Cahyo Nugroho, "Teori Utama Sosiologi Komunikasi (Fungsionalisme Struktural, Teori Konflik, Interaksi Simbolik)," Majalah Semi Ilmiah Populer Komunikasi Massa 2, no. 2 (2021): 185–94.

[13] Wawancara Informan A, "Penolakan Berasal Dari Ibu Balita.," 2025, 10 Juni, jam 13.00 - 14.00 WIB.

medical interpretations that are considered inconsistent with the daily reality she experiences with her child. This is in line with a study that states that differences in understanding stunting can provide different images and perceptions so that the results are different. For example, the difference in the perspective of medical personnel who state the size of stunting from curves and medical data, while parents, especially mothers, understand it as a condition where only sick or weak children are considered stunted.[14] In a study it was stated that the lack of comprehensive understanding of stunting from parents can trigger feelings of suspicion, anger, and offense when there is a case of stunting that concerns them.[15]

Moreover, this perception is strengthened by social and psychological influences. Posyandu cadres interviewed noted that some parents still place more trust in local traditions and personal experiences than in medical recommendations,"*The mother was offended when she was told her child was stunted. Since then, she hasn't gone to the integrated health post (posyandu), feeling humiliated.*"[16] This shows that the diagnosis of stunting is not only understood as medical information, but also as a social symbol that implies failure or deficiency in the role of parent. Within the framework of social construction, the label stunting becomes*your objective*Unacceptable because it contradicts the meanings parents have constructed about their role and success in raising children. Therefore, health intervention strategies that fail to address these cognitive and symbolic dimensions risk being rejected, even if medically necessary. The holistic approach taken by mothers with children diagnosed with stunting does indeed lead to feelings of distress about the diagnosis.[17]

[14] Jenny Ratna Suminar et al., "Stunting, Polemikkomunikasi Yang Tidak Kunjung Usai Di Jawa Barat," Ilmu Komunikasi UNPAD 224 (2020); Suyanto Suyanto et al., "Understanding Stunting Risk Factors in Kampar Regency: Insights from Mothers with Stunted Children (Qualitative Study)," SAGE Open Medicine 12 (2024): 20503121241244662.

[15] Patimah Azzahra et al., "Parents' Understanding Of Children At Risk Of Stunting (Case Study of RW 03 Karangbesuki Village, Sukun District, Malang City)," Proceedings Series of Educational Studies, no. 5 (2024): 1285–92.

[16] Ibu M, "Kader Posyandu Puskesmas Majegan," 2025, 02 Juni, jam 12.00 - 13.00 WIB.

[17] Ika Juita Giyaningtyas et al., "Holistic Response of Mother as Caregiver in Treating Stunting Children," Pakistan Journal of Medical and Health Sciences 13, no. 3 (2019): 928–32;

Rejection of the stunting diagnosis and reference to other responses, as expressed in the interviews, may be a reaction to this distress.[18]

3. Socio-Cultural Aspects in Diagnosis Rejection

The refusal of parents to accept a stunting diagnosis cannot be attributed solely to a lack of medical understanding. Rather, it is closely connected to the social norms, cultural values, and belief systems embedded in the community. In certain settings, *stunting* is viewed not only as a health issue but also as a reflection of the family's inability to meet its parental responsibilities.This stigma is attached not only to the child but also to the parents, especially the mother as the primary caregiver. A community health post (Posyandu) cadre stated,*"The mother seemed to be in denial because she felt ashamed that her child was being called stunted. Furthermore, her family's lifestyle was luxurious. So she felt like she was being treated like a poor person receiving aid, even though she claimed to be well-off."*[19] This suggests that rejection arises not from a rejection of the substance of the diagnosis itself, but rather from the symbolic and social impact of the label, which is considered to injure class identity and family self-esteem. This stigma can trigger anger and a tendency for parents to withdraw from the medical intervention needed for their child diagnosed with stunting.[20] Furthermore, a rejection of the diagnosis by the mother or child's caregiver is often related to a lack of support from the child's immediate family and a fear of being labeled, such as a parent who failed in parenting or something similar.[21] Social pressure can even affect the psychology of parents with stunted children, ultimately triggering parental rejection of their child's stunting diagnosis.[22]

Saripah Saripah, "Anak Penderita Stunting Dan Psikologis Orang Tua: Kajian Di Desa Teluk, Batanghari," JIGC (Journal of Islamic Guidance and Counseling) 6, no. 1 (2022): 29–48.

[18] Emma Aprilia Hastuti et al., "Masalah Psikososial Ibu Dengan Anak Stunted: Studi Deskriptif Kualitatif," Jurnal Keperawatan'Aisyiyah 9, no. 2 (2022): 173–86.

[19] Ibu M, "Kader Posyandu Puskesmas Majegan," 2025.

[20] Ligar Tresna Darmawan Putri et al., "Self-Stigma, Experiences and Psychological Conditions of Mothers Having Children with Malnutrition-Stunting: Literature Review," Media Publikasi Promosi Kesehatan Indonesia (MPPKI) 7, no. 7 (2024): 1764–71.

[21] Fulziah Alwita Sari and Zulian Fikry, Hubungan Dukungan Sosial Dengan Penerimaan Diri Pada Ibu Yang Memiliki Balita Berstatus Stunting Di Kota Bukittinggi, n.d.

[22] Saripah, "Anak Penderita Stunting Dan Psikologis Orang Tua: Kajian Di Desa Teluk, Batanghari"; Kun A Susiloretni et al., "The Psychological Distress of Parents Is Associated with

Local culture also acts as a pivotal factor in shaping societal perceptions of child development.[23] For example, several interviews revealed that grandparents, as primary caregivers, sometimes reject a diagnosis, believing short stature to be genetic or inherited. In another case, a grandmother expressed rejection of her grandson's diagnosis because she felt it was symbolic humiliation."*The grandmother said, 'My children used to be small but healthy, so why is it that now her grandson is said to be stunted?'*". [24] This statement demonstrates how traditional value systems and intergenerational experiences interact with modern medical authority. When a medical diagnosis conflicts with deeply rooted cultural values, resistance emerges as a defense of the family's collective identity and social integrity. A systematic review also confirmed that family socio-cultural factors significantly influence factors contributing to stunting.[25]

4. Economic Response and Practical Rationality in Refusing Intervention

Rejection of stunting interventions does not necessarily stem from a denial of medical information but is often grounded in a form of practical rationality shaped by economic conditions and perceptions of external assistance. Among the interventions commonly implemented for children diagnosed with or at risk of stunting are supplemental feeding programs.[26] In this case, parents from middle- to upper-income families whose children are at risk of stunting actually reject interventions such as government-provided supplementary feeding or milk, believing they are capable of meeting their

Reduced Linear Growth of Children: Evidence from a Nationwide Population Survey," PloS One 16, no. 10 (2021): e0246725.

[23] Nur Alam Fajar, "Analisis Stunting Pada 1000 Hari Pertama Kehidupan Dalam Aspek Sosial Budaya: Systematic Review," Jurnal Kesehatan 12, no. 1 (2023): 35–46.

[24] Wawancara Informan C, "Penolakan Dari Nenek, Sebagai Pengasuh Utama Balita," 2025, 10 Juni, jam 14.00 - 15.00 WIB.

[25] Henniyati Harahap et al., "Stunting and Family Socio-Cultural Determinant Factors: A Systematic Review," Pharmacognosy Journal 16, no. 1 (2024); Khalifatus Zuhriyah Alfianti et al., Cultural Perspectives of Stunting Prevention: A Systematic Review. Pediomaternal Nursing Journal, 9 (1), 36–41, 2023.

[26] Mira Ulpayani Harahap and Rapotan Hasibuan, "Analysis Implementation of The Stunting Prevention Programme," Journal of Health Science and Prevention 7, no. 2 (2023).

children's needs independently. One informant stated,*"I work, my husband works, and my child is short but healthy. So if I receive assistance, I think it's better for others who need it more. I can afford it myself."* [27]

Children from wealthy families are also at risk of stunting.[28] The narrative above demonstrates that the decision to refuse is not based on a diagnosis, but rather on economic pride and a desire to distance themselves from the perception of being "beneficiaries." Within the framework of social construction, this refusal serves as a mechanism to maintain an established social identity and economic status.

On the other hand, for parents from lower-middle income groups, resistance stems from the logistical and time burdens of accessing intervention services. One mother stated that she didn't have time to get supplementary food or attend health counseling because she had to work from early morning.*"I work at the market at 3 a.m., get home at 9, and then take care of the house in the afternoon. Sometimes I think it's a hassle to get extra food, especially if I have to go to the health center all the time."*[29] In this context, medically necessary interventions are perceived as an unrealistic additional burden on busy daily routines. This economic rationality suggests that resistance to health programs is often not an ideological one, but rather a reflection of the practical compromises families must make in managing limited time, energy, and resources.[30]

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[27] Wawancara Informan B, "Penolakan Berasal Dari Ibu," 2025, 10 Juni, jam 13.00 - 14.00 WIB.

[28] Leny Latifah et al., "Can Living In A Wealthy Family Free Child From The Stunting Risk? Studies On Wealthy Indonesian Families In Urban Areas.," Journal of Namibian Studies 33 (2023).

[29] Wawancara Informan D, "Ponalakan Dari Pihak Ibu, Namun Sekarang Sudah Menerima Baik Kondisi Anak Dan Intervensi Yang Diberikan," 2025, 10 Juni, jam 14.00 - 15.00 WIB.

[30] Yosef Emanuel Jelahut et al., "Fenomena Stunting Sebagai Dampak Degradasi Kesejahteraan Sosial-Ekonomi Masyarakat," Jurnal Dakwah Tabligh 24, no. 2 (2023): 1–13.

5. Rejection as a Form of Incompatibility with the Principle of *Maqāṣid al-Syari'ah*

In the perspective of *Maqāṣid al-Syari'ah*, children's health is an integral part of sharia obligations in taking care of the five main aspects of human life, namely religion (*hifz al-din*), soul (*hifz al-nafs*), reason (*hifz al-'aql*), descendants (*hifz al-nasl*), and property (*hifz al-mal*).[31] Rejection of stunting diagnosis and intervention is essentially a form of ignoring the principle of*hifz al-nafs* And *hifz al-nasl*, because it has the potential to threaten the survival and quality of life of future generations. In an interview with an academic in the field of Islamic jurisprudence, it was explained that,*"According to the Maqāṣid al-Syari'ah, parents have an obligation to safeguard their intellect, soul, and offspring. Refusing medical intervention, especially one that benefits the child, could conflict with that principle. This is especially true if it's simply due to pride or embarrassment."*[32] Rejection on the basis of emotions or personal pride cannot be allowed by syar'i when it has the potential to harm the child's growth.

Ironically, some parents do not perceive health interventions as part of their religious obligations. This attitude is influenced by limited religious literacy, particularly concerning the practical dimensions of health and well-being of the *Maqāṣid al-Syari'ah*. Yet, Islamic teachings strongly emphasize the importance of maintaining health and protecting offspring as a form of parental moral responsibility. A local religious figure, in an interview, stated,*"Religion isn't just about worship, but also about protecting children's health. If the government's program is good, we support it. It's part of upholding our parental responsibility."*[33] However, the lack of involvement of religious figures in stunting education often results in a less than optimal religious approach as a bridge to public understanding.

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[31] Abdul Wahab Khallaf, 'Ilm Ushul al Fiqh (Dar al-Qalam, 1978); Afthon Yazid, "The Discovery of Islamic Law with the Turas Books: Method Development," MAQASHID: Jurnal Hukum Islam 6, no. 1 (2023): 1–14.

[32] Bapak S, "Akademisi Yang Berpendidikan Agama Islam," 2025, 11 Juni, jam 16.00 - 17.00 WIB.

[33] Bapak T, "Tokoh Agama Dan Takmir Masjid Al-Akbar," 2025, 05 Juni, jam 16.00 - 17.00 WIB.

This disparity between the substance of sharia and social practices presents both an opportunity and a challenge in integrating religious values into stunting management strategies. This study found that resistance to diagnosis and intervention is not entirely based on religious principles, but rather on personal or cultural interpretations that are inconsistent with the *Maqāṣid al-Syari'ah*. Therefore, community-based stunting interventions need to be designed by integrating a contextual and communicative sharia approach. A religious instructor stated in an interview that,*"We haven't been involved much in the stunting program, even though if we were given the space, we could convey that caring for children is also part of our worship."*[34] This statement indicates the importance of cross-sector collaboration, particularly between health workers and religious leaders, in strengthening health messages as part of the public interest.

6. Socially and Religiously Sensitive Health Communication Strategies

The effectiveness of health interventions, especially in the management of stunting, is heavily influenced by the communication strategies employed. Approaches that depend exclusively on medical data and technical explanations often prove ineffective in addressing the deeper layers of parental values, cultural beliefs, and emotional contexts. Resistance to stunting diagnoses and interventions can be reduced if information is conveyed with empathy and prioritizes values understood and respected by the community. A nutrition officer shared her experience:*"If we only explain it using medical data, parents sometimes don't believe it. But if we engage in everyday conversation and share our experiences, they slowly start to open up."*[35] This shows that a personal and contextual approach is more effective in building trust and reducing resistance.

Moreover, integrating religious values into communication strategies is key in a religious society. When education about children's health is linked to religious obligations, parents are more likely to accept and internalize the

[34] Bapak M, "Penyuluh Agama Dari Desa Sedayu," 2025, 11 Juni, jam 16.00 - 17.00 WIB.
[35] Ibu A, "Petugas Gizi Puskesmas Majegan," 2025, 02 Juni, jam 12.00 - 13.00 WIB.

information.[36] A religious instructor stated,*"When I explained to residents that maintaining children's health is part of their Islamic responsibility, many immediately understood. They saw it as not just a worldly matter, but also a trust from Allah."* [37]This narrative emphasizes the importance of involving religious leaders in health communication programs, not merely as symbolic complements, but as strategic actors capable of bridging understanding between medical approaches and the community's religious value framework.[38] Thus, communication strategies with a more communal social and religious approach, such as through weekly religious studies, Friday sermons, or other means, not only increase program acceptance but also strengthen the ethical and spiritual legitimacy of stunting intervention efforts.

7. Structural and Ethical Dimensions in Rejecting Stunting Diagnosis: Integration of Social Construction and *Maqāṣid al-Syari'ah*

The causal relationship between social constructions and resistance to a stunting diagnosis is then reviewed through the lens of the *Maqāṣid al-Syari'ah*. In this model, parental resistance is mapped as the result of a series of social constructions involving personal perceptions, collective values, and socio-economic pressures. Factors such as limited understanding of stunting, the dominance of cultural values that relativize a child's physical condition, the stigma associated with the label "parenting failure," and concerns about the economic burden are at the root of this resistance. Through Berger and Luckmann's approach, this framework demonstrates that the reality of stunting is not accepted as objective but is socially negotiated within a highly complex intersubjective space.

Field findings show that each factor in the framework is mutually reinforcing. For example, in the case of the family Informants A and C, limited

[36] Noviansyah Noviansyah et al., "Strategy for Accelerating Stunting Prevention through Religious Approach to Generate Qualified Generation," Int J Public Health Sci 11 (2022): 1058.

[37] Bapak M, "Penyuluh Agama Dari Desa Sedayu," 2025.

[38] Siti N Zahrah and Nyoman A Damayanti, "The Relationship between Religious Leaders and the Knowledge of Mothers in Reducing Stunting: A Literature Review," Journal of Public Health in Africa 14, no. 2 (2023): 6.

understanding coupled with family cultural values that refuse to be categorized as “failure” leads to total resistance to intervention. Informant A stated, “*I've fed him well, given him clean clothes, and given him affection. My child isn't fussy or sick. How can he be called stunted? I can't accept it.*.”[39] Meanwhile, according to the integrated health post cadre, “*The mother was offended when she was told her child was stunted. Since then, she has not gone to the integrated health post (posyandu), feeling as if she has been humiliated*.”[40] On the other hand, Informant B refused not because of ignorance, but because of economic abundance and a reluctance to be associated as a 'poor family receiving aid.' He stated, “*I think it's better to give aid to those who need it more. I can afford it myself*.”[41] Thus, denial of diagnosis is the result of different social constructions, depending on the structures of meaning that prevail within the family and community.

From a *Maqāṣid al-Syari’ah* perspective, all the factors that lead to this rejection, if left unchecked, can actually threaten the three main objectives of sharia: safeguarding the soul (hifz al-nafs), the mind (hifz al-‘aql), and the offspring (hifz al-nasl).[42] This means that resistance to diagnosis and intervention is not merely a technical or structural issue, but also involves negligence in carrying out religious obligations. Religious leaders convey, "*Religion isn't just about worship, but also about maintaining children's health. If the government's program is good, we support it*.”[43] Therefore, the framework in Table 1 below, not only explains why rejection occurs, but also provides direction on how an integrative approach, namely synergy between social construction-based education and the values of *Maqāṣid al-Syari’ah*, needs to be developed to target the root of the problem while touching the spiritual awareness of society.

[39] Wawancara Informan A, “Penolakan Berasal Dari Ibu Balita.,” 2025.
[40] Ibu M, “Kader Posyandu Puskesmas Majegan,” 2025.
[41] Wawancara Informan B, “Penolakan Berasal Dari Ibu,” 2025.
[42] Afthon Yazid and Arif Sugitanata, “The Complexity and Diversity Methods of Legal Discovery in Islam: In the Perspective Ulama of Mazhab al-Arba’ah,” Kawanua International Journal of Multicultural Studies 4, no. 2 (2023): 152–64.
[43] Bapak T, “Tokoh Agama Dan Takmir Masjid Al-Akbar,” 2025.

Table. 1
Framework for Analysis of Social Construction and *Maqāṣid al-Syari'ah*

Berger's Social Construction Factors	Review of *Maqāṣid al-Syari'ah*
Parents' understanding of stunting *(Externalization)* — Parents express their personal experiences and beliefs about child health through daily practices and language, such as defining "healthy" based on appetite and cheerfulness rather than height indicators. *(Objectivation)* — These subjective understandings become social facts shared collectively in the community, forming the belief that "short children are common and healthy." *(Internalization)* — Over time, these social beliefs are reabsorbed by individuals as unquestioned truths, shaping their rejection of medical diagnoses.	Ignoring the principles of *hifz al-'aql* (protection of the mind) and *hifz al-nafs* (protection of the soul) due to misperceptions about health risks.
Local cultural values and beliefs *(Externalization)* — Traditional values such as *nrimo* (acceptance) and respect for elders are expressed through parenting attitudes and health decisions. *(Objectivation)* — Cultural norms, like equating a child's short stature with hereditary traits, become collective truths reinforced by older generations. *(Internalization)* — These values are reaccepted by young parents, maintaining resistance to medical advice.	It has the potential to conflict with the principle of *hifz al-nasl* (protection of offspring) if it hinders children's access to their health rights.
Social interaction *(Externalization)* — Parents communicate their feelings of shame or pride through social gatherings, community meetings, or religious	Maintaining social solidarity is in line *with Maqāṣid al-Syari'ah*, but if it causes information isolation, it becomes counter-productive.

events. *(Objectivation)* — These emotions crystallize into shared social expectations (e.g., being labeled "failed parents" if one's child is diagnosed stunted). *(Internalization)* — The stigma becomes internalized, discouraging participation in health programs.	
Economic factors *(Externalization)* — Families express economic self-sufficiency or limitations as part of their social identity (e.g., refusing aid to preserve dignity). *(Objectivation)* — Economic capacity becomes a symbolic marker of family worthiness, shared and recognized by the community. *(Internalization)* — Economic pride or resignation then shapes attitudes toward health assistance.	Rejection for economic reasons can weaken the protection of the soul and mind if the child's basic needs are not met.
Stigma and social perception *(Externalization)* — Negative labeling of "stunted children" or "careless parents" is expressed in community discourse. *(Objectivation)* — Such labeling becomes a dominant narrative embedded in social identity and gossip networks. *(Internalization)* — Families internalize this stigma, choosing denial to protect self-esteem.	Stigma can hinder efforts to protect generations (*hifz al-nasl*) and reduce concern for children's health.

C. CONCLUSION

Findings from this study indicated that parental resistance to a stunting diagnosis cannot be attributed solely to a lack of knowledge or medical skepticism. Instead, it reflects a multifaceted social construction shaped by cognitive perceptions, cultural beliefs, economic realities, and aspects of social identity. Result from each interview indicated that rejection is shaped by experiences, local values, and symbolic perceptions attached to the label

"stunting" as a representation of parenting failure. Berger and Luckmann's social construction theory explains how these perceptions are externalization, objectivation, and internalization in social interactions. Meanwhile, factors such as social prestige, stigma, economic constraints, and a lack of understanding of children's health rights further strengthen resistance to nutritional interventions and health services.

From the point of view of *Maqāṣid al-Syari'ah*, this phenomenon of rejection indicates the existence of incompatibility between the behavior of parents and the principles of soul protection (*hifz al-nafs*), reason (*hifz al-'aql*), as well as descendants (*hifz al-nasl*) in Islam. Resistance to health efforts aimed at saving future generations is seen as a neglect of religious obligations. It was found that many parents showed limited awareness of the intended goals. Therefore, stunting intervention approaches need to be designed in a more contextual and collaborative manner, taking into account prevailing social values and integrating strong religious narratives. Stunting education programs need to formally involve religious instructors in cadre training modules and outreach. Furthermore, a family-based approach that is sensitive to local norms should be facilitated by health workers in a personal and participatory manner.Involving religious leaders and designing socially and religiously sensitive communication strategies is key to bridging the gap between medical authorities and local values, thereby fostering more effective and meaningful community acceptance of stunting reduction programs.

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