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ANALYSIS OF KNOWLEDGE, ATTITUDES, AND PRACTICES OF CADRES REGARDING GROWTH MONITORING, PROVISION OF SUPPLEMENTARY FOOD, AND PROVISION OF INFANT AND CHILD FOOD IN STUNTING LOCUS AREAS

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ABSTRACT
Stunting is a major problem in Indonesia. Stunting can affect physical, mental, cognitive and intellectual development so that children are unable to learn optimally. Banyuasin Regency is ranked 3rd in toddlers who experience stunting out of 17 districts/cities in South Sumatra. Stunting control is carried out through specific interventions in the form of providing additional food (PMT), monitoring toddler growth, and providing infant and child food (PMBA). The aim of this research is to find out the knowledge, attitudes and behavior of cadres regarding providing additional food, monitoring the growth of toddlers, and feeding babies and children in stunting locus area. This type of research is quantitative with a quantitative research method with a cross-sectional approach. This research was conducted in 3 stunting locus sub-districts in Banyuasin Regency. In August-September 2024. The population in this study were all posyandu cadres in Banyuasin Regency. The sample in this study was 102 posyandu cadres with the Cluster random sampling technique. Data analysis was carried out descriptively. This study shows that there is a need to improve the knowledge, attitudes, and behavior of community health cadres regarding monitoring child growth and providing supplementary feeding. Aspects that need to be strengthened include understanding of signs of growth disorders, age and gender criteria for recipients of supplementary feeding, and involvement in data collection and planning with nutritionists. Further training and closer collaboration are needed to improve program effectiveness.

Keywords: growth monitoring; PMBA; PMT; stunting

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INTRODUCTION
Stunting is a major problem in Indonesia, because the growth of stunted children is not only hampered by physical development but also brain development. Children who experience stunting can experience physical, mental, cognitive and intellectual development disorders so that children are unable to learn optimally (Fauza et al., 2022). Stunting children have low cognitive abilities and if not treated before reaching the age of five, they can die (Hasriani, 2023). Indonesia ranks third in the world with the highest prevalence of stunting in the Southeast Asia region according to data from the World Health Organization (KEMENKES, 2018). The results of the 2022 Indonesian Nutritional Status Survey (SSGI) stated that the stunting rate in Indonesia in 2022 was 21.6%. Meanwhile, in South Sumatra based on SSGI (2022) it was 18.6%. Banyuasin Regency is ranked 3rd in toddlers who experience stunting out of 17 districts/cities in South Sumatra with a stunting prevalence rate based on SSGI (2022) of 13.3%.

In order to address the problem of stunting in Indonesia, the government issued Presidential Regulation No. 72 of 2021 concerning the Acceleration of Stunting Reduction which regulates the National Strategy for the Acceleration of Stunting Reduction in Indonesia through specific and sensitive interventions (Besin, 2023). One of the ways to handle stunting is through specific interventions in improving toddler nutrition in the form of Providing Additional Food (PMT), Monitoring Toddler Growth and Providing Infant and Child Food (PMBA) (Rahman et al., 2023). Stunting can be identified by measuring body length and then comparing it with age. Weight according to age also describes the child's growth. To determine their growth, it is necessary to carry out routine and continuous monitoring by officers (Addawiah et al., 2020). In early life until the age of 4 months, monitoring can be carried out every week and then can be done at least once a month (Sumarjono et al., 2020). Growth monitoring is intended for early detection of growth disorders to prevent signs of malnutrition in children through Providing Additional Food (PMT) and Providing Infant and Child Food (PMBA) (Rochmawati et al., 2023)

Providing additional food (PMT) and Providing Infant and Child Food (PMBA) is one form of strategy to increase access to nutritious food in order to fulfill children's needs to overcome nutritional problems. Infant and child food is given since newborns and Additional Food (MT) is given to all toddlers aged 6-59 months in order to prevent toddlers from being thin accompanied by the provision of nutritional education and given to Thin Toddlers aged 6-59 months until the nutritional status of the toddler improves which can be monitored through an increase in body weight (Ministry of Health of the Republic of Indonesia, 2022). Providing Additional Food (PMT) and Providing Infant and Child Food is an intervention program given to toddlers who experience nutritional problems, with the aim of improving the nutritional status of children and meeting nutritional needs in order to achieve good nutritional conditions according to their age. PMT can be in the form of local food or factory food, adjusted to the nutritional needs of toddlers. This program is one strategy to deal with nutritional problems in toddlers, especially those who experience malnutrition or severe malnutrition (Ministry of Health of the Republic of Indonesia, 2022). Posyandu has a role in monitoring the nutritional status of toddlers so that malnutrition can be prevented through the Provision of Supplementary Food (PMT) and Provision of Infant and Child Food (PMBA). Posyandu is a form of community participation in the health sector which is managed by cadres targeting all members of the community. Posyandu as a media for promotion and monitoring the growth of Stunting toddlers. (Faizah et al., 2023). In addition, posyandu is also a place to provide assistance and provide additional food as well as provide food for babies and children (Daemonika et al., 2022). With the activities of monitoring growth, providing additional food and providing food for babies and children at posyandu, it is hoped that it can help prevent stunting in children and ensure that children's growth and development are in accordance with the standards that should be (Linda Fitria Nuraini et al., 2024).

However, in the implementation of providing additional food, monitoring the growth of toddlers and providing food for babies and children, the involvement of Posyandu cadres is needed. Because Posyandu cadres have close access to the community in their area. The presence of cadres in the community is used as a bridge between health workers and the community and helps the community to overcome their health problems and get health services (Nugraheni & Malik, 2023). Therefore, researchers are interested in identifying and analyzing the role of Posyandu cadres in Providing Additional Food (PMT), Monitoring Toddler Growth and Providing Food for Babies and Children (PMBA) towards the incidence of Stunting in Banyuasin Regency as a stunting locus area.

METHOD

This research is quantitative research with a cross-sectional approach. This research was conducted in three stunting locus sub-districts in Banyuasin Regency. In August-September 2024. The population in this study were all posyandu cadres in Banyuasin Regency. The research has obtained permission from the Ethics Committee of the Faculty of Public Health, Universitas Sriwijaya with ethics number 318 / UN9.FKM / TU.KKE / 2024.

The minimum sample size is calculated using the Lemeshow formula as follows:

$$n = \frac{NZ^2 1{-}\propto 2P(1{-}P\ )}{(N{-}1)d^2 + Z^2 1{-}\propto /2P(1{-}P)}$$

$$n = \frac{3334 \times 1{,}92^2 \times 0.5\ (1 - 0.5)}{(3334{-}1)0.1^2 + 1.96^2 \times 0.5\ (1{-}0.5)}$$

$$n = \frac{3334 \times 3.8416 \times 0.5 \times 0.5}{3333 \times 0.01 + 3.8416 \times 0.5 \times 0.5}$$

$$n = \frac{3201.9736}{34.2904} = 93{,}37$$

Description:
n = minimum sample size required
N = population size
$Z^2 1 - \frac{\propto}{2} =$ Z value at the level of significance (usually 95% = 1.96)
P = maximum estimate = 0.5
d = expected precision limit 10% = 0.1

Based on the results obtained, the number of samples was 93.37 rounded to 93 as a sample representing the study population. To anticipate drop out, the researcher added a sample of 10%. So, the minimum sample in this study was 102 respondents. The sample in this study was 102 posyandu cadres. The researcher took the research location in 5 stunting loci, namely Banyuasin I, Banyuasin III, Rambutan, Talang Kelapa and Rantau Bayur Districts. After using Cluster sampling, the location of 3 sub-districts of stunting locus was obtained, consisting of 2 sub-districts with the highest stunting locus, namely Banyuasin I and Talang Kelapa, then for 1 sub-district with the lowest stunting locus, namely Banyuasin III. Data analysis in this study used descriptive analysis with the help of the Stata application version 15. After obtaining descriptive statistics, the next step is to interpret the results. Descriptive statistics provide an overview of data distribution and data variation. These results can help to understand the basic characteristics of the existing data and provide guidance for further analysis.

RESULT

The number of cadres involved in this study was 102 people. The demographic characteristics of the cadres (table 1) show a diverse age range, with the majority being between 40-49 years old (34.31%). Most cadres have a high school education (61.76%), while fewer have a college education (14.71%). The majority of cadres are housewives (78.43%), followed by laborers/farmers (15.69%), and civil servants/military/police and self-employed (5.88% and 4.90% respectively).

Table 1.
Demographic Characteristics of Cadres (n=102)

Karakteristik	f	%
Age		
<20 years	1	0.98
20-29 years	7	6.86
30-39 years	26	25.49
40-49 years	35	34.31
50-59 years	27	26.47
>60 years	6	5.88
Education		
College	15	14.71
SMA/SMK/MA	63	61.76
SMP/MTS	18	17.65
SD/MI	6	5.88
Occupation		
Laborer/Farmer	16	15.69
Housewife/Not working	80	78.43
PNS/TNI/Polri	1	0.98
Self-employed	5	4.90

The results of the knowledge questionnaire in table 2 show varying levels of understanding among respondents regarding child growth monitoring, supplementary feeding, and infant and young child feeding practices. Most participants correctly identified the gold standard and objectives of PMBA (96.08% and 69.61%, respectively). However, knowledge of the objectives of PMBA was still below 80%, namely 69.61%. In PMT, a high percentage knew the target group (82.35%) and objectives (81.37%), while fewer knew the local PMT components (64.71%). Regarding growth monitoring, most knew how to measure growth (96.08%), but fewer understood the signs of growth disorders (41.18%). Overall, the results indicate the need for increased education in certain aspects, especially recognizing growth problems.

Table 2.
Cadre Knowledge Regarding Growth Monitoring, Providing Additional Food, and Providing Food for Infants and Children in Stunting-Locus Areas

Knowledge Aspects related to PMBA, PMT, and Monitoring of Infants and Children		True	False
		f (%)	f (%)
PMBA			
1	The gold standard of PMBA	98 (96.08)	4 (3.92)
2	The purpose of PMBA	71 (69.61)	31 (30.39)
3	The impact of children not being given food according to their age	81 (79.41)	21 (20.59)
4	The purpose of PMBA Counseling	85 (83.33)	17 (16.67)
PMT			
1	Main Target of PMT	84 (82.35)	18 (17.65)
2	Objective of PMT	83 (81.37)	19 (18.63)
3	Type of PMT	73 (71.57)	29 (28.43)
4	Elements of PMT-Local	66 (64.71)	36 (25.49)
5	Consistency/texture of PMT	86 (84.31)	16 (15.69)
Pemantauan			
1	KIA Book Information	97 (95,10)	5 (4.90)
2	How to measure child growth and development	98 (96.08)	4 (3.92)
3	Signs of growth disorders in children	42 (41.18)	60 (58.82)
4	Purpose of weighing and monitoring growth and development	94 (92.16)	8 (7.84)

The results of the attitude questionnaire showed generally positive views among respondents regarding key aspects of child growth monitoring, complementary feeding, and complementary feeding practices. The majority stated the importance of complementary feeding for children aged 0-5 years (91.2%) and supported the practice of complementary feeding for infants (94.1%). In addition, most felt confident and comfortable in their role as community health cadres (90.2%). In the PMT section, almost all participants recognized the need for accurate data collection on children under five years for complementary feeding (98%) and supported complementary feeding planning (98%). However, a smaller proportion (75.5%) were on specific criteria for age and sex in selecting recipients of complementary feeding, highlighting potential concerns about uniformity. In the monitoring aspect, most respondents consistently emphasized the importance of explaining growth monitoring to parents (93.1%) and using growth monitoring cards (92.2%). However, a significant number of respondents (59.8%) were not aware of the importance of using accurate scales, indicating a gap in awareness about the accuracy required for accurate growth assessment. Overall, the results of the study indicate that attitudes are largely supportive, but improvements are needed in certain areas, particularly in the aspect of growth monitoring.

Table 3.
Cadre Attitudes Regarding Growth Monitoring, Provision of Additional Food, and Provision of Infant and Child Food in Stunting-Loces Areas

Attitude Aspects related to IYCF, PMT, and Monitoring of Infants and Children		Positive	Negative
		f (%)	f (%)
PMBA			
1	Awareness about Infant and Child Feeding (PMBA) for children aged 0-5 years	93 (91.2)	9 (8.8)
2	Support for providing MPASI for toddlers	96 (94.1)	6 (5.9)
3	Feeling comfortable and confident in becoming a Posyandu cadre	92 (90.2)	10 (9.8)
PMT			
1	Awareness to conduct data collection of prospective PMT target toddlers according to age group and gender.	100 (98.0)	2 (2.0)
2	Support to prepare a PMT implementation schedule starting from planning the time, place and type of PMT and its alternatives	100 (98.0)	2 (2.0)
3	Criteria for age and gender of toddlers receiving PMT.	77 (75.5)	25 (24.5)
4	Equal treatment during PMT implementation for all toddlers	79 (77.5)	23 (22.5)
Pemantauan			
1	Awareness to take measurements with toddler scales accurately	41 (40.2)	61 (59.8)
2	Always provide easy-to-understand explanations to parents of toddlers about the importance of growth monitoring	95 (93.1)	7 (6.9)
3	Consistency in using KMS in monitoring toddler growth	95 (92.2)	8 (7.8)
4	Attention to the condition of the measuring device before use.	100 (98.0)	2 (2.0)

The results of the practice questionnaire provide valuable insights into the active involvement of community health cadres in child growth monitoring, complementary feeding, and supplementary feeding programs. In the PMBA aspect, most cadres actively assist mothers in planning meals for young children (92.2%) and provide counseling for children with feeding difficulties (90.2%). However, the majority collaborate with nutrition officers for the implementation of the complementary feeding program (bar 60.8%) and fewer cadres (71.6%) actively provide education to mothers on continuing breastfeeding until the child reaches two years of age. In the PMT aspect, a relatively smaller percentage of cadres are actively involved in collecting data for the supplementary feeding program (53.9%) and providing direct education on preparing nutritious food (50%). While most cadres (93.1%) regularly visit and monitor children receiving supplementary feeding, there is little consistency in planning menus with nutritionists (54.9%) and ensuring adherence to appropriate feeding schedules (56.9%).

Table 4.
Cadre Behavior Related to Growth Monitoring, Providing Additional Food, and Providing Food for Babies and Children in Stunting-Locus Areas

Behavioral Aspects Related to PMBA, PMT, and Monitoring of Infants and Children		Active	Non-active
		f (%)	f (%)
PMBA			
1	Assistance for mothers of toddlers who have difficulty in preparing toddler food menus	94 (92.2)	8 (7.8)
2	Counseling on Feeding if the child experiences Closed Mouth Movement (GTM)	92 (90.2)	10 (9.8)
3	Collaboration with nutrition officers in the implementation of PMBA	62 (60.8)	40 (39.2)
4	Providing information about the importance of early initiation of breastfeeding.	87 (85.3)	15 (14.7)
5	Providing education for mothers of toddlers to continue breastfeeding until the child is 2 years old	73 (71.6)	29 (28.4)
PMT			
1	Managing the implementation of the PMT program, I collect data on prospective toddlers targeted for PMT according to age group and gender.	55 (53.9)	47 (46.1)
2	Provide counseling on PMT and practice directly how to make it.	59 (57.8)	43 (42.2)
3	Together with the health center nutrition officers, plan a supplementary food menu before implementing PMT.	56 (54.9	46 (45.1)
4	Provide counseling to mothers of toddlers on how to make nutritious supplementary food according to the age of the toddler.	51 (50.0)	51 (50.0)
5	Conduct routine visits and monitoring to the homes of toddlers who are targeted for PMT-recovery.	95 (93.1)	7 (6.9)
6	Discipline and consistency in data collection, accompanying and monitoring the families of toddlers who are targeted for PMT-Recovery.	58 (56.9)	44 (43.1)
Pemanatauan			
1	Always record the results of toddler weight and height measurements carefully and accurately.	94 (92.2)	8 (7.8)
2	Always use the Healthy Menu Card (KMS) to monitor toddler growth.	96 (94.1)	6 (5.9)
3	Always routinely provide counseling on nutrition and health to parents of toddlers.	67 (65.7)	35 (34.3)
4	Often hold meetings with fellow posyandu cadres to discuss developments and problems faced	58 (56.9)	44 (43.1)
5	I can use growth measuring tools such as head circumference measuring tapes for toddlers well.	69 (67.6)	33 (32.4)

Meanwhile, in terms of monitoring, most cadres diligently stated that they always measured growth (92.2%) and used growth monitoring cards (94.1%). However, fewer cadres (65.7%) consistently provided nutrition and health counseling to parents, and only about half regularly held meetings to discuss child development issues (56.9%). The use of growth measurement tools such as head circumference measuring tapes was also still below 80%, at 67.6%. Overall, the results showed active participation in key practices but highlighted areas, particularly in supplementary feeding education and routine monitoring, that required further involvement and consistency.

DISCUSSION

The demographic characteristics of the cadres in this study showed that most were aged between 40-49 years, with a significant proportion (61.76%) having completed secondary education. In addition, 78.43% of the cadres were housewives. Cadres with higher education tend to have better knowledge of health issues and necessary interventions. This allows them to provide accurate and relevant information to the community (Vilasari et al., 2024). A study showed that cadres with higher education have better abilities in delivering health messages and conducting counseling to the community (Mardiyanti, 2016). The dominance of housewives as health cadres is consistent with the expectation that women, especially mothers, play a key role in child and family health at the community level (Hutri Paulina Utami, 2020). Through nutrition education, emotional attachment, developmental stimulation, and social support, mothers contribute significantly to community health. Therefore, it is important to continue to support the role of mothers in health programs to achieve better results at the family and community levels (Aston et al., 2016). Educational background is critical in enhancing the capacity of cadres to deliver health interventions effectively, as higher education tends to enhance knowledge and communication skills, which are essential for tasks such as counseling and community mobilization. Findings related to knowledge aspects indicate that while most respondents understood key aspects of child growth monitoring and supplementary feeding (IYCF), knowledge gaps persisted, particularly regarding the purpose of IYCF and signs of growth impairment (Astani et al., 2023). Lack of awareness of local IYCF components also suggests the need for more targeted and context-specific training to improve the effectiveness of interventions. This lack of understanding can delay early detection of growth problems, potentially allowing growth retardation or malnutrition to progress unchecked.

Early identification of growth problems is critical to providing timely interventions that can prevent long-term health consequences. Overall, these findings highlight the need for targeted education and training to address knowledge gaps, particularly in recognizing growth problems and understanding local feeding programs (Sudirman et al., 2024). Without improving these areas, the effectiveness of child health initiatives may be compromised, limiting their impact in reducing growth retardation and improving child health outcomes (Sugiyanto et al., 2024). By equipping mothers and health workers with the necessary knowledge, child health initiatives can foster sustainable practices that support long-term health improvements (Zurc J, 2023).

The findings of this study on attitudes of cadres indicate that positive attitudes towards child growth monitoring, supplementary feeding, and complementary feeding practices are good. However, concerns arise from the low awareness (75.5%) of age and sex criteria for supplementary feeding, which may lead to inconsistencies in program implementation. In addition, 59.8% of respondents were not aware of the importance of accurate scales for growth monitoring. Accurate anthropometric measurements are essential for assessing nutritional status and monitoring child growth. Inaccurate measurements can lead to misclassification of a child's nutritional status, which can delay necessary interventions for problems such as stunting and malnutrition (Dian et al., 2024).

Research has shown that inaccurate measurements can result in significant losses in effective health care interventions (Sunjaya et al., 2021). Without appropriate measurement tools and techniques, the ability to detect these problems can be significantly delayed, leading to ineffective health interventions. Most cadres assisted mothers in meal planning (92.2%) and provided counseling for children with feeding difficulties (90.2%), indicating strong involvement in early childhood nutrition. However, only 60.8% of cadres collaborated with nutrition officers to implement complementary feeding, and a small proportion (71.6%)

actively educated mothers on continuing breastfeeding for up to two years. Regarding complementary feeding, while 93.1% of cadres regularly monitored children receiving complementary feeding, only 53.9% actively participated in data collection, and 50% provided direct education on preparing nutritious food. This indicates inconsistency in participation in the critical tasks of data collection and nutrition education, which are critical to the success of the complementary feeding program. In addition, there was low consistency in planning menus with nutritionists (54.9%) and ensuring adherence to appropriate feeding schedules (56.9%), which may lead to suboptimal implementation of the feeding program.

Strengthening collaboration between health cadres and nutritionists is critical to improving child health outcomes. Nutritionists have specialized knowledge of child nutrition and feeding practices, and their expertise is critical in ensuring that feeding programs are well planned and implemented (Kearsey et al., 2023). However, without the active involvement of community health workers, the effectiveness of these programs may be limited. Health workers, who are often trusted community members, can bridge the gap between technical knowledge and practical implementation, ensuring that nutrition interventions reach those who need them most (Wulandari et al., 2024). Providing training that focuses on nutrition education and implementation of feeding programs is equally important. Many health workers may be willing to help, but they may not have the skills and knowledge needed to monitor growth or implement feeding strategies effectively. Training programs should emphasize key areas such as accurate data collection, the importance of proper meal planning, and consistency of feeding schedules. By addressing these gaps, health interventions can be more efficient and tailored to the specific needs of the community.

CONCLUSION

This study provides information support on what aspects of knowledge, attitudes, and behaviors need to be emphasized to health workers when providing refresher training for health workers in this area that is vulnerable to stunting. There are several aspects that need to be improved in terms of knowledge, attitudes, and behavior of community health cadres related to child growth monitoring, complementary feeding, and supplementary feeding. Knowledge: Although most cadres have a good understanding of PMSA standards and objectives, there is a lack of knowledge about signs of growth disorders and local components of PMT. Further education and training are needed to ensure that cadres can identify growth problems correctly and understand PMT components according to the local context. Attitude: Most cadres have positive attitudes towards complementary feeding and growth monitoring. However, there is a slight discrepancy in understanding the importance of age and gender criteria in selecting recipients of supplementary feeding. A more in-depth educational approach on the application of these criteria should be introduced to improve consistency in program implementation. Practice: In terms of practice, although many cadres are actively involved in providing counseling and growth monitoring, involvement in data collection and planning with nutritionists is still lacking. Further training on the importance of accurate data and consistency in following the supplementary feeding schedule will improve the quality of the program. Overall, strengthening training and collaboration between cadres and nutritionists is needed to improve the effectiveness of growth monitoring and supplementary feeding programs.

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