



The Relationship Between Material Knowledge About Child Nutrition and Stunting at The Age of 0-5 Years

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Received: 9 November 2022; Revised: 25 November 2022; Accepted: 30 November 2022

Abstract

Stunting is a problem that is found in many developing countries, especially in Indonesia. Stunting is a condition of failure to thrive in children caused by chronic malnutrition so that children are too short for their age and have a risk of intellectual decline and an increased risk of degenerative diseases in the future. The purpose of this study was to determine the relationship between maternal knowledge about child nutrition and the incidence of stunting in children aged 0-5 years in Kelambir Village. This study used correlation analytical design with cross sectional approach. The population in this study was all parents who had stunted children aged 0-5 years. The sample was obtained using random sampling, which was as many as 90 people. The instrument used in this study was a questionnaire. The results showed that most respondents had good knowledge about stunting, which was 57 respondents (63.3%). There is a significant relationship between maternal knowledge about stunting and nutrition of children aged 0-5 years in Kelambir Village, Pantai Labu District in 2022. Suggestion: Health education is very important in order to increase maternal knowledge about stunting and the importance of knowing nutrition in children aged 0-5 years.

Keywords: Child Nutrition, Knowledge, Stunting

Introduction

Stunting is a chronic nutritional problem experienced by the State of Indonesia that must be addressed. Stunting is a condition of failure to thrive in children under five caused by chronic malnutrition so that children are too short for their age. The condition of short children is a sign of growth problems and nutritional status. The nutritional status of toddlers is measured based on age (U), weight (BB), and height (TB). BB and TB variables are presented in the form of three anthropometric indicators, namely weight according to age (BB / U), height according to age (TB / U), and weight according to height (BB / TB). The BB/U indicator gives an indication of general nutritional problems. This indicator does not give an indication of nutritional problems of a chronic nature because body weight is positively correlated with age and height. In other words, low body weight can be caused by short children (chronic) or because

of diarrhea or other infections (acute) (WHO, 2017). The incidence of short toddlers or stunting is one of the nutritional problems experienced by toddlers in the world today. In 2018, the prevalence of stunting in children in the world was 22%. The prevalence of stunting children in Indonesia is included in the high category because based on data from Riskesdas in 2018, nationally the prevalence of stunting is 30.8%. Data on the prevalence of stunting toddlers collected by WHO, Indonesia is included in the third country with the highest prevalence in the Southeast Asia region (Riskesdas 2018).

The direct causes of stunting children are low birth weight, low energy intake and low protein intake, other direct factors are poor parenting practices, not exclusive breastfeeding and 2 out of 3 children aged 0-24 months do not get complementary foods (Ministry of Health RI, 2011). Economic components that have implications for stunting. In addition, the mother's height, poverty level related to salary, education

level, knowledge results from knowing and occurs after someone senses an object (Mubarak, 2011).

The impact of stunting can be seen from the imperfect cognitive, motor and verbal development of children, increased fear, increased health costs, disability, and graduation. Other impacts can include decreased body size, mood capacity, decreased financial efficiency, regenerative capacity and an increased likelihood of metabolic diseases and heart infections (Perkins JM et al, 2017). The most complex causes of malnutrition are factors of knowledge and feeding behavior or incorrect nutritional parenting. Many factors cause the high incidence of stunting in toddlers. Direct causes of lack of food intake and the presence of infectious diseases (Umeta, 2013).

A mother's knowledge will affect the nutritional status and development in the child and is indispensable to support in the process of growth and development. Lack of maternal knowledge, wrong parenting, poor sanitation and hygiene and low health services, besides that people have not realized that short children are a problem, because short children in the community are seen as children with normal activities, unlike thin children must be addressed immediately (Unicef, 2016). In Q.S An-nisa explains:

وَلْيَخْشَ الَّذِينَ لَوْ تَرَكَوْا مِنْ خَلْفِهِمْ ذُرِّيَّةً
ضِعْفًا خَافُوا عَلَيْهِمْ فَلْيَتَّقُوا اللَّهَ وَلْيَقُولُوا قَوْلًا
سَدِيدًا

"And fear the gods of those who leave behind them weak children, whom they fear for their (welfare). Therefore let them speak the right words."

"Weak" as the verse above, contains many meanings. It can be interpreted as economically weak, weak in faith, weak in character or ethics, and weak in science. Including physical weakness related to health, such as stunting. As an effort to prevent, Islam offers several steps as the word of Allah Almighty in Q.S Al-Baqarah verse 233 as follows: "Mothers should breastfeed their children for two full years, that is, for those who want to perfect breastfeeding. And it is the duty of the father to feed and clothe the mothers in a ma'ruf way."

Three things to note from the verse above. First, a mother should breastfeed children for two years. Secondly, the father's job is to ensure that the mother of his children is well nourished. Third, the family (both father and mother) must get used to a healthy lifestyle. Based on the background description above, the researcher is interested in taking a study entitled The Relationship of Maternal Knowledge about Child Nutrition with Stunting at the Age of 0-5 Years in Kelambir Village, Pantai Labu District because in that village the incidence of stunting is still high.

Materials and Method

The design of this study is a correlation that aims to determine whether there is a relationship between maternal knowledge and child nutrition on the incidence of stunting at the age of 0-5 years in Kelambir Village, Pantai Labu District in 2022. In this study, the population studied was all parents (mothers) who had children aged 0-5 years in Kelambir Village. The sample in this study amounted to 90 respondents obtained using random sampling techniques. Initial information is collected by means of surveys, each respondent is asked to fill out a survey with a survey sheet that has been given to parents / mothers, where previously researchers gave consent sheets to become respondents. After all respondents fill out surveys and other information processes, data processing is carried out.

Results and Discussion

Identity of the Respondent's Family

In table 1 there are two posyandu in Kelambir Village, namely posyandu 1 located in Hamlet I and Hamlet II, posyandu 2 located in Hamlets III and IV. Based on the posyandu demographic data that we examined in Kelambir Village in table 1, the highest percentage of posyandu users were in Dusun III and Dusun IV with 60% and 40% in Dusun I and Dusun II posyandu. The analysis above shows that people in Hamlets III and IV use posyandu more than people in Hamlet I and Hamlet II. Table 2 contains the age of mothers under five in Kelambir Village, from the results we examined. Based on the demographic data of the age of mothers and children that we examined in Kelambir Village in the second table, the largest percentage was 44.4% for 26-30 years old, 35.6% for 31-35 years old, 12.2% for 21-25 years old, 4.4% for 41-45 years old. From the data above, we can see that the av-

Table 1. Posyandu

	Fre- quency	Persent	CI 95%	
			Lower	Upper
Posyandu Dusun I and II	36	40%	30.0	50.0
Posyandu Hamlets III and IV	54	60%	50.0	70.0
Total	90	100%	100.0	100.0

Table 2. Mother's age

	Fre- quency	Percent	CI 95%	
			Lower	Upper
16-20 years	3	3.3%	0	7.8
21-25 years	11	12.2%	5.6	18.9
26-30 years	40	44.4%	34.4	54.4
31-35 years	31	35.6%	25.6	45.6
41-45 years old	4	4.4%	1.1	8.9
Total	90	100%	100.0	100.0

Table 3. Father's education

	Fre- quency	Persent	CI 95%	
			Lower	Upper
Graduated from elementary school	10	11,1%	4.5	17.8
Graduated from junior high school	29	32,2%	22.2	42.2
Graduated from High School	45	50,0%	38.9	61.1
Graduated from College	6	6,7%	2.2	12.2
Total	90	100%	100.0	100.0

Table 4. Maternal Education

	Fre- quency	Per- sent	CI 95%	
			Lower	Upper
Graduated from elementary school	6	6,7%	2.2	12.2
Graduated from junior high school	21	23,3%	14.5	32.2
Graduated from High School	57	63,3%	53.3	73.3
Graduated from College	6	6,7%	2.2	12.2
Total	90	100%	100.0	100.0

Table 5. Father's work

	Fre- quency	Per- sent	CI 95%	
			Lower	Upper
Not Working	6	6,7%	2.2	12.2
Laborer	12	13,3%	6.7	21.1
Self employed	42	46,7%	36.7	57.7
Farmer	9	10,0%	4.4	16.7
Fisherman	15	16,7%	10.0	24.4
Civil Serv- ants/TNI/ Polri	4	4,4%	1.1	8.6
Private Em- ployees	2	2,2%	0	5.6
Total	90	100%	100.0	100.0

Table 6. Mother's work

	Fre- quency	Per- sent	CI 95%	
			Lower	Upper
Not Working	73	81,1%	73.3	88.9
Laborer	5	5,6%	1.1	11.1
Self em- ployed	8	8,9%	3.3	14.4
Farmer	2	2,2%	0	5.6
Private Em- ployees	2	2,2%	0	5.6
Total	90	100%	100.0	100.0

Table 7. Parents' Income

	Fre- quency	Per- sent	CI 95%	
			Lower	Upper
IDR 0 – IDR 500,000	13	14,4%	7.8	22.2
IDR 600,000 – 1,000,000	11	12,2%	5.6	18.9
IDR 1,500,000 – 2,000,000	33	36,7%	26.7	46.7
>IDR 2,000,000	33	36,7%	26.7	46.7
Total	90	100%	100.0	100.0

Table 8. Age of Child (in months)

	Frequency	Persent	CI 95%	
			Lower	Upper
0-12 Months	22	24,4%	16,7	33.3
13-24 Months	17	18.9%	11,1	26.7
25-36 Months	25	27,8%	18,9	37,8
37-48 Months	11	12,2%	5.6	18,9
49-60 Months	15	16,7%	8,9	24.4
Total	90	100%	100.0	100.0

Table 9. Gender of Child

	Frequency	Persent	CI 95%	
			Lower	Upper
Man	37	41,1%	31.1	51.1
Woman	53	58,9%	48.9	68.9
Total	90	100%	100.0	100.0

Table 10. Child Weight

	Frequency	Persent	CI 95%	
			Lower	Upper
1-5 kg	41	45,6%	5.1	56.7
5-10 kg	47	52,2%	5.1	62.2
11-15 kg	2	2,2%	1.5	5.6
Total	90	100%	100.0	100.0

Table 11. Children's Height

	Fre- quency	Persent	CI 95%	
			Lower	Upper
45-50 cm	5	5,6%	1.1	11.1
51-60 cm	9	10,0%	4.4	16.7
61-70 cm	6	6,7%	2.2	12.2
71-80 cm	14	15,6%	8.9	23.3
81-90 cm	23	25,6%	16.7	35.6
91-100 cm	22	24,4%	15.6	33.3
101-110 cm	9	10,0%	4.4	16.7
111-120 cm	2	2,2%	0	5.6
Total	90	100%	100.0	100.0

Table 12. Nutritional Status

	Frequen- cy	Persent	CI 95%	
			Lower	Upper
Stunting	11	12,2%	6.7	20.0
No Stunting	79	87,8%	80.0	93.3
Total	90	100%	100.0	100.0

Table 13. Child weight at birth

	Frequency	Persent	CI 95%	
			Lower	Upper
1-2 kg	12	13,3%	6.7	21.1
2.1-3 kg	41	45,6%	35.6	55.6
3.1-4 kg	33	36,7%	26.7	47.8
4.1-5 kg	4	4,4%	1.1	8.9
Total	90	100%	100.0	100.0

Table 14. Child's Weight Status

	Fre- quency	Persent	CI 95%	
			Lower	Upper
Low	9	10%	4.4	17.7
Usual	81	90%	82.3	95.6
Total	90	100%	100.0	100.0

Table 15. Have had ARI, diarrhea, and tuberculosis from the last 3 months

	Frequen- cy	Persent	CI 95%	
			Lower	Upper
Not	85	94.4%	88.9	98.9
ISPA	1	1.1%	0	3.3
DIAR- RHEA	3	3.3	0	7.8
TUBER- CULOSI S	1	1.1	0	3.3
Total	90	100%	100.0	100.0

Table 16. Eating History Questionnaire

	Frequency	Persent	CI 95%	
			Lower	Upper
Is the mother's child given colostrum at birth? (milk that first comes out and yellowish in color)				
Yes	71	78,9%	71.1	86.7
Not	19	21,2%	13.3	28,9
Not yet	0	0	0	0
Total	90	100%	100.0	100.0
Before breast milk comes out, is the mother's child given honey / water / sugar water?				
Yes	41	45,6%	34.5	55.6
Not	49	55,4%	44.5	65.6
Not yet	0	0	0	0
Total	90	100%	100.0	100.0
Is the mother's child at the age of less than 6 months breastfed with an amount or frequency of at least 8 times per day?				
Yes	67	74,4	64,4	83,3
Not	22	24,4	15,6	34,4
Not yet	1	1,1	0	3,3
Total	90	100%	100.0	100.0
Is the mother's child breastfed alone until 6 months of age				
Yes	67	74,4	65,6	83,3
Not	22	24,4	15,6	34,4
Not yet	1	1,1	0	3,3
Total	90	100%	100.0	100.0
Whether the mother's child after more than 6 months remains breast-fed				
Yes	77	85,6	76,7	92,2
Not	12	13,3	6,7	21,1
Not yet	1	1,1	0	3,3
Total	90	100%	100.0	100.0
Whether when it is over 6 months the child has been given canned milk or formula milk				
Yes	77	85,6	51,1	71,1
Not	12	13,3	26,7	45,6
Not yet	1	1,1	0	7,8
Total	90	100%	100.0	100.0

Is it when it is over 6 months that children begin to be introduced to MP-ASI (such as milk porridge / bread / thawed biscuits)				
Yes	80	88,9	82,2	94,4
Not	9	10,0	4,4	16,7
Not yet	1	1,1	0	3,3
Total	90	100%	100.0	100.0
Is MP-ASI at the age of 6 months given 2 times a day				
Yes	72	80,0	72,2	87,8
Not	16	17,8	10,0	25,6
Not yet	2	2,2	0	5,6
Total	90	100%	100.0	100.0
Is at the age of 6-12 months the portion of food children per day 6 tablespoons / more				
Yes	75	83,3	75,6	91,1
Not	13	14,4	7,8	22,2
Not yet	2	2,2	0	5,8
Total	90	100%	100.0	100.0
Is it at the age of 6 months and above usually fed by his grandmother / sibling				
Yes	59	65,6	55,6	75,6
Not	29	32,3	22,2	42,2
Not yet	2	2,2	0	5,6
Total	90	100%	100.0	100.0
Is MP-ASI at the age of 7-12 months given 3 times a day				
Yes	64	71,1	62,2	81,1
Not	24	27,6	16,7	35,6
Not yet	2	2,2	0	5,8
Total	90	100%	100.0	100.0
Is it at the age of 12-24 months that the mother gives MP-ASI in soft form (corn grits/ rice porridge/ team rice)				
Yes	72	80,0	71,1	87,8
Not	13	14,4	7,8	22,2
Not yet	5	5,5	1,1	11,1
Total	90	100%	100.0	100.0
Whether at 12-24 months, the portion of children's food per day is 1/2 portion of adults				
Yes	53	58,9	48,9	68,9
Not	32	35,6	25,6	54,6
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0

Is MP-ASI at the age of 12-24 given 3 times a day				
Yes	68	75,6	65,6	84,4
Not	19	21,1	13,3	30,0
Not yet	3	3,3	0	7,8
Total	90	100%	100.0	100.0
At the age of 12-24 months, breast milk is still given				
Yes	65	72,2	62,2	81,1
Not	21	23,3	14,4	32,2
Not yet	4	4,4	1,1	8,9
Total	90	100%	100.0	100.0
Whether at the age of 12 months and above the child begins to be introduced to family food				
Yes	79	87,8	80,0	94,4
Not	6	6,7	2,2	12,2
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0
Whether at the age of 12 months and above family food is given 3 times a day				
Yes	66	73,3	63,3	82,2
Not	19	21,1	12,2	30,0
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0
Whether at the age of 12 months and above the child is given interlude food				
Yes	79	87,8	80,0	94,4
Not	7	7,8	2,2	14,4
Not yet	4	4,4	1,1	8,9
Total	90	100%	100.0	100.0
Is it at the age before 24 months and above that children are given interlude food 2 times a day				
Yes	75	83,3	75,6	91,1
Not	10	11,1	5,6	17,8
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0
Is it at the age before 24 months how to feed the child by being fed				
Yes	60	66,7	56,7	75,6
Not	21	23,3	14,4	32,2
Not yet	9	10,0	4,4	16,7
Total	90	100%	100.0	100.0

Is it at the age of 20-24 months that the child is accustomed to eating alone

Yes	46	51,1	41,1	61,1
Not	34	37,8	27,8	47,8
Not yet	10	11,1	4,4	17,8
Total	90	100%	100.0	100.0

Does the mother prepare the needs of the child

Yes	82	91,1	85,6	96,7
Not	3	3,3	0	7,8
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0

Is the child used to being given sweet tea?

Yes	59	65,6	55,6	74,4
Not	25	27,8	18,9	37,8
Not yet	6	6,6	2,2	12,2
Total	90	100%	100.0	100.0

In giving food to children, whether it includes porridge / rice, vegetables, and side dishes

Yes	79,	87,8	81,1	94,4
Not	5	5,6	1,1	11,1
Not yet	6	6,6	2,2	12,2
Total	90	100%	100.0	100.0

Whether feeding is stopped when the child is full

Yes	79	87,8	80,0	94,4
Not	6	6,7	2,2	12,2
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0

When the child is fed is persuaded to finish his food

Yes	54	60,0	50,0	70,0
Not	31	34,4	24,4	54,5
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0

If the child does not finish his food, is the rest stored for re-feeding?

Yes	18	20,0	11,1	28,9
Not	66	73,3	63,3	82,2
Not yet	6	6,7	2,2	12,2
Total	90	100%	100.0	100.0

Does the child's diet vary every day?				
Yes	81	90,0	83,3	95,6
Not	4	4,4	1,1	8,9
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0
Do you know your child's appetite every day?				
Yes	80	88,9	82,2	94,4
Not	5	5,6	1,1	11,1
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0
Are there certain food restrictions in children				
Yes	33	36,7	26,7	46,7
Not	53	58,9	48,9	68,9
Not yet	4	4,4	1,1	8,9
Total	90	100%	100.0	100.0
If there is good food in the family, is it preferable for children than other family members?				
Yes	82	91,1	84,4	96,7
Not	3	3,3	0	7,8
Not yet	5	5,6	1,1	11,1
Total	90	100%	100.0	100.0
At the time when the child is in a state of illness is given special food				
Yes	38	42,2	33,3	52,2
Not	48	53,3	42,2	63,3
Not yet	4	4,4	1,1	8,9
Total	90	100%	100.0	100.0

erage age of mothers of children is 26-30 years in Kelambir Village.

Table 3 contains the education of fathers of children living in Kelambir Village from the results we examined. Based on family identity data, the highest percentage in the education table of fathers of children in Kelambir Village is 50.0% The father's last education was graduated from high school, as many as 32.2% of education graduated from junior high school, as many as 11.1% of education graduated from elementary school, as many as 6.7% graduated from college. From the results above, we can see that the average father of a child in Kelambir has a final high school graduation.

Table 4 contains the education of mothers and children living in Kelambir Village from the results we examined. Based on family identity data, the highest percentage in the education

table of father children in Kelambir Village is 63.3% The last education of the child's mother is graduated from high school, as many as 23% of education graduated from junior high school, as much as 6.7% of education graduated from elementary school, as many as 6.7% graduated from college. From the results above, we can see that the average mother child in Kelambir has a final high school graduation.

Table 5 shows the work of father children in Kelambir Village that we examined. Based on the identity of the respondent's family, the highest percentage of fathers' jobs in the father-child employment table in Kelambir Village was 6.7% Unemployed, 13.3% Laborers, 46.7% Self-employed, 10% Farmers, 16.7 Fishermen, 4.4 Civil Servants/TNI/Polri, 2.2% Private Employ-

ees. From the results above, we can see that the average work of father children in Kelambir Village is self-employed.

Table 6 shows the work of mothers in Kelambir Village that we examined. Based on the identity of the respondents' families, the highest percentage of maternal employment in the employment table of mothers and children in Kelambir Village is 81.1% Not Working, 13.3% Laborers, 5.6% Self-employed, 8.9% Farmers, 2.2%, as many as 2.2% Private Employees. From the results above, we can see that the average work of mothers of children in Kelambir Village is Not Working.

Table 7 shows the income of parents in Kelambir Village that we examined. Based on the identity of the respondents' families, the highest percentage in the largest parental income table is IDR 1,500,000-IDR 2,000,000 and above IDR 2,000,000 as much as 36%, IDR 0-IDR 500,000 as much as 14.4%, and IDR 600,000-IDR 1,000,000 as much as 12.2%. From the results above, we can see that the average income of parents in Kelambir Village is IDR 1,000,000 to above IDR 2,000,000.

Identity of the Subject

Table 8 shows the age of children in Kelambir Village that we studied. Based on the identity of the subject, the percentage of the largest in the children's age table, namely 25-36 Months as much as 27.8%, 0-12 Months as much as 24.4%, 13-24 Months as much as 18.9%, 49-60 Months as much as 16.7%, and 37-48 Months as much as 12.2%. From the results above, we can see that the average age of children we studied in Kelambir Village is 25-36 months.

Table 9 shows the gender of children in Kelambir Village that we have examined. Based on subject identity data, the largest percentage was 58.9% for the female gender and 41.1% for the male gender. From the results above, we can see that most of the respondents' data are girls in Kelambir Village.

Table 10 contains the weight of children in Kelambir Village that we have examined. Based on anthropometric data on children's weight, the largest percentage is 52.2% for body weight 5-10 kg, and 45.6% for body weight 1-5 Kg, as much as 2.2% for body weight 11-15 Kg. From the table above it can be seen that most of the children we studied have a body weight of 5-10 Kg.

In Table 11 of Children's Height in Kelambir Village that we have examined. Based on anthropometric data on children's weight, the largest percentage is 25% for height 81-90 cm, 24.4% for 91-100 cm, 15.6% for 71-80 cm, 10.0% for 51-60 cm and 101-110 cm, 6.7% for 61-70 cm, 5.6% for 45-50 cm, 2.2% for 111-120 cm. From the table above, we can see that the average height of children in Kelambir Village is 81-90 cm.

In table 12, the nutritional status of children in Kelambir Village that we have studied. Based on anthropometric data on the nutritional status of children's bodies, the largest percentage is 87.8% for the non-stunting category, 12.2% for the stunting category. From the data above, we can see that more children are not stunted than those who are stunted in Kelambir Village.

Table 13 shows that the child's weight at birth that we examined in Kelambir Village. Based on anthropometric data on children's weight at birth, the largest percentage is 45.6% for the 2.1-3 Kg category, 36.7% for the 3.1-4 Kg category, 13.3% for the 1-2 Kg category, 4.4% for the 4.1-5 Kg category. from the table above we can see that the child's weight in Kelambir Village at birth is 2.1-3 Kg.

Table 14 shows that the weight status of the children we examined in Kelambir Village. Based on anthropometric data on children's weight status, the highest percentage is 90% for the Normal category and 10% for the Low category. From the table above, it shows that the weight status of children in Kelambir Village is normal.

Table 15 shows that we have suffered from IISPA, diarrhea, and tuberculosis from the last 3 months in Kelambir Village that we have studied. Based on anthropometric data above, it shows that the highest percentage is 94.4% as many as 85 children do not experience the above diseases, for 3.3% as many as 3 children have suffered from diarrhea in the last 3 months, for 1.1% as many as 2 children have experienced tuberculosis and ARI in the last 3 months. We can see that many children have not experienced the above diseases for the last 3 months.

Table 16. show he Parenting Questionnaire that we examined in Kelambir Village. Based on the questionnaire we distributed, the highest percentage of mothers who gave their first colostrum directly to their children was 54.4%, as many as 49 mothers did not give their children their first milk at birth. The highest percentage for mothers who gave sugar or honey at the time of giving

birth to their children was 74.4% for 67 mothers who did. The highest percentage was for mothers who breastfed their children in the first 6 months at least 8 times a day, namely 74.4%, as many as 67 mothers did so. The highest percentage was for mothers who fully breastfed their children up to 6 months, namely 74.4% for 67 mothers who fully breastfed for 6 months. The highest percentage for mothers who breastfeed for more than 6 months is 85.6% for 77 mothers. The percentage of mothers who gave additional formula milk to their children aged 6 months and over was 85.6% for 77 mothers. The percentage of mothers who introduced MP-ASI to children aged 6 months and over was 88.9% for 80 mothers. The percentage of mothers who gave MP-ASI to children aged 6 months 2 times a day was 80% for 72 mothers. The percentage of mothers who gave children aged 6 to 12 months 6 tablespoons per day was 83.3% for 75 mothers. The percentage of children aged 6 months who were fed by their siblings was 65.6% for 59 mothers. The percentage of mothers who gave MP-ASI to children aged 7-12 months 3 times a day was 71.1% for 64 mothers.

The percentage of mothers who gave MP-ASI to children aged 12-24 months who were given soft food was 80% for 72 mothers. The percentage of mothers who gave their children half the adult portion of food per day for children aged 12-24 months was 58.9% for 53 mothers. The percentage of mothers who gave MP-ASI to children aged 12-24 months 3 times a day was 75.6% for 68 mothers. The percentage of mothers who continue to breastfeed children aged 12-24 months is 72.2% for 65 mothers. The percentage of mothers who introduced family foods to children aged 12 months and over was 87.8% for 79 mothers. The percentage of mothers who gave family food to children aged 12 months and over 3 times a day was 73.3% for 66 mothers. The percentage of mothers who gave snacks to children aged 12 months and over was 87.8% for 79 mothers. The percentage of mothers who gave snacks to children aged 12 months and over 2 times a day was 83.3% for 75 mothers. The percentage of mothers who fed their children before the age of 24 months by eating bribes was 66.7% for 60 mothers. The percentage of mothers in children aged 20-24 months who are used to eating alone is 52.1% for 46 mothers. The percentage of mothers who provide for their own children's needs is 91.1% for 82 mothers. The percentage of mothers who are used to giving their children sweet tea is 65.6% for 59 mothers. The percentage of mothers who gave food to their children including side dishes was

87.8% for 79 mothers. The percentage of mothers who stopped eating their children when they were full was 87.8% for 79 mothers. The percentage of mothers who coax their children to finish their food when they are fed is 60% for 54 mothers. The percentage of mothers who gave food to their children varied every day as much as 90% for 81 mothers. The percentage of mothers who know their child's appetite every day is 88.9% for 80 mothers. The percentage of children who have certain food restrictions is 36.7% for 33 children. The percentage of mothers who prioritized good food for their children was 91.1% for 82 mothers. The percentage of mothers who gave special food when their children were sick was 42.2% for 38 mothers.

Discussion

1. The relationship between mother's knowledge and the incidence of stunting

Knowledge is a very important domain for the information of one's actions. (Notoatmodjo, 2018). Knowledge itself is usually obtained from good information obtained from formal education and other information such as radio, television, internet, newspapers, magazines, counseling, etc. Education level affects a person in receiving information. People with a better level of education will find it easier to receive information than people with a less educational level. This information is used as a provision for mothers to care for their toddlers in everyday life. Perception itself can be interpreted as a person's perspective on something after obtaining knowledge, either directly or indirectly. Berdasarkan hasil penelitian yang kami lakukan di Desa Kelambir Sebagian besar pendidikan responden pada tingkat SMA (63,3%). Pendidikan sangat erat hubungannya dengan pengetahuan, dimana dapat diasumsikan bahwa dengan Pendidikan yang tinggi maka orang tersebut akan semakin luas pula pengetahuannya. Pendidikan yang rendah tidak menjamin seorang ibu tidak mempunyai pengetahuan yang cukup mengenai gizi keluarganya.

The results of this study are in line with the research of Ni'mah and Nadhiro (2015) in Surabaya which states that mother's knowledge is a factor related to stunting. It can be seen in table 4 that the mothers of toddlers in the case group have a lower level of knowledge about breastfeeding than the moth-

ers of toddlers in the control group. This shows that the low knowledge of mothers about breastfeeding affects the incidence of stunting in toddlers. The low knowledge of mothers about breast milk causes a lack of food quality for toddlers, this will certainly affect the lack of intake of toddlers which can hinder their growth and development during the golden age.

2. Relationship between child nutrition and stunting

Food plays an important role in the growth and development of children, where the food needs of children are different from adults. The effect of exclusive breastfeeding on changes in stunting status is due to the function of breastfeeding as an anti-infection. Most mothers of toddlers combine breastfeeding with formula milk. Giving breast milk together with formula milk can meet the nutritional needs of children so that their growth is not disturbed. However, formula milk does not contain antibodies compared to breast milk so that children are susceptible to disease. The emergence of the problem of malnutrition is not only due to insufficient food intake, but also disease. Several studies have found that infectious diseases are a risk factor for stunting.

Efforts to overcome stunting which is a public health problem can be done in various ways. First, in pregnant women by improving nutrition and health such as additional food during pregnancy. Second, when the baby is born, it is exclusively breastfed. Third, when babies aged 6-24 months are given proper MP-ASI and immunizations complete. Fourth, monitoring the growth of toddlers in posyandu to prevent stunting. Fifth, increasing PHBS behavior, as well as accelerating programs to accelerate nutrition improvement, especially on the first 1000 days of birth (HPK) in Indonesia.

In accordance with the results of our research it is known that most of them have consumed a variety of foods to meet nutritional needs. There are several children who have consumed a variety of foods, but their absorption of food is disrupted due to infectious diseases that children suffer from, causing their nutritional needs to be unfulfilled. Consumption of varied foods for children is the most dominant factor, which has a 90% chance of reducing the incidence of stunting in children than not providing varied foods. In accordance with research in Ghana shows that children who eat a variety of appropriate amounts improve health and reduce nutritional problems compared to children who do not consume varied foods (Fekadu, Mesfin & Haile, 2019).

Conclusion

Mother's knowledge about stunting in Kelambir Village, Pantai Labu Subdistrict, was good as many as 57 respondents (63.3%). Food is the main dominant in children aged 0-5 years is normal / not stunted as many as 72 respondents (80%).

Suggestion

Health services should advance the quality of health administration through efforts to provide health education, especially regarding stunting information and knowledge of the community of children in Kelambir Village. Mother respondents who have received health education about stunting and the importance of growth in children aged 0-5 years are expected to increase their knowledge so that they can prevent stunting in their next child. For future researchers, it is hoped that they can develop more variables related to child nutrition at the age of 0-5 years.

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