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Effectiveness of Stunting Extension of Knowledge, Attitude, and Pregnancy of Pregnant Women about Stunting Prevention in the East Timor Puskesmas Working Area Langsa City

Lina *[1], Elfida [2] & Eva Sulistiany [3]

1, 2, 3. Study Program D III Nursing Langsa Poltekkes Aceh Ministry of Health.
* Email: usalina48@yahoo.com

Abstract

Stunting is a chronic malnutrition problem that is caused by a lack of nutrition in a long time due to food that is not in accordance with nutritional needs. Stunting occurs when the fetus is still in the womb and only appears when the child is two years old. Educational efforts or nutrition counseling is one of the most important efforts to overcome the problem of malnutrition. Counseling as a process of behavior change involving aspects of knowledge, skills, and mental attitudes, so that they know, are willing and able to carry out changes in their lives in order to achieve improvement the welfare of his family. This study aims to determine the effectiveness of stunting counselling on knowledge, scap and behavior of pregnant women about stunting prevention in the East Langsa Public Health Center in Langsa City in 2019. This type of research is Quasi Experiment with two pretest-posttest design groups. The population of this study was 96 pregnant women. Bivariate analysis using paired t-test (dependent t-test), independent t-test and one way ANOVA with significance level (α) 0.05 (95%). There is a significant difference in the average knowledge of pregnant women after counseling and after reading leaflets with a value of p = 0,000. There was a significant difference in the average attitude of pregnant women after stunting counseling and after reading the Stunting leaflet with a value of p = 0.002. There was no significant difference in the average behavior of pregnant women after stunting counseling and after reading the stunting leaflet with a value of p = 0.437. It is hoped that the Eastern Langsa Health Center will improve cross-program and cross-sector collaboration and monitor and evaluate the Kadarzi program optimally, provide more intensive assistance to pregnant women who have nutritional problems, optimize education by using new innovations such as lokmin to deliver messages, especially on preventing Stunting.

Keywords: *Effectiveness, Counseling, Pregnant Women*

INTRODUCTION

Stunting is a problem in 72 countries in the world. Indonesia is the 5th country that contributes to stunting in the world, where nearly 9 million children, or more than a third of children under five years old (toddlers) in Indonesia, experience stunting, and Aceh is one of the provinces in Indonesia with the highest stunting rates. Very high (Pergub Aceh, 2019). The results of the 2018 Basic Health Research (Riskesdas) note that Aceh is ranked 3rd nationally for toddler stunting rates, below East Nusa Tenggara (NTT) and West Sulawesi (Subar). The prevalence of stunting in infants under 5 years old (toddlers) in Indonesia in 2018 was 30.8%; this figure is above the WHO threshold of 20%. The prevalence rate of stunting in infants under 2 years (Baduta) in Aceh is quite high at 37.9%, while the national average prevalence is 30.8%, so the Aceh government immediately made a governor's regulation on stunting and declared a joint movement. (Nova Iriansyah, 2019)

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Many factors cause the high incidence of stunting in toddlers. The direct causes are a lack of food intake and the presence of infectious diseases (UNICEF, 1990; Hoffiman, 2000; Umeta, 2003). Other factors are the mother's lack of knowledge, wrong parenting, poor sanitation and hygiene, and low health services (UNICEF, 1990). In addition, people do not realise that short children are a problem, because short children in society are seen as children with normal activities, not like thin children who must be treated immediately. Likewise, with maternal nutrition during pregnancy, the community has not realised the importance of nutrition during pregnancy in contributing to good nutritional conditions for babies born later (UNICEF Indonesia, 2013; Partners, 2015).

Maternal nutritional status before pregnancy has a significant influence on the incidence of LBW. Mothers with poor nutritional status before pregnancy have a 4.27 times higher risk of giving birth to LBW babies compared to mothers who have good (normal) nutritional status. A pregnant woman will give birth to a healthy baby if her health and nutrition levels are in good condition. Mothers who experience chronic energy deficiency (KEK) during pregnancy will cause problems for both the mother and the foetus. Problems that occur in the mother can cause risks and complications. The nutritional status of a mother during pregnancy has a very important influence on both her health and her ability to produce breast milk and breastfeed the baby. Nutritional needs will increase during pregnancy for both the mother and foetus (Denok, 2015).

According to the Indonesian Ministry of Health (2018), stunting prevention is known for its five pillars, one of which is a national campaign focusing on understanding behaviour change, political commitment, and accountability. One way to handle stunting is through specific interventions for pregnant women and children in the first 1,000 days of birth. This is in accordance with the big theme of the 2018 National Nutrition Day (HGN), which is to achieve family independence within 1000 HPK for stunting prevention. The slogan is that together with our family, we take care of 1000 HPK. Nutrition education or counselling is one of the most important efforts to overcome the problem of malnutrition. With this effort, it is hoped that someone can understand the importance of eating and nutrition so that they want to behave and act according to nutritional norms. The educational approach is a series of activities carried out in a systematic, planned, and directed manner with the active participation of individuals, groups, or communities to solve community problems by taking into account local socio-economic and cultural factors. (Maulana, 2007).

In the results of research conducted by Wati (2014) in the coastal area of the Siak Pekan Baru River, the results of the analysis found a significant relationship between knowledge about nutrition and chronic energy deficiency (CED) in pregnant women, and there was no significant relationship between family income and chronic energy deficiency (SEZ) for pregnant women in the Siak Pekan Baru River Coastal Area. Management of stunting is an indicator of the success of national health development and has become a target for sustainable development in the millennium development era (Sustainable Development Goals) as part of investing in human resources from an early age. Paramastri (2007) and Partners (2015) said that improving nutrition is important for improving health, reducing infant and toddler mortality, increasing growth and development abilities, physical, mental, and social development, work productivity, and academic achievement. One approach that is often used is to convey messages or information so that it can be received and understood. Extension interventions can be carried out in an effort to stimulate the community, especially families (i.e., housewives), to be able to become motivators in their household environment.

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According to data from the Langsa City Health Office for 2018, the health centre with the highest number of stunted and undernourished toddlers was the East Langsa health centre, with 43 stunted people and 52 undernourished people (Langsa City Health Office, 2018). Data from the Langsa Timur Public Health Centre in January 2019 totaled 822 toddlers, including 39 toddlers who experienced stunting and lived in sixteen villages in the East Langsa Puskesmas area. The number of pregnant women was 149. Based on the results of the interviews the researchers conducted with six pregnant women, it turned out that most of them said they did not know the causes of stunting. Based on the description above that pregnant women need knowledge about stunting prevention starting early, namely in adolescence and pregnancy, the authors conducted a study entitled "Effectiveness of stunting counselling on knowledge, attitudes, and behaviour regarding stunting prevention in pregnant women in the working area of the East Langsa Public

METHODOLOGY

This type of research has a quasi-experimental design with two groups: pre-test and post-test. The intervention group was given stunting counselling treatment, while the control group was only given leaflets. This research was carried out in the East Langsa Health Centre work area from June 1 to October 10, 2019. The population of this study was 149 pregnant women who lived in the East Langsa Health Centre in 2019. The sample in this study was 96 people. The sampling technique in this study used a simple random sampling technique by drawing lots according to the desired sample size of 96 people. Univariate analysis was carried out using descriptive statistics to see the frequency distribution of each research variable and presented in the form of a frequency distribution table. Bivariate analysis used the pairet sample t-test, the dependent t-test with a significance level of 0.05 (95%), if the data were normally distributed, and the Wilcoxon sign test if the data were not normally distributed.

RESULTS AND DISCUSSION

Result

Table 1: Knowledge, Attitudes and Behavior of Respondents who were given counseling about stunting at the East Langsa Health Center in Langsa City in 2019

No	Data	Frekuensi	Persentase
	Knowledge		
1	*Pretest* :		
	Not Good	39	81,2
	Good	9	18,8
2	*Postest*		
	Not Good	5	10,4
	Good	43	89,6
	Attitudes		
1	*Pretest* :		
	Negative	8	16,7
	Positive	40	83,3
2	*Postest*		
	Negative	0	000,0
	Positive	48	100,0
	Behavior		
1	*Pretest* :		
	Not Good	0	000,0

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	Good	48	100,0
2	*Postest*		
	Not good	0	000,0
	Good	48	100,0

Table 1 can be seen that before counselling (pretest) most of the respondents had insufficient knowledge about stunting as many as 39 people (81.2%), after counselling (posttest) most of the respondents had good knowledge about stunting as many as 43 people (89.6%) , the attitude of the respondents before counselling (pretest) most of the respondents had a negative attitude about stunting as many as 40 people (83.3%), after counselling (posttest) all respondents had a positive attitude about stunting as many as 48 people (100.0%), the attitude of respondents before counselling (pretest) all respondents had good behaviour regarding stunting prevention as many as 48 people (100.0%), after counselling (posttest) all respondents still had good behaviour regarding stunting prevention as many as 48 people (100.0%).

Table 2: Knowledge, Attitudes and Behavior of Respondents who read leaflets about stunting at the East Langsa Health Center in Langsa City in 2019

No	Data	Frekuensi	Persentas
	Knowledge		
1.	*Pretest* :		
	a. Not Good	43	89,6
	b. Good	5	10,4
2.	*Postest:*		
	a. Not Good	9	81,2
	b. Good	9	18,8
	Attitudes		
1.	*Pretest* :		
	a. Negative	11	22,9
	b. Positive	37	77,1
2.	*Postest:*		
	a. Negative	0	00,0
	b. Positive	48	10,0
	Perilaku		
1.	*Pretest* :		
	a. Not Good	6	12,5
	b. Good	42	87,5
2.	*Postest*		
	a. Not Good	7	14,6
	b. Good	41	85,4

Table 2 can be seen that before reading the leaflet (pretest) most of the respondents had insufficient knowledge about stunting as many as 43 people (89.6%), after reading the leaflet (posttest) most of the respondents still had less knowledge about stunting as many as 39 people (81, 2%), the attitude of the respondents before reading the leaflet (pretest) most of the respondents had a positive attitude about stunting as many as 37 people (77.1%), after reading the leaflet (posttest) all respondents had a positive attitude about stunting as many as 48 people (100.0 %), the behaviour of respondents before reading the leaflet (pretest) most of the respondents had good behaviour regarding stunting prevention as many as 42 people (87.5%),

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after reading the leaflet (posttest) most of the respondents still had go behaviourior regarding stunting prevention as many as 41 people (85.4%).

Table 3: t-test *dependent (paired t-test)*

Knowledge	Mean	SD	SE	P Value	N
Pretest	4,46	1,624	0,234	0,000	48
Postest	7,94	2,621	0,378		

Table 3 shows that the average knowledge of pregnant women before counselling on stunting is 4.46 with a standard deviation of 1.624, while the average knowledge after counselling on stunting is 7.94 with a standard deviation of 2.621. There is a difference in the mean before and after stunting counselling, which is -3.479 with a standard deviation of 2.576. Statistical test results obtained a p value of 0.000, meaning that at 5%, there is a significant difference in the average knowledge of pregnant women before and after counselling.

Table 4: t-test *dependent (paired t-test)*

Attitudes	Mean	SD	SE	P Value	N
Pretest	36,17	6,058	0,874	0,000	48
Postest	39,42	3,814	0,550		

Table 4 shows that the average attitude of pregnant women before counselling on stunting is 36.17 with a standard deviation of 6.058, while the average attitude after counselling on stunting is 39.42 with a standard deviation of 3.814. There is a difference in the mean before and after stunting counselling, which is -3.250 with a standard deviation of 5.704. The statistical test results obtained a p value of 0.000, meaning that at 5% negligence, there was a significant difference in the average attitude of pregnant women before and after counselling.

Table 5: t-test *dependent (paired t-test)*

Behaviour	Mean	SD	SE	P Value	N
Pretest	31,73	5,319	0,768	0,000	48
Postest	34,13	3,790	0,547		

Table 5 shows that the average behaviour of pregnant women before and after stunting counselling is 31.73 with a standard deviation of 5.319, while the average behaviour after stunting counselling is 34.13 with a standard deviation of 3.790. There is a difference in the mean value before and after stunting counselling, which is -3.396 with a standard deviation of 4.598. Statistical test results obtained a p value of 0.001, meaning that at 5% alpha, there is a significant difference in the average behaviour of pregnant women before and after counselling.

Table 6: t-test *dependent (paired t-test)*

Knowledge	Mean	SD	SE	P Value	N
Pretest	3,00	2,183	0,315	0,074	48
Postest	3,56	2,500	0,361		

Table 6 shows that the average knowledge of pregnant women before reading the stunting leaflet is 3.00 with a standard deviation of 2.183, while the average knowledge after reading the stunting leaflet is 3.56 with a standard deviation of 2.500. There is a difference in the mean before and after reading the stunt leaflet, which is -0.563 with a standard deviation of 2.133. The statistical test results obtained p = 0.074, meaning that at 5% alpha, there was no significant difference in the average knowledge of pregnant women before and after reading the stunting leaflet.

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Table 7: t-test *dependent (paired t-test)*

Attitudes	Mean	SD	SE	P Value	N
Pretest	1,77	0,425	0,061	0,041	48
Postest	2,00	0,000	0,000		

Table 7 shows that the average attitude of pregnant women before reading the stunting leaflet is 35.00 with a standard deviation of 4.668, while the average attitude after reading the stunting leaflet is 36.56 with a standard deviation of 5.074. There is a difference in the mean before and after reading the stunt leaflet, which is -1.563 with a standard deviation of 5.157. The statistical test results obtained a p value of 0.041, meaning that at 5% alpha there was a significant difference in the average attitude of pregnant women before and after reading the stunting leaflet.

Table 8: t-test *dependent (paired t-test)*

Behaviour	Mean	SD	SE	P Value	N
Pretest	32,90	4,943	0,713	0,608	48
Postes	33,33	5,915	0,854		

Table 8 shows that the average behaviour of pregnant women before reading the stunting leaflet is 32.90 with a standard deviation of 4.943 and a standard deviation of 0.713, while the average behaviour of pregnant women after reading the stunting leaflet is 33.33 with a standard deviation of 5.915. There is a difference in the mean before and after reading the stunt leaflet, which is -0.438 with a standard deviation of 5.878. The statistical test results obtained p = 0.608, meaning that at 5% alpha, there was no significant difference in the average behaviour of pregnant women before and after reading the stunting leaflet.

Table 9: t-test *independent (paired samples t-test)*

Knowledge	Mean	SD	SE	*P Value*	N
Intervention group	3,40	2,558	0,369	0,000	48
Control Group	0,44	2,163	0,312		48

Table 9 shows that the average knowledge of pregnant women after stunting counselling is 3.40 with a standard deviation of 2.558, while the average knowledge after reading the stunting leaflet is 0.44 with a standard deviation of 2.163. The statistical test results obtained a p value of 0.000, meaning that at 5% negligence, there was a significant difference in the average knowledge of pregnant women before and after stunting counselling.

Table 10: t-test *independent (paired samples t-test)*

Attitudes	Mean	SD	SE	P Value	N
Intervention group	3,23	5,695	0,822		48
Control Group	1,56	5,157	0,744	0,136	48

Table 10 shows that the average attitude of pregnant women after stunting counselling is 3.23 with a standard deviation of 5.695, while the average attitude after reading the stunting leaflet is 1.56 with a standard deviation of 5.157. The statistical test results obtained a value of p = 0.136, meaning that at 5%, there was no significant difference in the average attitude of pregnant women after counselling and after reading the stunting leaflet.

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Table 11: t-test *independent (paired samples t-test)*

Behaviour	Mean	SD	SE	P Value	N
Intervensi	2,40	4,598	0,664	0,159	48
Control	0,85	5,957	0,860		48

Table 11 shows that the average behaviour of pregnant women after counselling on stunting is 2.40 with a standard deviation of 4.598, while the average behaviour after reading the stunting leaflet is 0.85 with a standard deviation of 5.957. The statistical test results obtained p = 0.159, meaning that at 5% there was no significant difference in the average behaviour of pregnant women after stunting counselling and after reading stunting leaflets.

DISCUSSION

There is a difference in the mean before and after the stunting counselling of -3.479, with a standard deviation of 2.576. The statistical test results obtained a p value of 0.000, meaning that at 5% negligence, there was a significant difference in the average knowledge of pregnant women before and after counselling. The results of the study in the control group showed that the average knowledge of pregnant women before reading the stunting leaflet was 3.00 with a standard deviation of 2.183, while the average knowledge after reading the stunting leaflet was 3.56 with a standard deviation of 2.500. There is a difference in the mean before and after reading the stunt leaflet, which is -0.563 with a standard deviation of 2.133. The statistical test results obtained p = 0.074, meaning that at 5% alpha, there was no significant difference in the average knowledge of pregnant women before and after reading the stunting leaflet. The results of this study also show that the average knowledge of pregnant women after stunting counselling is 3.40 with a standard deviation of 2.558, while the average knowledge after reading the stunting leaflet is 0.44 with a standard deviation of 2.163. The results of the statistical test obtained a value of p = 0.000, meaning that at 5% negligence, there was a significant difference in the average knowledge of pregnant women before and after stunting counselling. The conclusion of the research results shows that counselling is very effective in increasing pregnant women's knowledge about stunting.
The research results are in accordance with the results of the study of Tusy Tri Wahyuni et al. (2018), where the average level of knowledge of student guardians before counselling is 40.68 and the average level of knowledge of student guardians after counselling is 72.70. There was a significant uniform difference between the level of knowledge of parents about stunting criteria before and after counselling (p = 0.032).

The results of this study are also in accordance with the results of Kiki Liwut's research (2018) showing that the knowledge of high-risk pregnant women at the Amurang Health Centre regarding antenatal care after the intervention of health education was all good, as much as 35 (100%), and no one had sufficient or insufficient knowledge. Statistical test results using the Wilcoxon Sign Rank Test showed that there were differences in the mean before and after the intervention. The mean before the intervention was 7.22, while after the intervention it increased to 9.6. The standard deviation value before the intervention was 1.41, and after the intervention it was 0.53. The asymp.sig (2-tailed) shows the number 0.000 0.05, which means that there is an influence of health education about antenatal care on the knowledge of high-risk pregnant women at the Amurang Health Centre. This research is also in accordance with the results of Sulastri's research, Vivi (2019), showing that before nutritional food counselling was carried out, most respondents had insufficient knowledge; after conducting nutritional food counselling, most respondents had good knowledge. The Wilcoxon Signed Rank Test

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statistical test showed that the value of p = 0.000 (0.05) means that there is an effect of nutritional food counselling on the level of knowledge about nutritional food for mothers under five at the Ciptomulyo Health Centre, Malang City, that is statistically significant. The results of Agus Hendra Al Rahmad's research (2019) with data analysis using the T-test That is, there is an effect of increasing counselling in the first 1000 days of life for couples of childbearing age in urban and rural areas, with p 0.05. Counselling for the first 1000 days of life has better effectiveness in increasing the knowledge of couples of childbearing age, with p 0.05. While the comparison of knowledge shows that the average score in urban areas (50) is higher than in rural areas (45), The results of Teti Herta Dolok Seribu's research (2018) concluded that it is necessary to conduct outreach or training about 1000 HPK to religious leaders who provide premarital counselling for prospective brides, and it is suggested that information about the importance of 1000 HPK be integrated into premarital counselling materials for prospective brides. Knowledge is the result of "knowing," and this occurs after people perceive a particular object. Sensing of objects occurs through the five human senses, namely sight, hearing, smell, taste, and touch alone. The time of sensing to produce knowledge is greatly influenced by the intensity of perceptual attention to objects. Most human knowledge is obtained through the eyes and ears (Notoatmodjo, 2012). The educational approach is a series of activities carried out in a systematic, planned, and directed manner with the active participation of individuals, groups, or communities to solve community problems by taking into account local socio-economic and cultural factors. (Maulana, 2007).

A leaflet is a folded piece of paper containing printed text and some specific pictures on a specific topic for a specific goal and purpose. The advantages of target leaflets are that they can be adjusted and studied independently and are practical because they reduce the need to take notes. Targets can see the content at a relaxed and very economical time; various pieces of information can be given or read by various target groups so that they can be discussed; they can provide detailed information that is not given orally; they are easy to make, reproduce, and repair; and they can be easily adapted to the target group. The weaknesses of leaflets are that they are not suitable for individual targets, they are not durable and easily lost, they will be useless if the target is not actively involved, and they need a good duplication process (Luice, 2005; Nur Syamsiah, 2013).

According to researchers, education or nutrition counselling is one of the most important efforts to overcome stunting problems. With this effort, it is hoped that someone can understand the importance of eating and nutrition so that they want to behave and act according to nutritional norms. Counselling can increase knowledge, attitudes, and behaviour about stunting prevention, while giving leaflets cannot increase knowledge, attitudes, and behaviour about stunting prevention because leaflets are not suitable for individual goals, are not durable, and are easily lost. Individuals do not understand the contents of the leaflet, resulting in a lack of concentration and interest in reading leaflets. This can be seen when counselling is carried out for pregnant women. Extension workers show enthusiasm for the importance of preventing stunting, receive directions and explanations one by one about stunting until it is clear, and if they do not understand, they are given the opportunity to ask questions. They look more active and enthusiastic, while in the leaflet group, they are only limited to reading without direction, lack interest in reading, lack of concentration, and the opportunity to ask questions only to their fellows, and are at risk of getting information that is lacking or unclear.

There is a difference in the mean before and after the stunting counselling of -3.250 with a standard deviation of 5.704. The statistical test results obtained a value of p = 0.001, meaning

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that at 5% alpha, there was a significant difference in the average attitude of pregnant women before and after stunting counselling. The results of the study in the control group showed that the average attitude of pregnant women before reading the stunting leaflet was 35.00 with a standard deviation of 4.668, while the average attitude after reading the stunting leaflet was 36.56 with a standard deviation of 5.074. There is a difference in the mean before and after reading the stunt leaflet, which is -1.563 with a standard deviation of 5.157. The statistical test results obtained a p value of 0.041, meaning that at 5% alpha, there was a significant difference in the average attitude of pregnant women before and after reading the stunting leaflet. The results of this study also showed that the average attitude of pregnant women after being given stunting counselling was 3.23 with a standard deviation of 5.695, while the average attitude after reading the stunting leaflet was 1.56 with a standard deviation of 5.157. The statistical test results obtained a value of p = 0.136, meaning that at 5%, there was no significant difference in the average attitude of pregnant women after counselling and after reading the stunting leaflet. The conclusion of the results of this study shows that counselling is more effective in changing the attitude of pregnant women than reading leaflets. The results of this study are in accordance with the results of Yovi's research, Alfira Ningsih (2015), that there is a significant difference between the results of the pretest and posttest knowledge and attitudes of pregnant women in the experimental group and also in the control group (p = 0.001). There was a significant difference in the results of knowledge and attitudes between pregnant women in the experimental group and pregnant women in the control group (p = 0.001). Which means there is an influence of counselling on changes in knowledge and attitudes among pregnant women in the experimental group.

This study is also consistent with a comparative study on the relationship between counselling and pregnant women's knowledge, attitudes, and behaviours about HIV and the voluntary counselling and testing programme. There is a significant relationship between counselling and the level of knowledge and attitudes about HIV, as well as the level of knowledge, attitudes, and behaviour about VCT, but there is no significant relationship with behaviour regarding HIV. This research is also in accordance with the research of Sumiyati et al. (2018), The Effectiveness of Health Education on the Knowledge and Attitudes of Mothers and Toddlers about Pulmonary TB in Children in Banyumas Regency in 2018. The results showed that health education using guidance and counselling methods through flipcharts and leaflets media was significantly increasing the knowledge of mothers of toddlers about pulmonary TB in children (p-value = 0.0001) and can also significantly improve the attitudes of mothers of toddlers about pulmonary. TB in children (p-value = 0.0001). The results of research by Ai Kustiani and Artha Prima (2018) showed that there was a significant change (p 0.05) in the knowledge, attitudes, and practises of mothers in providing MP-ASI after providing nutritional counselling. Therefore, nutritional counselling has an effect on increasing the knowledge, attitudes, and behaviours of mothers in providing complementary breastfeeding at 6–24 months.

Attitude is a willingness to act and is not a coercion of a certain motive; a motive is a readiness for a reaction to certain environmental objects as an appreciation of the object. Attitude is a reaction or response that is still closed from someone to a stimulus or object. Attitudes actually show the connotation of appropriate reactions to certain stimuli, which in everyday life are reactions that are emotional in nature to social stimuli, as is the case with knowledge (Notoatmodjo, 2012). Counselling is a process of changing behaviour concerning aspects of knowledge, skills, and mental attitudes so that people know, are willing, and are able to implement changes in their lives in order to achieve improvements in family welfare that are

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to be achieved through health development. The process of changing behaviour is demanded so that the goals change not solely because of the addition of knowledge, but it is also hoped that there will be changes in skills as well as a permanent attitude that lead to better, more productive, and more profitable actions or work. Counselling as a process of changing behaviour is not easy; it requires long preparation and adequate knowledge of counselling and its objectives. Counselling as a process of changing behaviour, apart from requiring a relatively long time, also requires careful, directed, and sustainable planning (Maulana, 2007).

Leaflets are as wide as folded paper and contain printed writing and certain pictures on a specific topic for specific goals and objectives. The advantages of target leaflets are that they can be adjusted and studied independently and are practical because they reduce the need to take notes. Targets can see the content at a relaxed and very economical time; various pieces of information can be given or read by various target groups so that they can be discussed; they can provide detailed information that is not given orally; they are easy to make, reproduce, and repair; and they can be easily adapted to the target group. The weaknesses of leaflets are that they are not suitable for individual targets, they are not durable and easily lost, they will be useless if the target is not actively involved, and they need a good duplication process (Luice, 2005; Nur Syamsiah, 2013).

According to researchers, education or nutrition counselling is one of the most important efforts to overcome stunting problems. With this effort, it is hoped that someone can understand the importance of eating and nutrition so that they want to behave and act according to nutritional norms. Counselling is very effective in increasing knowledge, attitudes, and behaviour about stunting prevention, while giving leaflets without counselling is less effective in increasing knowledge, attitudes, and behaviour about stunting prevention because leaflets are not suitable for individual targets; they don't last long and are easily lost; individuals lack understanding of the contents of the leaflet, resulting in a lack of concentration and interest in reading the leaflet. This can be seen when counselling is carried out for pregnant women. Extension workers show enthusiasm for the importance of preventing stunting, receive directions and explanations one by one about stunting until it is clear, and if they do not understand, they are given the opportunity to ask questions. They look more active and enthusiastic, while in the leaflet group, they are only limited to reading without direction, lack interest in reading, lack of concentration, and the opportunity to ask questions only to their fellows, and are at risk of getting information that is lacking or unclear.

There is a difference in the mean before and after the stunting counselling of -3.396, with a standard deviation of 4.598. The statistical test results obtained a value of p = 0.001, meaning that at 5% alpha, there was a significant difference in the average behaviour of pregnant women before and after counselling. The results of the study in the control group showed that the average behaviour of pregnant women before reading the stunting leaflet was 32.90 with a standard deviation of 4.943 and a standard deviation of 0.713, while the average behaviour of pregnant women after reading the stunting leaflet was 33.33 with a standard deviation of 5.915. There is a difference in the mean before and after reading the stunt leaflet, which is -0.438 with a standard deviation of 5.878. The statistical test results obtained p = 0.608,8 meaning that at 5% alpha,a there was no significant difference in the average behaviour of pregnant women before and after reading the stunting leaflet. The results of this study also showed that the average behaviour of pregnant women before reading the stunting leaflet was 32.90 with a standard deviation of 4.943 and a standard deviation of 0.713, while the average behaviour of pregnant women after reading the stunting leaflet was 33.33 with a standard deviation of 5.915.

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There is a difference in the mean before and after reading the stunt leaflet, which is -0.438 with a standard deviation of 5.878. The statistical test results obtained p = 0.608,8 meaning that at 5% alpha, a there was no significant difference in the average behaviour of pregnant women before and after reading the stunting leaflet. In conclusion, although the results were not significant after counselling or reading leaflets, the average behaviour score was higher in the group that received counselling than leaflets.

This research is in accordance with a comparative study on the relationship between counselling and pregnant women's knowledge, attitudes, and behaviours about HIV and voluntary counselling and testing programmes. There is a significant relationship between counselling and the level of knowledge and attitudes about HIV, as well as the level of knowledge, attitudes, and behaviour about VCT, but there is no significant relationship with behaviour regarding HIV. The results of this study are also in accordance with the research of Ai Kustiani and Artha Prima (2018), which shows that there is a significant change (p 0.05) in the knowledge, attitudes, and practises of mothers in providing MP-ASI after providing nutritional counselling. Therefore, nutritional counselling has an effect on increasing the knowledge, attitudes, and behaviours of mothers in providing complementary breastfeeding at 6–24 months.

According to Notoatmodjo (2007), to change one's behaviour, one must follow the stages of the change process: knowledge, attitude, and practise. Counselling acts as a method of adding and increasing one's knowledge as the initial stage of behaviour change. According to Benjamin Bloom, there are three domains of behaviour: cognitive, affective, and psychomotor. These three aspects are interrelated, and this determines the formation of new behaviours. In general, the emergence of behaviour begins in the cognitive domain. Individuals know there is a stimulus, so new knowledge is formed. Furthermore, an inner response arises in the form of an individual's attitude towards the object he knows. In the end, objects that are known and fully realised will cause a response in the form of action (psychomotor).

Cognitive or "knowledge" is the result of curiosity that occurs through the sensory processes of the five senses, especially the eyes and ears for certain objects. Knowledge is organised information, so it can be applied to problem solving. Knowledge can be interpreted as information that can be acted upon or information that can be used as a basis for action to make decisions and pursue new directions or strategies. Kaswan (2013). Attitude is a person's closed response to a stimulus or object, both internal and external, so that its manifestations are not directly visible. Attitude is an organisation of opinion, a person's belief about a stable, realistic object or situation, accompanied by certain feelings, that provides a basis for that person to respond or behave in a certain way that he chooses.

The psychomotor domain is known as the skills domain, namely the mastery of fine and gross motor skills with a level of complexity in neuromuscular coordination. The psychomotor domain includes goals related to manual or motor skills. Skills, or psychomotor skills, are easy to identify and measure because they basically include movement-oriented activities. Movement (motor) is a bodily activity caused by a stimulus or response. The psychomotor or practise level begins with perception, namely recognising and selecting various objects according to the actions to be performed. Second, the guided response, i.e., the individual can do something in the right order according to the example, third, mechanism, that is, individuals can do something correctly automatically or are used to it. Finally, adaptation is an action that has been developed and modified without reducing the truth.

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Limited mothers' knowledge and local cultural influences become obstacles in childcare. The more knowledge you have about nutrition, the more you take into account the type and amount of food chosen for consumption. Ordinary people who do not have enough knowledge about nutrition will choose foods that appeal to the five senses without paying attention to the nutritional value of the food. Cultural elements that are able to create eating habits in the population can conflict with the principles of nutrition (Sediaoetama, 2010; Saputri, 2016). Counselling is a process of changing behaviour concerning aspects of knowledge, skills, and mental attitudes so that people know, are willing, and are able to implement changes in their lives in order to achieve improvements in family welfare that are to be achieved through health development. The process of changing behaviour is demanded so that the goals change not solely because of the addition of knowledge, but it is also hoped that there will be changes in skills as well as a permanent attitude that lead to better, more productive, and more profitable actions or work. Counselling as a process of changing behaviour is not easy; it requires long preparation and adequate knowledge of counselling and its objectives. Counselling as a process of changing behaviour, apart from requiring a relatively long time, also requires careful, directed, and sustainable planning (Maulana, 2007).

Nutrition education is part of health education activities, defined as a planned effort to change the behaviour of individuals, families, groups, and communities in the health sector. Academic Nutrition and Dietetics (AND) defines nutrition education as a formal process to train or increase the client's ability to choose food, physical activity, and behaviours related to maintaining or improving health. Thus, the activities that must be carried out to improve nutrition knowledge, attitudes, and behaviours are nutrition education. Nutrition education can increase mothers' knowledge and feeding practises even though child growth does not increase directly. Nutrition education for mothers and carers of toddlers is one of Unicef Indonesia's recommendations to overcome the problem of stunting in Indonesia. Nutrition education can be done individually or in groups. From the research that has been done, the nutritional counselling intervention method has proven to be able to increase knowledge. (Mariyati Dewi, 2016).

According to Notoatmodjo (2012), one of the factors that determines behaviour about a person's health is knowledge; the higher a person's knowledge, the more he can utilise this ability. In the opinion of Sediaoetama (2010 in Saputri (2016), limited mother's knowledge and the influence of local culture are obstacles in childcare. The more knowledge you have about nutrition, the more you take into account the type and amount of food chosen for consumption. Ordinary people who do not have enough knowledge about nutrition will choose foods that appeal to the five senses without paying attention to the nutritional value of the food. Cultural elements create a habit of eating among the population that can conflict with the principles of nutrition.

The Indonesian government has also created a stunt prevention programme, including formulating the five pillars of stunt management. Pillar 1: Commitment and Vision of the State's Highest Leaders; Pillar 2 of the National Campaign focuses on understanding, behaviour change, political commitment, and accountability. Pillar 3: convergence, coordination, and consolidation of national, regional, and community programmes; Pillar 4: encouraging access to nutritious food policy; and Pillar 5: monitoring and evaluation In the context of interventions for handling stunting in 2018, 100 districts and cities throughout Indonesia are targeted. (Ministry of Villages, 2017). According to researchers, there are many factors influencing changes in the behaviour of pregnant women in preventing stunting, including knowledge,

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attitudes, the economy, and family support. To change the behaviour of pregnant women to prevent stunting, support from family and community leaders is needed. Increasing knowledge and positive attitudes can be started before pregnancy, during pregnancy, and up to the age of toddlers. The level of knowledge greatly influences pregnant women's implementation of stunting prevention behaviours during pregnancy because pregnant women who have good knowledge will have a more mature attitude towards changes in themselves, making it easier for them to accept positive influences from outside.

Nutrition counselling is one of the most important efforts to overcome the problem of stunting. With this effort, it is hoped that someone can understand the importance of eating and nutrition so that they want to behave and act according to nutritional norms. Counselling can increase knowledge, attitudes, and behaviour about stunting prevention, while giving leaflets cannot increase knowledge, attitudes, and behaviour about stunting prevention because leaflets are not suitable for individual goals, are not durable, and are easily lost. Individuals do not understand the contents of the leaflet, resulting in a lack of concentration and interest in reading leaflets. This can be seen when the counselling was carried out. The mothers received explanations one by one about stunting until it was clear, and if they did not understand or did not understand enough, they were given the opportunity to ask questions. They were more active and enthusiastic, while in the leaflet group they were only limited to reading without direction. It was seen that there was less interest in reading, a lack of concentration, the opportunity to ask only of their fellows, and the risk of getting less or unclear information.

CONCLUSION

There was no significant difference in the average behaviour of pregnant women before and after reading the stunting leaflet, according to the results of the statistical test ($p = 0.608$). There is no significant difference in the average behaviour of pregnant women after stunting counselling and after reading stunting leaflets, with statistical test results obtained of $p = 0.437$.

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