

Improving Knowledge, Attitude, and Practices of Complementary Feeding Using Practical Intervention Training for Parents Living in Central Lombok, Indonesia: A Community-Based Study

by Lina Nurbaiti

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Improving Knowledge, Attitude, and Practices of Complementary Feeding Using Practical Intervention Training for Parents Living in Central Lombok, Indonesia: A Community-Based Study

Abstract

Background: Stunting remains a major public health concern in Indonesia despite many interventions. This study aimed to assess the effectiveness of interventions in the form of education and demonstration on preparing complementary feeding (CF) to increase knowledge, attitude, and practices (KAP) of CF among parents living in villages with high stunting prevalence in Central Lombok, Indonesia. **Materials and Methods:** This is a quasi-experimental community-based study, conducted from June to August 2019. Three villages were divided into three groups, i.e., control group (CG), education alone (EA) group, and education-demonstration (ED) group. We assessed KAP before and after intervention with a 4-week interval. **Results:** A total of 205 participants were enrolled in this study, consisting of 67, 70, and 68 participants in the CG, EA, and ED groups, respectively. In within-group analysis, parents' attitudes ($P = 0.015$) and practices ($P = 0.014$) improved in the ED group while only parents' practices ($P = 0.034$) improved in the EA group. In between-group analysis, parental attitude ($P = 0.039$) and practices ($P = 0.008$) improved in the ED group when compared to the CG. In the EA group, only parents' practices improved when compared to the CG ($P = 0.006$). There was no significant difference in KAP score in the EA and ED groups. **Conclusion:** A combined approach of education and demonstration works better to promote healthy CF practices among mothers.

Keywords: Attitude, complementary feeding, knowledge, practices, stunting

Introduction

Despite the government efforts in decreasing the national stunting prevalence to 30.8% in 2018, West Nusa Tenggara (WNT) province still had a high stunting prevalence compared to the average national prevalence (31.4% in 2018).^[1] Improving practices of complementary feeding (CF) is considered an essential component of stunting-specific interventions.^[2] After the first 6 months of life, breast milk falls short of providing full nutritional requirements for infants, and CF plays a critical role in providing sufficient nutrition for growing infants.^[3-5]

In general, CF practices in Indonesia were still suboptimal, in terms of introduction time, frequency, texture, feeding methods, hygiene, dietary quality (lack of animal-based protein), and adequacy of essential vitamin, minerals, and calories.^[5-7] Recent evidence shows that

health promotion through community platforms is an effective and potential way to reach all segments on nutrition interventions and health services.^[8]

Ensuring appropriate knowledge, attitude, and practices (KAP) of CF among parents in villages with high stunting prevalence in Central Lombok is important for success of stunting reduction programs. Therefore, this study aimed to explore the effectiveness of practical educational interventions in improving parents' KAP in practicing CF.

Materials and Methods

Research design

This was a quasi-experimental community-based study, in three villages of Central Lombok, WNT, Indonesia, with high stunting prevalence from June to August 2019. This regency has approximately 1 million people, or 20% of all the WNT population.^[9] Central Lombok regency

Jeslyn Tengkwawan^{1,2},
Ayu Anandhika Septisari²,
Zulfikar Ihyauddin²,
Titi Pambudi
Karuniawaty³,
Lina Nurbaiti³,
Nurhandini Eka Dewi⁴,
Ani Sekartini⁵

¹Bloomberg School of Public Health, Johns Hopkins University, Baltimore, USA, ²Yayasan Capella Project Indonesia, Jakarta, Indonesia, ³Department of Child Health, Faculty of Medicine, Mataram University, West Nusa Tenggara, Indonesia, ⁴Department of Child Health, Faculty of Medicine, University of Indonesia and Cipto Mangunkusumo Hospital, Jakarta, Indonesia, ⁵Indonesian Pediatric Society, West Nusa Tenggara Province, Indonesia

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Address for correspondence:

Dr. Jeslyn Tengkwawan,
Yayasan Capella Project
Indonesia, Taman Surya 5
Ruko Avenue Blok Kk1 No. 57,
Cengkareng, Jakarta Barat
11730, Indonesia.
E-mail: jeslynteng@yahoo.com

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was selected purposively due to its high contribution to stunting prevalence and proximity to the research center (Universitas Mataram).^[10,11] Three study villages (out of ten) were selected based on random sampling, using the village as the randomization unit. These villages were then categorized into no intervention (control group [CG]), education alone (EA) group (1-day seminar), and education-cum-demonstration (ED) group (1-day seminar along with workshop) using a random selection process. The study protocol and all amendments were reviewed and approved by the Health Research Ethics Committee of the Faculty of Medicine, Mataram University, in compliance with local law.

Population and subjects

All parents of 6–12 months children in those villages, who came to the monthly Integrated Service Post (*Pos Pelayanan Terpadu/Posyandu*), were invited to participate and provided a plain language statement and an informed consent form. The parents who did not consent, provide full information, or did not participate in the intervention were excluded.

Research procedures

All participants were interviewed by a trained research personnel using a validated questionnaire. Every eligible participant was assessed for their socioeconomic and anthropometric data. Anthropometric measurements were conducted with calibrated measuring instrument, using Omron weight scale and length board for baby, and measurement tape to measure upper arm length circumference and head circumference.

The KAP questionnaire consisted of 10 items for knowledge, 6 items for attitude, and 7 items for practices [Appendix 1]. After all eligible participants had been assessed and provided informed consent, research team scheduled the intervention sessions for the two intervention groups.

Interventions were delivered similarly to both arms by the same team consisting of general practitioners and a pediatrician. The details for interventions are as followed:

1. Educational session was delivered as a 90-min seminar without breaks for two topics, i.e., stunting and CF practices. Materials include CF principles, planning of CF, food safety and hygiene, CF menu arrangement, food processing and handling, CF preparation, and administration. All materials were based on guidelines published by the Indonesian Ministry of Health, the Indonesian Pediatric Society (IPS), and the WHO. Each participant received a booklet of CF practice published by the IPS and a stunting pamphlet published by the Indonesian Ministry of Health
2. Demonstration sessions were held as 60-min workshop [Appendix 2]. Participants were divided into seven

small groups (9–10 participants each) and provided with complete sets of food and tools needed for cooking. Participants were encouraged to try and practice: proper food handling; food safety and hygiene; types of food source, emphasizing on animal-protein source; right texture and amount of CF; and responsive feeding.

Due to the nature of the study, all participants were aware of their allocation; however, they did not know what were the interventions given to other villages. The second KAP assessment was conducted for all villages, with a 4-week interval from the first KAP assessment.

Statistical analysis

Collected data were analyzed with IBM SPSS Statistics version 22.0 (IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp). Double entry was performed before the analysis, to avoid data entry errors. The primary outcome was change in the knowledge, attitude, and practice score of participants, before and after intervention, i.e., in 4-week interval. We classified the KAP score into three categories, i.e., poor (0–4), moderate (5–7), and good (8–10) for knowledge; poor (3–8), moderate (9–13), and good (14–18) for attitudes; and poor (7–17), moderate (18–26), and good (27–35) for practices. The primary analysis was by intention to treat. The data were found to be nonparametric. Wilcoxon test for mean differences was used to compare pre- and posttests, while the inter-group comparison was calculated using analysis of variance test. Multivariate analysis using logistic regression was performed to obtain the odds ratios for intervention compared to CG using the difference between pretest and posttest as the outcome which was classified into a binary variable of decreased/able and improved, after adjusting for baseline score, mother's age, child's age, number of children, number of antenatal care attended, mothers' educational level, and family's income.

Results

Sociodemographic characteristics

A total of 205 participants were enrolled in this study, consisting of 67, 70, and 68 participants for CG, EA, and ED groups, respectively [Figure 1]. Most of the participants in the three groups (>60%) had low education, i.e., total education time of less than or equal to junior high school (9 years) and income which was under the provincial minimum wage in that area. The majority of participants had poor knowledge (75.1%), moderately appropriate attitude (62.4%), and moderately healthy practice (51.7%) in giving CF to children [Table 1].

Effectivity of intervention within and between each group

Within-group assessment showed a slight increase in knowledge after intervention compared to CG,

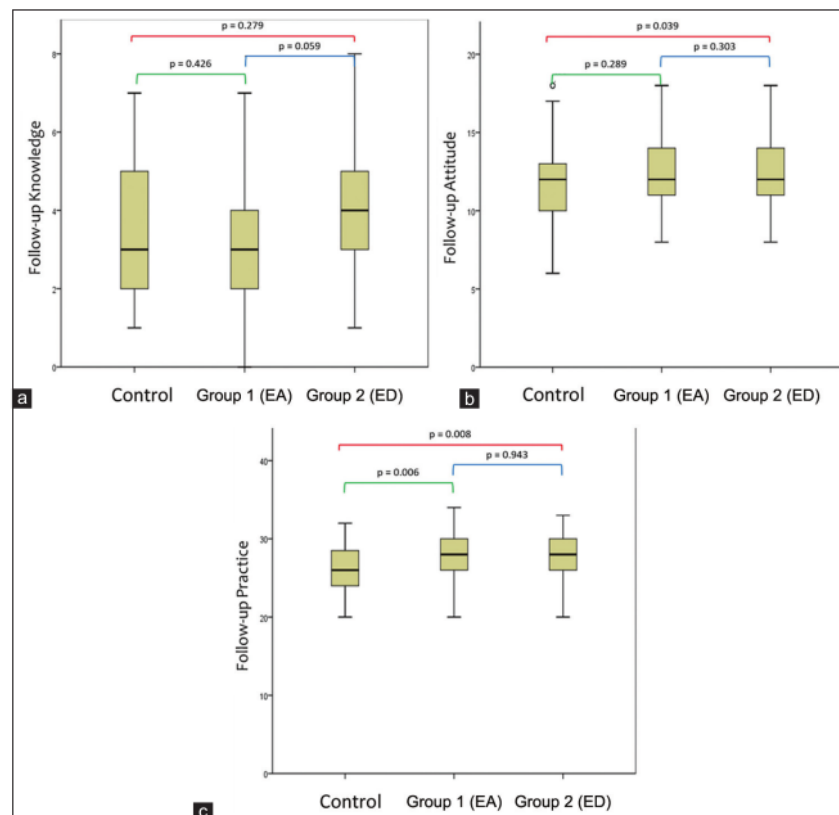


Figure 1: Between-group analysis (control vs. Group 1 (seminar only intervention) and Group 2 (seminar and workshop intervention) for parents' knowledge (a), attitude (b), and practice (c) using analysis of variance test. EA: Education alone, ED: Education-cum-demonstration

but not statistically significant³⁹ however, there were significant changes in practice in the first intervention group ($P = 0.034$) and attitudes²⁶ and practices aspects in the second intervention group ($P = 0.015$ and 0.014 , respectively [Table 2]).

The results for between-group analysis showed that EA intervention increased practice scores ($P = 0.006$), while combined education and demonstration intervention increased both practice ($P = 0.008$) and attitude ($P = 0.039$) scores significantly, compared to no intervention³⁶ the CG [Figure 1]. However, the between-group analysis showed that there was no difference between interventions in group 1 and group in changing parents' KAP scores ($P \geq 0.05$) [Figure 1]. After adjusting for potential confounders, the first and the second intervention groups show¹⁵ a significant increase only in parents' practices, i.e., adjusted odds ratio (aOR): 2.55 (95% confidence interval [CI]: 1.09–5.96) and aOR: 3.79 (95% CI: 1.58–9.08), respectively [Appendix 3].

Discussion

Our study showed that, in general, parents who lived in villages with high prevalence of stunting

in under-5-year-old children in Central Lombok, Indonesia, had poor knowledge (75.1%), moderate attitude (62.4%), and moderate practice (51.7%) related to CF of children. This finding was generally similar to other low-to-middle-income countries that also struggled with stunting problem²⁵ in their regions. For instance, only half of the parents in Pakistan (54%), Karachi (57.2%), and Ghana (60%) knew the correct time to give CF, while in Allahabad, India, only 38.7% of children received CF in correct frequency.^[12,13]

We observe that educational intervention had promoted a positive result in parents' practice, while the implementation of both education and practical demonstration resulted in better scores in parental attitudes and practices both. However, no statistically significant differences were observed between the two sets of interventions in improving parental total KAP score.

The inadequate improvement in parents' knowledge observed in both the intervention groups could be due to parent's low education level, the nature of the intervention (only conducted once). A study by Shi *et al.* in China which had follow-up data at 6 months showed

Table 1: Baseline characteristics of the three study groups

Variables	Control, n (%)	EA group, n (%)	ED group, n (%)
Overall	67 (32.7)	70 (34.1)	68 (33.2)
Mother's age (mean±SD)	28.12±6.71	27.46±6.55	28.03±7.81
Low (9 years/less)	43 (64.2)	46 (65.7)	42 (61.8)
Middle (high school)	17 (25.4)	22 (25.4)	15 (22.1)
High (diploma/bachelor)	7 (10.4)	2 (10.4)	11 (16.2)
Household income			
Low	60 (89.5)	50 (71.4)	50 (73.5)
Middle low	5 (7.5)	12 (17.1)	12 (17.6)
Middle high	2 (3.0)	8 (11.4)	6 (8.8)
Child's age (months) (mean±SD)	10.48±2.08	9.34±1.82	9.52±1.89
Child's sex			
Male	30 (44.8)	26 (37.1)	33 (48.5)
Female	37 (55.2)	44 (62.9)	35 (51.5)
Parents' knowledge of complementary feeding			
Poor (0-4)	44 (65.7)	56 (80)	54 (79.4)
Moderate (5-7)	23 (34.3)	10 (14.3)	10 (14.7)
Good (8-10)	0	4 (5.7)	4 (5.9)
Parents' attitude of complementary feeding			
Poor (3-8)	15 (22.4)	4 (5.7)	10 (14.7)
Moderate (9-13)	43 (64.2)	42 (60)	43 (63.2)
Good (14-18)	9 (13.4)	24 (34.3)	15 (22.1)
Parents' practice in complementary feeding			
Poor (7-17)	1 (1.5)	0	0
Moderate (18-26)	39 (58.2)	34 (48.6)	33 (48.5)
Good (27-35)	27 (40.3)	36 (51.4)	35 (51.5)

SD: Standard deviation, EA: Education alone, ED: Education-cum-demonstration

Table 2: Within-group analysis of parents' knowledge, attitude, and practices before and after the intervention*

Variables	Control, n (%)	Group 1 (EA), n (%)	Group 2 (ED), n (%)
Overall	67 (32.7)	70 (34.1)	68 (33.2)
Knowledge differences (P) ^a	0.297	0.528	0.178
Decrease/stable	43 (64.2)	42 (60)	36 (52.9)
Increase	24 (35.8)	28 (40)	32 (47.1)
Attitude differences (P)	0.128	0.631	0.015
Decrease/stable	31 (46.3)	40 (57.1)	29 (42.6)
Increase	36 (53.7)	30 (42.9)	39 (57.4)
Practice differences (P)	0.257	0.034	0.014
Decrease/stable	36 (53.7)	32 (45.7)	25 (36.8)
Increase	31 (46.3)	38 (54.3)	43 (63.2)

*Wilcoxon signed ranks test. EA: Education alone, ED: Education-cum-demonstration

that the intervention group had a significant improvement in parent's CF practices.^[14] However, in this study, the intervention included home visits in addition to the combination of group training, demonstration, and booklet administration. Moreover, their interventions were delivered in multiple sessions, rather than once.

In the implementation of the intervention, the involvement of community health workers is important to ensure a successful intervention for the community. However, several aspects could still be improved, such as implementing additional interpersonal session with the participants by having an individual counseling and home visit. This method was implemented³⁰ Hotz and Gibson in Malawi and resulted in improved knowledge and behavior on food selection and preparation of parents.^[15] Another study by Shi *et al.* also noted that the involvement of family members³⁴ mainly husband and parents-in-law, is also essential to create a supportive environment for the improvement of parents on preparing CF.^[14] This China study showed a significant result after a 12-month follow-up period, both in parent's practice on giving various meal compositions, such as meats and beans and in children's anthropometry, i.e., increased weight gain (0.22 kg more weight for the intervention group) and increased length (0.66 cm more length in the intervention group).^[14]

While due to its design, there was lack of blinding, its effect was minimized by training all the trainers prior to the interventions to give a standardized and similar intervention for both the intervention groups. Second, no other child-specific intervention was given which might have further been more effective. Not including other family members and a short follow-up were other limitations.

Conclusion

Parents who lived in villages with high stunting prevalence in Central Lombok had low KAP on CF. It is possible to improve attitude and practice related to CF of mothers using educational approaches of seminars and demonstrations. Its integration into regular health system should be explored. In addition, improving CF KAP requires multidimensional approaches.

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Declaration

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This manuscript has been read and approved by all the authors, the requirements for authorship as stated earlier in this document have been met, and each author believes that the manuscript represents honest work.

Ethics approval

ical permission for conducting the study was granted by the Ethical Committee for Medical Research, Faculty of Medicine, the University of Mataram, Indonesia. Register No: 376/UN18.8/ETIK/2018.

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Conflicts of interest

There are no conflicts of interest.

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Appendix

Appendix 1: Knowledge, attitude, and practice question items

Knowledge

Statements	Correct answer
Complementary feeding should be started from 7 months	False
Complementary foods should contain carbohydrates, while proteins, fats, vitamin, and minerals enough at the small portions	False
Homemade complementary foods are healthier than instant complementary foods	False
Coconut milk can be given to increase fat consumption in children	True
Foods can be reheated after being left at room temperature for >2 h	False
Honey can be given as a complementary food since 6 months of age	False
Feeding can be conducted up to 1 h	False
Wasted children should be given formula milk as an addition	False
Tofu, tempeh, and nuts are far more important than animal proteins, such as eggs and chicken	False
Vegetables should be given at least half of complementary food portion	False

Attitude

Statements	Agree	Neutral	Disagree
Complementary foods can be given to children <6 months			
Breast milk or formula milk can be yielded if complementary feeding has been started			
Children should be forced to eat			
Feeding practice can be done >30 min			
High-carbohydrate foods should take the largest portion in complementary foods			
Children who first started complementary feeding practice, can only be given one type of food			

Practice

Statements	Never	Seldom	Rarely	Often	Always
I give complementary foods three times a day					
I give breast milk even when my child has started complementary feeding					
If my children do not have appetite, I will keep forcing them					
I wash my hands with soap before preparing complementary foods					
I separate cooked and raw foods					
I feed my children <15 min					
I give animal-sourced proteins, such as meat, egg, fish, and chicken					

Appendix 2: Pictures of complementary feeding cooking workshop

Picture A. Our team explained and promoted good complementary feeding practices



Picture B. We provided types of food that can be used as complementary feeding, including the right amount and the importance of animal protein.



Appendix 3: Multivariate logistic regression for changes in complementary feeding knowledge, attitude, and practices

	Knowledge		Attitude		Practice	
	OR	P	OR	P	OR	P
	(95% CI)		(95% CI)		(95% CI)	
Control group	Reference		Reference		Reference	
EA group	1.25 (0.56-2.80)	0.585	1.10 (0.46-2.63)	0.835	2.55 (1.09-5.96)	0.031
ED group	1.54 (0.71-3.37)	0.275	1.67 (0.73-3.86)	0.227	3.79 (1.58-9.08)	0.003

Adjusted for baseline scores, mother's age, children's age, antenatal care attendance, mother's educational level, and family. EA: Education alone, ED: Education-cum-demonstration, OR: Odds ratio, CI: Confidence interval

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