ORIGINAL ARTICLE

Analysis of the completeness of specific nutritional interventions as an effort to prevent stunting: an observational study

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ABSTRACT

Introduction: Handling stunting through nutritional interventions is classified into two categories: specific nutrition interventions and sensitive nutrition intervention. Specific nutrition interventions referring to causal factors directly related to nutrition, aimed at pregnant women and breastfeeding mothers, are the responsibility of the health sector, contributing 30%. The completeness of specific nutritional interventions for breastfeeding mothers according to standards are more challenging. The purpose of this study is to analyze several factors that influence the completeness of specific nutritional interventions in breastfeeding mothers to create prediction models. **Methods:** This was a quantitative study with a cross sectional design. The population was all breastfeeding mothers with a total of 193 nursing mothers. Samples of 128 people were taken using a simple random sampling technique. Data analysis using univariate analysis, bivariate analysis with Chi square analysis and Multivariate analysis with logistic regression analysis. **Result:** In bivariate analysis there were 8 influencing variables. The Mother's education with p=0.006, Mother's knowledge with p=0.001, Mother's Attitudes with p=0.001, Mother's Job with a p=0.001, Parity with p=0.001, Husband's Support with p=0.001, Health Workers' Support with p=0.001, Village Officials' Support with p=0.001. The most influential variable was the health workers' support variable with OR=20.56. Through multivariate analysis, a predictive model of achieving completeness of specific nutritional interventions is produced so that it can be used as a preventive effort in overcoming these problems. **Conclusion:** The completeness of specific nutritional interventions for breastfeeding mothers has not been achieved according to the government's target, it is necessary to intervene on the factors that influence it which include mother's knowledge, mother's attitude, husband's support, health workers' support and village apparatus' support.

KEYWORDS
stunting, nutritional support, specific intervention

INTRODUCTION

Chronic undernutrition in early childhood – most often measured as linear growth failure, or stunting is now widely recognized as having exceptionally high individual and social costs, including both child morbidity and mortality, delayed cognitive development and poor schooling outcomes, and lower productivity and wages in adulthood that ultimately retard economic growth.[1] Stunting represents a long-term and cumulative manifestation of chronic undernutrition, recurrent infections, lack of psychosocial stimulus or increased emotional stress in childhood. It can also occur before birth during fetal development brought about by malnourishment of the mother and other pregnancy factors.[2]

Stunting is influenced by several factors and is not only caused by nutritional intake factors experienced by pregnant women and children under five, therefore the intervention must also be multi-factorial.[3] Nutritional status in the first thousand days of life (1000 HPK), which is 270 days during pregnancy and 730 days in the baby's first life, is critical because the consequences are permanent and irreparable.[4] In line with the programs launched by the government, namely: sensitive nutritional interventions and specific nutritional interventions. Intervention needs to be carried out in the First 1000 Days of Life (HPK) of children under five.[5] Sensitive nutrition interventions are carried out by the government outside the health sector as preventive and promotive efforts, while specific nutrition interventions are mostly carried out by the health sector with specific targets, namely pregnant women, breastfeeding mothers and mothers of toddlers.[6]

Of the several causes of the high prevalence of stunting, a comprehensive intervention plan is needed to reduce the prevalence of stunting.[6] In 2010, a global movement known as Scaling-Up

Nutrition (SUN) was launched with the basic principle that all citizens have the right to have access to sufficient and nutritious food.[7] The Indonesian government joined the movement in 2012 by designing two major Stunting Intervention frameworks.[8] The Stunting Intervention Framework was then translated into two, namely Specific Nutrition Intervention and Sensitive Nutrition Intervention . Specific Nutrition Intervention is an intervention aimed at children in the First 1000 Days of Life (HPK) and contributes to a 30% reduction in stunting and is generally carried out in the health sector.[9]

This intervention is also short term in nature where the results can be recorded in a relatively short time. Specific Nutrition Intervention Activities are divided into several main interventions starting from the mother's pregnancy period through childbirth to toddlers:[9] Specific nutritional interventions targeting pregnant women, including providing additional food (PMT) to pregnant women to overcome chronic energy and protein deficiencies, overcome iron and folic acid deficiencies, overcome iodine deficiencies, overcome worms in pregnant women and protect pregnant women from Malaria. Specific nutritional interventions targeting breastfeeding mothers and children aged 0-6 months, including encouraging early initiation of breastfeeding/IMD, especially through providing plain breast milk/colostrum as well as encouraging exclusive breastfeeding.[1] Specific nutritional interventions targeting breastfeeding mothers and children aged 7-23 months, including encouraging continued breastfeeding until the child/infant is 23 months old, providing MP-ASI after 6 months of age, providing worm medicine, providing zinc supplementation, carrying out substance fortification iron into food, providing protection against malaria, providing complete immunization, and preventing and treating diarrhea.[10]

Growing cognizance of the vital importance of improving nutrition in early childhood has resulted in ambitious global targets, such as the World Health Assembly target of reducing under-5 stunting prevalence by 40% by 2025, as well as the incorporation of stunting reduction in Sustainable Development Goal 2.[11] From several available data, specific nutritional intervention efforts aimed at breastfeeding mothers have not yet been achieved optimally, this reduces the effectiveness of efforts to accelerate stunting reduction aimed at postnatal factors.[12] Specific nutrition interventions are those directed at the immediate causes of anemia, such as diet and infection, whereas nutrition-sensitive interventions address underlying determinants of hemoglobin (Hb) concentration and anemia, such as food insecurity and insufficient maternal and child health care services.[6]

Early nutrient deficits and excesses during sensitive developmental windows have long-lasting consequences, particularly on metabolic, neurocognitive, and immunologic functions—commonly referred to as "early programming".[13] Several existing facts and information show that 60% of children aged 0-6 months do not receive breast milk (ASI) exclusively, and 2 out of 3 children aged 0-24 months do not receive complementary foods for breast milk (MP-ASI).[1] Complementary foods for breast milk is given/started to be introduced when toddlers are over 6 months old. Apart from its function of introducing new types of food to babies, complementary foods for breast milk can also meet the nutritional needs of the baby's body which can no longer be supported by breast milk, as well as building the body's resistance and development of the child's immunological system towards food and drink.[14] Limited health services including ANC/AnteNatal Care (health services for mothers during pregnancy) Post Natal Care and optimizing child growth and development are risk factors for stunting.[3]

The population of Bekasi Regency in 2017 was 2,611,467 people, with an average population density of 2050 people per km2, Bekasi Regency has been designated as an integrated stunting prevention and reduction locus in 2020 along with 260 regencies/cities in Indonesia. In 2020, there were 23 villages in Bekasi Regency that were the locus (focus locations) of stunting and are targeted to reach 75 villages by 2022. South Cikarang District is the district with the highest stunting rate. The highest village in South Cikarang District is Sukaresmi Village with a total incidence of very short toddlers of 10 people and stunting toddlers of 42 people. From the available data, the coverage of specific nutritional interventions for breastfeeding mothers is still below the target expected by the government, which is 100%. [15] So there is still a gap between the target and the current achievement. The purpose of this study was to analyze several factors that influence the completeness of specific nutritional interventions in breastfeeding mothers to create prediction models.

METHODS

This type of research uses quantitative analytical research with a cross sectional design.[15] The population in this study was all breastfeeding mothers in Sukaresmi Village, South Cikarang District with a total of 198 breastfeeding mothers. Respondents were breastfeeding mothers in the South Cikarang District area. The sample calculation used the formula of Isaac and Michael with the sample calculation results of 128 people taken using a simple random sampling technique. The study was conducted by collecting data to the research sample using questionnaires that had been tested for validity and reliability. The results of the Validity Test showed the r value of the result > r. table standard (0.361) meaning that all questions were declared valid. The results of the reliability Test showed a Cronbach Alpha value of 0.92 which means it is very reliable. Validity and reliability tests were analyzed using SPSS version 24. Data collection was carried out for one month. The data analysis technique used univariate analysis to calculate the Frequency distribution of each variable, followed by bivariate analysis with Chi square analysis and continued with Multivariate analysis with logistic regression.

RESULTS

In accordance with the research objectives, the research results were analyzed in 3 stages to produce a predictive model of factors that influence the completeness of specific nutritional interventions for breastfeeding mothers in Bekasi district.

Table 1. Frequency distribution of completeness of specific nutritional interventions for breastfeeding mothers and toddlers 0-23 months

Variable	Category	Frequency (%)
Completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers aged 0-23 months	Incomplete	57(44.5)
	Complete	71(55.5)
	Total	128(100)

Notes: *The completeness of specific nutritional interventions refers to the standards set by the government for breastfeeding mothers and children aged 0-23 months

From the research results, it is known that in this study the sample size was 128 breastfeeding mothers, most of whom were breastfeeding mothers who had the complete category at 55.5%. Most breastfeeding mothers had received complete specific nutrition interventions, but when compared to the government's target of 100%, this figure is still far below the target. The low achievement of the completeness of specific nutrition interventions shows that there is still a large risk of stunting in the region.

Table 2. Frequency distribution of independent variables

Variable	Category	Frequency (%)	Percentage (%)
Mother's Education	Low	76	59.4
	Medium-High	52	40.6
Mother's Knowledge	Low	57	44.5
	Good knowledge	71	55.5
Mother's Attitude	Not Good	58	45.3
	Good	70	54.7
Mother's Job	Work	53	41.4
	Housewife	75	58.6
Parity	Many (more than 3)	51	39.8
	Sufficient (1 to 3)	77	60.2
Husband's support	Less support	46	35.9
	Support	82	64.1
Health workers' support	Less support	46	35.9
	Support	82	64.1
Village Officials' support	Less support	55	43.0
	Support	73	57.0

Note: n=128

From the table above, it is known that there were 8 variables studied. Based on the education variable, it is known that the group with the highest percentage of low-educated mothers was 76 people (59.4%), based on the mother's knowledge variable, the highest percentage is the group that had maternal knowledge as many as 71 people (55.5%). For the mother's attitude variable, the highest percentage was in the support group, namely 70 people (54.7%). For the mother's job variable, the highest percentage was in the group of housewives, namely 75 people (58.6%), in the parity variable, the highest was in the group with sufficient parity, namely 77 people (60.2%). For the husband's support variable, the highest percentage in the support group was 82 people (64.1%). The health workers' support variable, the highest percentage was in the support group of 82 people (64.1%). The highest percentage of village officials' support variable was in the support group of 73 people (57.0%).

Table 3. Results of bivariate analysis of completeness of specific nutrition interventions for breastfeeding mothers and toddlers aged 0-23 months

	Completeness of specific nutritional interventions			p-value	OR (CI 95%)
Mother's Education	**Incompletef (%)**	**Completef (%)**	**Total f (%)**		
Low	42 (55.3)	34 (44.7)	76(100)	0.006	3,05 (1,44 to 6,46
Medium-High	15 (28.8)	37 (71.2)	52(100)		
Total	57 (65.9)	71 (55.5)	128(100)		
Mother's knowledge					
Low	47(82.5)	10(17.5)	57(100)	0.000	28.67 (11.02 to 74.54)
Good	10(14.10)	61(85.9)	71(100)		
Total	57(44.5)	71(55.5)	128(100)		
Mother's attitude					
Not Good	46(79.3)	12(20.7)	58(100)	0.000	20.56 (8.32 to 50.79)
Good	11(15.7)	59(84.3)	70(100)		
Total	57(44.5)	71(55.5)	128(100)		
Mother's job					
Work	47(88.7)	6(11.3)	53(100)	0.000	18.69 (6.24 to 55.92)
House wife	10(13.3)	65(86.7)	75(100)		
Total	57(44.5)	71(55.5)	128(100)		
Parity					
Many	39(76.5)	12(23.5)	51(100)	0.000	10.653 (4.62 to 24.55)
Sufficient	18(23.4)	59(76.6)	77(100)		
Total	57(44.5)	71(55.5)	128(100)		
Husband's Support					
Less Support	46(90.2)	5(9.8)	51(100)	0.000	55,2 (17,97 to 169,54)
Support	11(14.3	66(85.7)	77(100)		
Total	57(44.5	71(55.9)	128(100)		
Health workers' Support					
Less Support	36(78.3)	10(21.7)	46(100)	0.000	10.46 (4.43 to 24.67)
Support	21(25.6)	61(74.4)	82(100)		
Total	57(44.5)	71(55.5)	128(100)		
Village Officials' support					
Less Support	46(83.6)	9(16.4)	55(100)	0.000	28.81 (11.03 to 75.24)
Support	11(15.1)	62(84.9)	73(100)		
Total	57(44.5)	71(55.5)	128(100)		

Notes :
p <0.05 indicates a significant relationship on the Chi Square Test.
The OR value of >1 indicates that there is a difference in risk in 2 groups

From the bivariate analysis results table, it is known that all variables have a p <0.05, meaning that all variables had a relationship with the completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers, namely the variables Education, Knowledge, Attitude, Employment, Parity, Husband's Support, support from health workers and support from Village officials. The results of bivariate analysis showed that there was a relationship between the Education Variable and the completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with p=0.006 and OR=3.047 (1.438 to 6.46).

There was a relationship between knowledge and the completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with p=0.001 and OR=28.67 (11.03 to 74.54). There was a relationship between Mother's Attitudes and the completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with a value of p=0.001 and OR = 20,56 (8,32 to 50,79).

There was a relationship between Mother's Job and completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with a p=0.001 and OR=18.688 (6.24 to 55.92). There was a relationship between parity and completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with p=0.001 and OR=10.65 (4.62 to 24.55).

There was a relationship between Husband's Support and the completeness of Specific Nutrition Interventions for breastfeeding mothers and toddlers with p=0.001 and OR = 55.2 (17.97 to 169.54). There was a relationship between Support from Health Workers with complete Specific Nutritional Interventions for breastfeeding mothers and toddlers with a p=0.001 and OR = 10.46(4.43 to 24.67). There was a relationship between support from village officials and the completeness of specific nutritional interventions for breastfeeding mothers and toddlers with a p = 0.001 and OR=28.81 (11.03 to 75.24).

Table 4. Final multivariate modeling of Completeness of Specific Nutrition Interventions for Breastfeeding Mothers and Toddlers Aged 0-23 Months

Variable	Coefficient	SE	p	OR
Village Officials support	2.334	0.854	0.006	10.324
Mother's Attitude	2.160	0.887	0.015	8.668
Mother's knowledge	2.679	0.963	0.005	14.570
Husband's support	2.643	0.898	0.003	14.051
Health Workers Support	3.023	1.003	0.003	20.560
Constant	-7.255	1.547	0.000	0.001

Notes: The p value of <0.05 in binary logistic regression shows a significant effect

Final multivariate modeling of Completeness of Specific Nutrition Interventions for Breastfeeding Mothers and Toddlers Aged 0-23 Months. The final model equation formed: Logit of stunting incidence in children under five = 2.334*support from village officials+2.160*mother's attitude 2.679*mother's knowledge+2.643*husband's support+3.023*support from health workers. The similarity of this model could mean that there was a contribution from the support of village officials, mothers' attitudes, mothers' knowledge, husband's support and health workers' support, to the completeness of specific nutritional interventions for breastfeeding mothers.

The amount of contribution of each variable, amounting to the coefficients that existed in each variable in accordance with the regression equation. The most dominant factor is the health workers' support variable with OR=20.56. Breastfeeding mothers who received support from health workers had a 28 times greater chance of receiving complete specific nutritional intervention compared to those who did not receive support from health workers. In this test, the model formed was a fit model (seen from the p model in the omnibus test of model coefficient 0.001 <0.05) so that it was able to predict the completeness of specific nutritional interventions for toddlers**.**

DISCUSSION

Table 1 shows that in this study the sample size was 128 breastfeeding mothers, the majority of whom were breastfeeding mothers with a complete category of 55.5%. This shows that government intervention in reducing and overcoming the stunting problem in South Cikarang District has not achieved its target. This target was set by the government to reduce the incidence of stunting in all regions in Indonesia. The government's target is that all breastfeeding mothers receive 100% specific nutritional interventions, especially in areas that are the focus locations for reducing stunting. The government had expanded the focus locations for interventions to reduce stunting to 514 districts/cities in 2022, from 360 in 2021. Cooperation is needed from all parties to achieve a reduction in stunting prevalence from 27.67 percent to 14 percent in 2024. Target for achieving specific nutritional interventions is one indicator of the achievement of reducing stunting from 27.67% to 14% in Indonesia. The results of previous research, conducted by Iwan et al, 2021, the achievement of specific nutritional interventions is still not optimal, the specific nutrition intervention policy in efforts to overcome stunting is still around the provision of PMT, the provision of Fe tablets and then the provision of additional food from the village (existing programs). Programs carried out by Community Health Center (Puskesmas) in the implementation of specific nutrition interventions: programs that have been implemented are pregnant women classes, adolescent Integrated Healthcare Center (Posyandu) programs, toddler class programs carried out during Posyandu or outside Posyandu days of service. The Head of Puskesmas does not yet have a special stunting program. The results of another study conducted by Khalid, et all that specific nutritional interventions in several countries have not been achieved optimally. This is one of the triggers for the high number of stunting cases in several countries, especially in developing countries.

Stunting is a problem that is a government priority and has been synergized across several ministries.[16] Not only the Ministry of Health, but other ministries also play a role in the National Action Plan to reduce stunting with a target of 14% by 2024. The West Java government in 2023 launched Zero New cases of stunting, meaning, for the period from 2024 to the following year it is expected that there are no more new cases of stunting in West Java Province. This spirit is the basis for program synergy between all sectors. Pentahelix's mission to accelerate stunting reduction is carried out jointly between the government, private sector/industry, academics/education, media and also the community.[17]

The Indonesian government program, through specific nutritional interventions, is one of the strategic programs that is an indicator of the success of reducing stunting. One of the specific nutritional intervention targets is targeting breastfeeding mothers and children under five, namely 0-6 months of age and 7-23 months of age. This intervention for breastfeeding mothers and children aged 0-6 months is carried out through several activities that encourage early initiation of breastfeeding/IMD, especially through providing plain breast milk/colostrum as well as encouraging exclusive breastfeeding.[18] Specific Nutritional Interventions targeting Breastfeeding Mothers and Children Aged 7-23 months, including activities to encourage continued breastfeeding until the child/infant is 23 months old, providing MP-ASI after the child is 6 months old, giving anti-worm medicine, giving zinc supplementation, carrying out fortification of iron into food, providing protection against malaria, providing complete immunization, and preventing and treating diarrhea.[19]

The research results showed that 44.5% of the group of breastfeeding mothers and toddlers received incomplete specific nutritional intervention incomplete. This raises the risk of not achieving

the stunting reduction target. The government needs to increase efforts to increase the completeness of specific nutritional interventions so that the chain of stunting events can be prevented.[17]

Table 2 shows that all variables had a p<.05, meaning that all variables had a relationship with the completeness of Special Nutrition Interventions for breastfeeding mothers and toddlers, namely the variables Education, Knowledge, Attitudes, Work, Parity, Husband's Support, support from health workers and support from Village officials. According to Anderson regarding the use of health services, each individual has a different tendency to use health services. This can be predicted from patient/community characteristics which include: demographic characteristics, social structure and beliefs about health.[20] In detail, demographic characteristics are explained including: age, gender, education, knowledge, attitudes, motivation, experience, work, income, religion, etc.[21]

Another influencing factor is the Enabling factor (resources), to optimize the utilization of health services, the predisposing factors must also be supported by other things in the form of supporting factors (enabling factors), including income, health insurance and the availability of existing health service resources, including supporting facilities such as transportation facilities and ease of reaching the location of health service facilities.[22] If these factors are met, individuals tend to use existing health service facilities when they are sick or healthy to utilize health services. The need factor, namely the presence of a perceived disease, also influences people's behavior in utilizing health services. This factor focuses more on the issue of whether the individual and his family feel the presence of illness, or the possibility of illness so that they feel the need to implement a health program or utilize existing health services. Needs are measured by "perceived need" and "evaluated need" as well as the External Environment. This external environment can come from the family (husband's support, family support, friends, etc.), the health service facility environment (support from health workers, convenience, quality of service, etc.) and also support from government officials (village government, etc.).[23]

According to the study of Effendi, in the Jatiluhur Purwakarta Puskesmas working area, there was a correlation between the prevalence of stunting and special nutritional interventions in the 1000 HPK program.[24] Stunting was more likely to occur in toddlers who did not receive exclusive breastfeeding, did not receive appropriate complementary foods, did not receive vitamin A capsules, and did not receive complete immunization. Specific nutritional interventions, especially through education, knowledge and sanitation interventions, were able to reduce the incidence of stunting in Nepal.[25]

The research results show that there was a relationship between mother's Education Variable and the completeness of Specific Nutrition Interventions for breastfeeding mothers and toddlers with a value of p=0.001 and OR= 3.047 (1.438 to 6.46). Mothers with low education were 3.047 times more likely to not receive complete specific nutritional intervention compared to mothers with medium-high education. According to Stuart and Sundeen theory, education is the process of someone getting information. The educational process takes place over a certain period of time, education not only changes knowledge but also thought patterns and attitudes.[26] People with higher education will have a broad perspective and be able to receive information well and translate it into good attitudes and habits that will provide positive value for themselves. Apart from that, education is also synonymous with a person's readiness to get a decent job so that it influences family income. [27] Education is the process of a person changing attitudes and behavior in maturing themselves through teaching and training.[28]

The level of maternal exposure to health and nutrition information in rural areas contributes to the incidence of underweight and stunting in toddlers. The introduction of communication media such as interpersonal counseling or through certain health service systems has been proven to improve feeding practices.[25] Empowering women through increasing education and knowledge about nutrition and health is thought to be one way to overcome nutritional problems. Women are the main caregivers for children as well as being productive members of the household. In optimizing the achievements of specific nutritional interventions, interventions must be aimed not only at toddlers but also at mothers because mothers are usually the ones who care for children. The implications of this intervention could include women's empowerment and educational programs. Education through class programs for pregnant women, breastfeeding mothers and other activities will increase mother's knowledge so that it will influence mothers' thinking patterns and attitudes about the importance of maintaining the health of mothers and babies, one of which is in efforts to prevent the stunting generation through specific nutritional intervention programs.[29]

There was a relationship between mother's knowledge and completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with a value of p=0.004 and OR=28.67 (11.03 to 74.54). Mothers who had poor knowledge were 28.67 times more likely to have incomplete nutrition-specific interventions than those with good knowledge. Knowledge is very important in forming mothers' habits in achieving Specific Nutritional Interventions. According to government standards for specific nutritional interventions, mothers must know about the importance of early initiation of breastfeeding/IMD, especially through giving plain breast milk/colostrum, giving exclusive breast milk, giving breast milk until the child/baby is 23 months old, giving MP-ASI after the child is 6 months old, administering worm medicine, providing zinc supplementation, fortifying food with iron, providing protection against malaria, providing complete immunization, and preventing and treating diarrhea.[12]

Many mothers do not know about the benefits and importance of zinc supplementation when breastfeeding and the importance of iron fortification in baby/toddler food. Apart from that, there are still many mothers who have difficulty giving worm medicine and protection against malaria.[30] It is very important to provide information to mothers about correct and varied nutritional intake for pregnant and postnatal mothers because postnatal mothers need adequate nutritional intake that meets standards.[31] Mothers must know about the importance of exclusive breastfeeding and colostrum

in preventing stunting. Several studies show that babies who receive colostrum and exclusive breast milk have a lower risk of experiencing stunting.[32] This finding is supported by the fact that providing less than optimal early initiation of breastfeeding to babies is one of the factors causing stunting.[28] The babies who do not have early initiation of breastfeeding (IMD) experience stunting because they do not benefit from colostrum at the age of toddlers. In the case of exclusive breastfeeding, mineral absorption increases because the breast milk becomes more mature and the colostrum has higher lactose levels. This is beneficial for babies because it accelerates the growth of bones and body systems.[14] Good maternal knowledge will influence maternal efforts to complete specific nutritional interventions. This is a good effort to prevent stunting in children. Knowledge is the result of a person's senses which will influence their attitudes and behavior. By increasing knowledge, good practices in preventing stunting will be achieved.[29]

There was a relationship between Mother's Attitudes and the completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with a p=0.001 and OR=20.56 (8.323 to 50.79). Mothers who had less supportive attitudes were 20.56 times more likely to get incomplete specific nutritional interventions than mothers who had good attitudes. According to Green's Precede Proceed Model theory, attitudes will be formed when someone understands the importance of something. The process of providing positive information, especially that obtained from trusted sources, will influence a person's attitude towards something.[30] A positive attitude will encourage someone to want to do something. The urge to do something is based on awareness of the benefits and benefits that can be obtained if you do it and the impact that you will get if you don't do it. Attitude is a form of behavior that is still covered (covert behavior).[31] This will influence a person's actions, which can be seen in the efforts of breastfeeding mothers to optimize their achievements in specific nutritional interventions as an effort to prevent stunting.

There was a relationship between a mother's job and the completeness of specific nutritional interventions for breastfeeding mothers and toddlers with a value of p=0.001 and OR=18.69 (6.24 to 55.92). Working mothers were 18.69 times more likely to not receive complete specific nutritional interventions than mothers who had a supportive attitude. Work is a livelihood that someone does to earn a living. Working mothers will have a positive effect on the family's economic side, however, it will have a negative effect on child care.[32] Mothers who work from morning to evening tend to have little time for their children and family. Mothers are very important in caring for and regulating family members' food consumption.[33] Babies who still need breast milk will get less than their daily breast milk needs. Mothers often replace breast milk with other food sources that are not appropriate.[18] In addition, working mothers often entrust their children to other family members such as their grandmother. This results in decreased supervision of children so that children's needs are often neglected, including fulfilling specific nutritional interventions that children should receive.[34]

There was a relationship between parity and the completeness of Specific Nutritional Interventions for breastfeeding mothers and toddlers with a p=0.004 and OR=10.65 (4.62 to 24.55). Mothers who had multiple parties had a 10.65 times greater chance of getting incomplete specific nutritional interventions compared to mothers who had sufficient parity. Parity is related to the number of births experienced by the mother. Parity number is related to the number of children in the family.[34] The number of children and number of family members is related to the mother's behavior in parenting and the incidence of stunting. Studies in Haramaya, Ethiopia showed that the number of 2 or more children under five in the family was significantly related to the incidence of stunting.[35] The number of children under five in the family will have divided attention and allocate additional psychological resources and materials in meeting household needs, which can affect the nutritional needs of each child.[23] Feeding a family with a large number of family members tends to be less.[1] In addition, homes with a total number of family members of 5-8 people have 1.3 times higher rates of stunting.[28] Stunting occurs more often in mothers with higher parity. Cases of stunting in children aged 6-23 months in Kenya occur more often in mothers who give birth to 5 or more children compared to mothers with parity less than 5.[36] Based on the BKKBN category, families with more than 4 members are categorized as large families, while families with less than 4 members are categorized as small families. Small families are believed to have a more secure level of child welfare. This is influenced by family food consumption. A large number of family members will cause the distribution of food ingredients to be uneven, thereby increasing the risk of nutritional disorders in the large family category. All of the factors above will increase the incidence of stunting which has an impact on a child's life.[32]

There was a relationship between husband's support and the completeness of specific nutritional interventions for breastfeeding mothers and toddlers with a value of p=0.001 and OR=55.2 (17.97 to 169.54). Mothers who had poor husband's support were 55.2 times more likely to get incomplete nutrition-specific interventions compared to mothers who had good support. Husband's support influences the completeness of specific nutritional interventions.[33] This is in line with research by Salmung, et al, 2019, which stated that pregnant and breastfeeding mothers experience many physical and psychological changes, so they need good family support. This is also supported by research by Widarsson, 2020 which showed that husband's support is very important. Husband's support can be realized in the form of fulfilling the nutrition of mothers and toddlers by providing funds to meet their needs during breastfeeding and the nutritional needs of their toddlers.[34] Apart from that, support can also be provided in terms of being a mother's friend to communicate and complain about the breastfeeding process and parenting patterns, and the husband can provide positive information and advice in an effort to provide a solution. The husband can also provide direct physical support through his readiness to take the mother and toddler to the Posyandu/health facility to have their health checked. Husband's support can take the form of informational support, emotional support, physical support or financial support.[32] Good husband support will help mothers complete specific nutritional

interventions. Types of Husband Support: Emotional Support: This includes listening, understanding and providing emotional support to the partner. This could mean providing a shoulder to cry on, providing encouragement, or simply providing a feeling of security and comfort. Financial Support: This includes providing financial needs for the family, such as income for daily living expenses, children's education, and retirement preparation. Physical support: This includes contributing to household tasks, such as cooking, cleaning, caring for children, and managing the household in general, as well as taking the mother to a health worker or health facility if she wants to be checked.

Informational support: This involves support in providing information to the mother regarding health-related matters and government programs that are beneficial for the mother's health.[16] Husband's support can have a positive impact on maternal participation in specific nutritional interventions, such as nutritional education programs, nutritional supplementation programs, or supplementary feeding programs for children. Husband's support can influence maternal participation in nutritional interventions through several mechanisms, and this can be linked to several theories and research that have been conducted.[35]

There was a relationship between Health Worker Support and the completeness of Specific Nutrition Interventions for breastfeeding mothers and toddlers with a p=0.001 and OR = 10.46 (4.43 to 24.67). Mothers who had less support from health workers had a 55.2 times greater chance of not receiving complete specific nutritional intervention compared to mothers who had good support from health workers. Support from health workers has a big influence in increasing the achievement of completeness of specific nutritional interventions. According to Effendy, 2021 one of the roles of health workers is to improve communication and information to breastfeeding mothers, increase interaction through home visits and holding classes for pregnant and breastfeeding mothers, regarding how to breastfeed, how to make complementary foods for breast milk, carrying out iron fortification to baby and toddler food.[19] Research conducted by Vima, et all, also showed results that 23 respondents (27.7%) perceived the role of health workers as good and had high motivation and had a significant relationship with mothers' motivation in implementing stunting prevention efforts.[27]

There was a relationship between Village Officials support and the completeness of Specific Nutrition Interventions for breastfeeding mothers and toddlers with a p=0.001 and OR=28,81 (11,03 to 75,24). Mothers who had less supportive village officials had a 55.2 times greater chance of not receiving complete specific nutrition interventions compared to mothers who had good support from village officials. Apart from health workers, village officials have a strategic role in increasing the completeness of specific nutritional interventions for breastfeeding mothers and toddlers. [32] The Indonesian government has established five pillars to deal with stunting. Pillar 1 is the Commitment and Vision of the State's Highest Leadership; Pillar 2 is a National Campaign that focuses on understanding, behavior change, political commitment and accountability; Pillar 3 is Convergence, Coordination and Consolidation of National, Regional and Community Programs; Pillar 4 is Encouraging Nutritious Food Access Policies; and Pillar 5 is Monitoring and Evaluation.[6] The Ministry of Villages, Development of Disadvantaged Regions and Transmigration is directly involved in reducing stunting. The Village Minister's Regulation on the Utilization of Village Funds regulates special and sensitive interventions for stunting. This regulation provides an opportunity for village officials to actively participate in various activities related to stunting management.

The National Action Plan for Nutrition and Food Security has made tackling stunting a national development priority. In accordance with the Village Law, villages have the ability to plan relevant and village-scale activities through the Village Revenue and Expenditure Budget. Village Minister Regulation No.19 of 2017 strengthens village spending references for handling stunting. Village officials should be involved in monitoring families at risk of stunting. The Village's role in increasing the achievement of specific nutritional interventions for pregnant, breastfeeding mothers and school children includes: Assistance for pregnant, postpartum and breastfeeding mothers together with cadres, Assistance with data collection for pregnant women and toddlers together with cadres, Assistance with planning, delivery and complication prevention programs by cadres, Monitoring the growth of toddlers by cadres and providing PMT (supplementary food) for babies, toddlers and school children and also Home visits by cadres to monitor toddler growth.[32]

Apart from direct support to breastfeeding mothers and toddlers, the village also plays a role in target cadres, which includes: Increasing knowledge and skills of cadres through community health cadre training programs, Providing transportation for health cadres, Orientation of health cadres organized by the Village, Providing cadre transportation in the implementation of UKBM, Providing transportation for officers/cadres to Posyandu/Posbindu, Assistance in implementing home visits, transportation, Assistance for communities at risk, IVA (visual inspection with acetic acid) assistance, Assistance with target data collection and immunization sweeping, Cadre honor/incentives/rewards and also Health cadre meeting. With the involvement of village officials, support for breastfeeding mothers will be more optimal and efforts to prevent stunting will increase so that the stunting reduction target will be more easily achieved.[33]

Table 3 produces information that, based on multivariate analysis, the factors that influence the completeness of specific nutrition interventions are: support from health workers, support from husbands, support from village officials, knowledge and attitudes of mothers. This shows that mothers need a strong support system to help shape behavior in fulfilling certain nutritional interventions as an effort to prevent a generation of stunting. This support system will help change the mother's knowledge and attitudes so that it will optimize the mother's efforts in fulfilling specific nutritional interventions. The variable with the most dominant influence on the completeness of specific nutrition in breastfeeding mothers was the variable support from health workers with OR=20.56 at 95% CI (2.88 to 146.89).

Health worker support can have a major impact on maternal participation in specific nutrition interventions. Health workers play an important role in providing information, motivation, and technical assistance to mothers, which can increase their participation in specific nutrition intervention programs. The following are several forms of support from health workers in specific nutritional interventions, which can be linked to theory and research results: Nutrition Counseling and Education in that health workers can provide accurate and easy to understand information about the importance of balanced nutrition and how to achieve it.[34] Social Learning Theory by Albert Bandura says that individuals learn from observation and imitation of other people. In this context, health workers act as models who provide examples of good nutritional behavior.[35] Emotional Support: Health workers can provide emotional support by listening to the mother's concerns and problems related to nutritional interventions.

This emotional support can help mothers feel more and more motivated to participate in the program. Social Involvement Theory states that social support can increase individual involvement in health behavior. Monitoring and Feedback: Health workers can carry out routine monitoring of maternal and child health developments, as well as provide positive feedback on the progress that has been achieved. This can increase the mother's motivation and sense of accomplishment. Impact Appraisal Theory states that individuals tend to participate in behaviors that they judge to have a positive impact on their lives.

Technical Assistance: In some nutrition programs, health workers may provide technical assistance, such as helping mothers understand instructions for using additional foods or nutritional supplements. This technical support can increase mothers' understanding and compliance with nutrition programs. The results of research by Bhutta et al.,[11] showed that technical support from health workers can increase the success of nutritional interventions in children. Community Engagement: Health workers can also work within a community framework to create an environment that supports healthy nutritional practices. This could include group counseling, community activities, or involvement of community leaders. Social Mobilization Theory says that involving the community in changing health behavior can increase participation in nutrition interventions. Through the optimal role of health workers, the government's strategy to reduce the incidence of stunting through specific nutritional interventions will be more optimal.[18]

This study was an observational study, where researchers collect data on research variables according to the framework of concepts that are theoretically considered to affect mothers' efforts in fulfilling the completeness of specific nutritional interventions. The results of the study were in line with the existing theoretical framework.

CONCLUSION

The completeness of specific nutritional interventions for breastfeeding mothers has not been achieved according to the government's target. There is still a gap that is far from the set target. This will trigger the emergence of stunting events. To optimize efforts to reduce stunting, it is necessary to intervene on the factors that influence it which include: maternal knowledge, maternal attitude, husband's support, health workers' support and village apparatus' support. The role of health workers is very significant in improving the achievement of the completeness of specific nutritional interventions in breastfeeding mothers. It is necessary to refresh health workers in their ability to carry out IEC to the community.

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