Enhance Policy an Evaluation of South Nias Health Department in Implementation Stunting Management in South Nias District Year 2021

Swasti Elisabet Duha[1], Ermi Girsang[2], Sri Lestari Ramadhani Nasution[3]

[1]Master Program of Public Health, Faculty of Medicine, Universitas Prima Indonesia, Medan
[2]Lecturer, Public Health Master Study Program, Faculty of Medicine, Universitas Prima Indonesia, Medan
[3]Lecturer, Public Health Master Study Program, Faculty of Medicine, Universitas Prima Indonesia, Medan

Abstract— *Stunting is a chronic nutritional problem, namely the failure of a child to grow and develop optimally due to the impact of cumulative and continuous malnutrition so that the child is too short for his age. The purpose of the study was to analyze the policies of the South Nias Health Office in the implementation of stunting prevention in the South Nias Regency in 2021. This study was designed to use a qualitative case study approach that uses in-depth interviews and observation methods. The study was conducted in South Nias Regency in May 2021. The population in this study was 9 employees who worked at the South Nias Health Office. The sampling technique in this study used the Total Sampling technique. The results of the research on the implementation of the STBM Program (Community-Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region assisted by village heads, hamlet heads, local officials, and the surrounding community. Family-Based PHBS (Clean Living Behavior) Program. The Posyandu Program with Its Focus, Among Other Things, Overcoming Stunting is a posyandu program that focuses on addressing stunting, that the posyandu continues to carry out health education, especially to pregnant women and newly married mothers with a pregnancy program to have the will and focus on the nutritional level of the mother and fetus. during pregnancy, we provide counseling about what nutrition is good during pregnancy to prevent stunting at birth, then we have a program for pregnant women with pregnancy exercises and health checks for pregnant women. Food Fortification Program that food fortification in the form of Iodine is not carried out because there are no reports that the salt consumed does not contain Iodine. Equitable supply of nutritious food for children and pregnant women in the form of manufacturing (bread) to all pregnant women and toddlers has been running every month at the posyandu with the target of pregnant women with chronic energy deficiency (KEK) with an upper arm circumference of less than 23.5 cm and undernutrition under five, Below the red line, 2 T (two consecutive weighing does not increase) and for the provision of local food ingredients sourced from local wisdom, it is given to all pregnant women and toddlers who come to the posyandu. Suggestions for education as an additional reference in scientific development in the health sector regarding stunting in the community, for health centers as input for health centers in implementing education to reduce the incidence of stunting, for further researchers as an additional reference in developing further research with different variables and research methods different.*

Keywords— *Health Service Policy, Stunting Prevention.*

I. INTRODUCTION

The problem of malnutrition in the First 1000 Days of Life (HPK) begins with a slowdown or retardation of fetal growth known as IUGR (Intra Uterine Growth Retardation). Malnutrition in pre-pregnancy and pregnant women has an impact on the birth of IUGR and LBW children. Almost half of IUGR conditions are related to the nutritional status of the mother, namely the weight (BB) of the pre-pregnant mother that is not by the mother's height or short stature, and the weight gain during pregnancy (PBBH) is less than it should be. Children who are short at the age of 2 years tend to be short when they reach adulthood. Short pregnant women will tend to give birth to LBW babies (Victoria CG et al., 2016).

The World Health Organization (WHO) (2016) defines stunting (short) as a hidden tragedy. The global target is to reduce stunting by 40 percent by 2025 (Balitbangkes RI, 2015).

Based on the 2016 Human Development Report, Indonesia's HDI in 2015 was ranked 113, down from 110 in 2014 from 188 countries, while the Intelligence Level of Indonesian children in the fields of reading, mathematics, and science was in position 64 out of 65 countries (OECD PISA, 2012), and Indonesian children lag far behind Singaporean children (2nd position), Vietnam (17th position), Thailand (50th position) and Malaysia (52nd position). In 2030, according to Bambang, the

productive age group (15-64 years) is predicted to reach 68 percent of the total population and the older generation (65 and over) is around 9 percent. Meanwhile, the 2013 Basic Health Research (Riskesdas) showed that 37.2 percent (9 million children under five) in Indonesia in 2013 experienced stunting. This means that one in three children under five in Indonesia suffers from stunting.

According to Mitra (2015) that the 2015 Nutrition Status Monitoring (PSG) results, 29 percent of children under five in Indonesia are in a short category. Based on the age group of children under five, the older the age, the prevalence of stunting increases. The results of the Basic Health Research (Riskesdas) in 2010 found that the prevalence of stunting in Indonesia was 35.6 percent, whereas there was an increase in 2013 to 37.2 percent. The prevalence of stunting was highest at the age of 24-35 months, which was 42 percent, and decreased in children aged 36-47 months (39.7%) (Riskesdas, 2016).

Lintelo et al., (2016) explained that the commitments that have been built by the government need to be evaluated and one of the instruments that assess the government's commitment to the stunting problem can be seen with The Hunger and Nutrition Commitment Index (HANCI). HANCI itself consists of 2 sub-indices, namely the Hunger Reduction Commitment Index (HRCI) and the Nutrition Commitment Index (NCI). HRCI is more concerned with the government's commitment to

reducing hunger, while NCI is more concerned with the government's commitment to overcoming the problem of malnutrition. This research is because it discusses stunting, researchers focus more on looking at only one sub-index, namely the NCI, the reason is that NCI sees the government's commitment to reducing stunting.

II. LITERATURE REVIEW

2.1. Definition of Stunting

Stunting is one of the nutritional problems that occur in toddlers. Stunting that occurs in toddlers is the result of nutritional problems that have occurred since the beginning of their lives (UNICEF, 2017).

Stunting toddlers are toddlers who have a height that is not by their age, as indicated by the z-score of the height based on age, which is less than minus two SD (< -2 SD) (Kemenkes RI, 2016).

Stunting is a chronic condition that describes stunted growth due to malnutrition in the long term. According to the Decree of the Minister of Health Number 1995/MENKES/SK/XII/2010 concerning Anthropometric Standards for Assessment of Child Nutritional Status, the definition of short and very short is nutritional status based on the Body Length Index for Age (PB/U) or Height for Age (TB). /U) which is a term for stunted (short) and severely stunted (very short). Short toddlers are toddlers with nutritional status based on length or height according to the age when compared to the WHO standard, the Z-score value is less than -2SD and is categorized as very short if the Z-score value is less than -3SD (Kemenkes, RI 2016).

Susceptibility to degenerative and allergic diseases is caused by changes in normal flora in the digestive tract, metabolic response, and immune function (Luo et al., 2013; Rzehak et al., 2013; Dugas et al., 2016). Stunting toddlers as adults will experience stunting and this will affect their income because for every 1 cm increase in height, the income for adult men will increase by 4% and for adult women, it will increase by 6% (McGovern et al., 2017).

Stunting is a condition where toddlers have a length or height that is less than their age. This condition is measured by a length or height that is more than minus two standard deviations of the WHO child growth standard median. Stunting is caused by inadequate nutritional intake for a long time due to feeding that is not by nutritional needs. Stunting can occur from the time the fetus is still in the womb and only appears when the child is two years old (Kemenkes RI, 2018).

2.2. Maternal Factors with Stunting in Toddlers

Factors related to the mother (maternal) that affect the incidence of stunting in toddlers are maternal height, maternal age during pregnancy, birth order, close birth spacing, anemia during pregnancy, smoking during pregnancy, weight gain during pregnancy, age pregnancy during childbirth, history of abortion, fulfillment of nutritional intake before pregnancy, pregnancy and lactation, presence of infectious diseases during pregnancy and hypertension (WHO, 2013; Pandey et al., 2017). In this study, several maternal factors will be studied, namely maternal height, maternal age during pregnancy, birth order,

anemia during pregnancy, increased weight during pregnancy, and lack of energy and protein during pregnancy.

2.3 Stunting Classification

Stunting is defined as a condition of toddlers, where height for age is below minus 2 Standard Deviations (<-2SD) from the WHO median standard. The most frequent assessment of the nutritional status of children under five is using anthropometric assessment. In general, anthropometry relates to various measurements of body dimensions and body composition of various ages and nutritional levels. Anthropometry is used to see the imbalance of protein and energy intake. Some anthropometric indices that are often used are weight for age (W/W), height for age (TB/U), weight for height (W/TB) which is expressed by the standard deviation unit Z (Z-score) where anthropometric measurement results show a Z-score of less than -2SD to -3SD (short/stunted) and less than -3SD (very short/stunted) (Kemenkes RI, 2018). According to the Ministry of Health R1 (2018), the classification of nutritional status will be explained in the following table:

TABLE I. Nutritional Status Classification

Indeks	Status Gizi	Z-Score
Nutritional Status Index	Malnutrition	≤ -3 SD
Weight for age (W/W)	Malnutrition	≥ -3 SD To ≤ -2 SD
	Good nutrition	≥ -2 SD To ≤ -2 SD
	More nutrition	≥ 2 SD
Height by Age (TB/U)	Very short	≤ -3 SD
	Short	-3 SD To < -2 SD
	Normal	-2 SD
Weight According to Height (BB/TB)	Very thin	≤ -3 SD
	Thin	≥ -3 SD With ≤ -2 SD
	Normal	≥ -2 SD With ≤ -2 SD
	Fat	≥ 2 SD
Body mass index by age (BMI/U)	Very thin	≤ -3SD
	Thin	-3SD To ≤ -2 SD
	Normal	-2SD To 2SD
	Fat	≥ 2 SD

2.4 Factors Affecting Stunting Incidence

Family and household factors are further divided into maternal factors and home environmental factors. Maternal factors include poor nutrition during preconception, pregnancy and lactation, low maternal height, infection, teenage pregnancy, mental health, Intrauterine Growth Retardation (IUGR) and preterm birth, short birth spacing, and hypertension. Home environmental factors in the form of inadequate stimulation and activities of children, lack of care, inadequate sanitation, and water supply, lack of access and availability of food, inappropriate allocation in the household, and low education of caregivers. These factors include:

a. Women of Childbearing

Age with LILA <23.5 cm, Insufficient energy and protein intake in pregnant women can cause Chronic Energy Deficiency (KEK). Pregnant women are at risk for CED if they have an Upper Arm Circumference (LILA) <23.5cm. SEZ pregnant women are at risk of giving birth to low birth weight (LBW) babies which if not handled properly will be at risk of stunting (Kemenkes, RI 2016).

b. Energy Adequacy of Pregnant Women

Energy adequacy of pregnant women in Indonesia based on the Energy Adequacy Rate (AKE) from the 2014 Total Diet Study (SDT) is more than 50% of pregnant women both in urban and rural areas, their energy intake is 70% AKE (very low) (Ministry of Health, Republic of Indonesia, 2016).

c. Anemia in Pregnant Women

The condition that often occurs in pregnant women is anemia, especially iron-deficiency anemia. This can affect the growth and development of the fetus/baby during pregnancy and after birth. It is estimated that 41.8% of pregnant women worldwide are anemic. At least half of it is due to iron deficiency. Pregnant women are declared anemic if the hemoglobin is less than 11 mg/dl (Kemenkes RI, 2015). Riskesdas (2015) found that anemia occurred in 37.1% of pregnant women in Indonesia, 36.4% of pregnant women in urban areas, and 37.8% of pregnant women in rural areas (Kemenkes RI, 2016).

d. Mother's Height

The nutritional status of parents, especially the nutritional status of mothers, is closely related to the incidence of stunting in toddlers. It can be seen from the short mother, even though the father is normal, the prevalence of stunting under five is high, but even if the father is short, the mother is normal, the prevalence of stunting under five is still lower than the short mother. So the nutritional status of pregnant women determines the nutritional status of the baby to be born (Oktarina, 2016).

Mother's height is an indicator that serves to predict children affected by malnutrition. The mother's body posture also reflects the mother's height and the initial environment which will contribute to the height of her child. However, there are still many environmental factors that affect a child's height. The results showed that mothers who had short stature had a relationship with the incidence of stunting in their children. This is called the cycle of failure to thrive between generations, where IUGR, LBW, and stunting occur from generation to generation from one generation to the next.

e. Birth Weight

Low birth weight (LBW) is a baby's birth weight of fewer than 2500 grams. During pregnancy, the growth of the embryo and fetus takes place very quickly, from less than a milligram to about 3000 grams. This rapid growth is very important for the fetus to survive outside the womb. So, defects or deficiencies that occur during the fetal period are the main cause of poor health and death in infants (Oktarina, 2012). Birth weight is a strong predictor of future human body size. This is because most IUGR babies cannot catch up with their growth period to grow normally like other normal children (Oktarina, 2015).

According to WHO in 2004, the etiological factors that contribute to the incidence of low birth weight, especially in developing countries include tobacco use (smoking, consumption of chewing tobacco and tobacco for therapeutic purposes), lack of calorie intake, low body weight before pregnancy, primipara, type fetal sex, short stature, race, previous history of low birth weight, general morbidity, and environmental risk factors such as lead exposure (Putra, 2016).

LBW is closely related to fetal mortality and morbidity. This situation can inhibit cognitive growth and development, susceptibility to chronic disease later in life. At the population level, the proportion of infants with LBW is a picture of a multi-problem of public health including long-term malnutrition, poor health, poor health care, and pregnancy. Individually, LBW is a predictor of the health and survival of newborns. This is associated with a high risk of infant and child mortality (Putra, 2016).

2.5 Stunting Impact

Stunting causes a child's brain to be underdeveloped. This means that 1 in 3 Indonesian children will miss out on better opportunities in education and employment for the rest of their lives. Stunting is not only a short physical size but rather on the concept that the process of stunting coincides with the process of inhibition of growth and development of other organs, including the brain (Achadi, 2016).

The bad effects of stunting in the short term can cause brain disorders, intelligence, physical growth disorders, and metabolic disorders in the body. While in the long term the bad consequences that can be caused are decreased cognitive abilities and learning achievement, decreased immunity so that it is easy to get sick, high risk of diabetes, obesity, heart, and blood vessel disease, cancer, stroke, and disability in old age, and quality of work. uncompetitive which results in low economic productivity (Kemenkes RI, 2016).

III. METHOD OF RESEARCH

3.1 Research Types and Designs

This research was designed using a qualitative case study approach that uses in-depth interviews and observation methods. Qualitative research is research that intends to understand the phenomenon of what is experienced by research subjects such as behavior, how to describe it in words and language, in a special natural context, and by utilizing various natural methods (Moleong, 2014). The purpose of this study is to evaluate the policy of the South Nias Health Office in the Implementation of Stunting Prevention in the South Nias Regency in 2020.

3.2. Research Population

According to Sudjana (2010), the population is the totality of all possible values, the results of which are calculated or measured, quantitatively or qualitatively regarding certain characteristics of all members of a complete and clear group who want to study their properties. The population in this study were employees who worked in the South Nias Health Office. The total population of employees is 9 people consisting of 1 head of the health office, 1 secretary of the health office, 3 heads of fields, and 4 heads of sections.

3.3. In-depth Interview

The data collection carried out in this study used an in-depth interview method conducted by the researchers themselves with a duration of 30-60 minutes. In-depth interviews are in-depth questions and answers to participants. Here the researcher will try to dig up as much information as possible to the health service employees by the research sample to fulfill the data needed by the researcher from the participants by the research

sub focus that has been set by the researcher. The interview was conducted by compiling several questions as an interview guide.

The interview guide contains questions posed to participants, where the questions are made by the researcher himself. Interview guides are made based on theoretical foundations that are relevant to the problems to be explored in the research. The interview guide is in-depth, begins with open-ended questions, and is not rigid. Questions can develop according to the ongoing process during the interview without leaving the theoretical foundation that has been established. The interview guide was made to make it easier for researchers so that the interviews were directed and by the research objectives. In addition, interview guides were used to remind researchers of the main issues discussed (Streubert & Carpenter, 2015).

In the interview, the researcher also used a voice recorder and field notes to collect data. Voice recorders are used to record the results of interviews conducted by researchers with participants, while field notes which are written notes are used as notes for what is heard, seen, experienced, thought by researchers in the context of collecting data and reflecting on data in qualitative research in the form of response documentation. non-verbally during the interview process.

The results of the voice recorder were then rewritten in the form of researcher transcripts and field notes in this study containing the date, time, atmosphere of the place, descriptions or descriptions of participants, as well as participants' non-verbal responses during the interview process. To complement the results of the researcher's interviews, the researchers also documented in the form of pictures or photos between the researcher and the participants during the interview.

3.6 Data Analysis

The data analysis technique used in this study uses the analysis proposed by Miles and Huberman (Afrizal, 2016). Which consists of data reduction, data display, and conclusion drawing/verification which are processed in the following stages: (Afrizal, 2016).

1. Data Reduction (Data Reduction)

After the researcher finished conducting interviews with the participants, the researcher then summarized the results of the interviews conducted into a single transcript. From the transcript that has been made by the researcher, the researcher then selects the main things, focuses on the important things, looks for themes and patterns. After being reduced, the data obtained by the researcher will provide a clearer picture of the Implementation of Stunting Prevention in the South Nias Regency.

2. Data Display

After data reduction, the next step is to display the data using tables to assess the validity of the data which includes explaining the results of interviews and triangulation that has been made by researchers based on other data sources. So that the data obtained by the researcher is organized, arranged in a relationship pattern, and easier to understand.

3. Conclusion Drawing/Verification

After the researcher did the coding of the interview results and based on strong evidence that supported the data collection

stage. Then the researcher concludes the new findings based on the data that has been collected as a whole.

IV. ANALYZE AND RESULT

4.1 Overview of Research Locations

South Nias Regency is one of the regencies in North Sumatra Province, with a total area of 1,825.20 km² and consists of a group of large and small islands totaling 104 islands. The administrative boundaries of the government of South Nias Regency are as follows:
☐ Northside: Nias Regency and West Nias Regency
☐ Southside: Mentawai Islands, West Sumatra Province
☐ East side: Mursala Islands, Central Tapanuli Regency and Mandailing Natal Regency.
☐ West: Indian Ocean

4.2 In-depth Interview Results

- Participant 1

The results of the interview regarding the Implementation of the STBM (Community-Based Sanitation) Program Cross-Sectoral and Involving Stakeholders Per Region which is explained by participant 1 as follows:

"... STBM is carried out by monitoring, monitoring, and following up such as evaluating the community for the implementation of STBM. The success rate in achieving STBM implementation in the village is due to the factor of cooperation with the village head and the community in the village environment.

Based on the quote from the informant above, information can be obtained that the Implementation of the STBM Program (Community Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is STBM is carried out by monitoring, monitoring, and following up such as evaluating the community for the implementation of STBM.

- Participant 2

The results of the interview regarding the Implementation of the STBM (Community-Based Sanitation) Program Cross-Sectoral and Involving Stakeholders Per Region are explained by participant 2 as follows:

"... The implementation of STBM so far has reached villages in the working area assisted by related parties such as hamlets, village heads, and local officials, and cooperation from the surrounding community to achieve STBM. The implementation that has been carried out is then monitored and evaluated for reporting on the results of the STBM implementation that has been carried out".

Based on the quote from the informant above, information can be obtained that the Implementation of the STBM Program (Community Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is that STBM implementation has been carried out to villages assisted by village heads, hamlet heads, local officials and the surrounding community.

- Participant 3

The results of the interview regarding the Implementation of the STBM Program (Community Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region which is explained by participant 3 as follows:

".... The implementation of STBM is involved with surrounding parties, such as if STBM is carried out to the village, then the parties involved are village leaders such as village heads, local assistant officials and involve the community in the village so that the STBM implementation can run which is then evaluated by sectoral parties as part of village activities".

Based on the quote from the informant above, information can be obtained that the Implementation of the STBM Program (Community-Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is that STBM implementation is involved with surrounding parties as if STBM is carried out in the village, the parties involved are village leaders such as village heads, local assistant officials and involving the community in the village.

- Participant 4

The results of the interview regarding the Implementation of the STBM Program (Community Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region which is explained by participant 4 as follows:

"... The implementation of STBM starts from the villages, then to the sub-districts to the districts, the implementation is carried out by involving leaders in each village, sub-district, and district who are assisted by the puskesmas in monitoring the level of success of STBM in the implementation area so that the implementation of STBM can be carried out and accessible to the parties concerned.

Based on the quote from the informant above, information can be obtained that the Implementation of the STBM Program (Community-Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is the Implementation of STBM starting from the villages, then to the sub-district to the district, the implementation is carried out by involving leaders in each village, sub-district, and district. districts that are assisted by the puskesmas in monitoring the success rate of STBM in the implementation area so that the implementation of STBM can be carried out and reached by related parties.

- Participant 5

The results of the interview regarding the Implementation of the STBM Program (Community Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region which is explained by participant 5 as follows:

"... STBM is carried out in each sector under the auspices of the health office involving the puskesmas which then related parties from the health office and puskesmas go directly to the field or the community to monitor community-based total sanitation which consists of washing hands thoroughly, waste treatment household, household food processing. STBM activities have been carried out in villages assisted by the village responsible party or village head to involve the community in the implementation of STBM.

Based on the quote from the informant above, information can be obtained that the Implementation of the STBM Program (Community-Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is that STBM activities have been carried out to villages assisted by the village responsible party.

4.3. Implementation of the STBM (Community-Based Sanitation) Program Cross-Sectoral and Involving Stakeholders Per Region

According to the Ministry of Health, R.I, (2012) that Community-Based Total Sanitation (STBM) is an approach to change hygiene and sanitation behavior through empowerment with the triggering method. The goal of STBM is to achieve total sanitation conditions by changing hygiene and sanitation behavior through community empowerment which includes 3 components, namely the creation of a supportive environment, increasing sanitation needs, increasing sanitation provision, and developing innovations according to the regional context. STBM implementation is carried out through stages of activities involving all stakeholders. All stages of preparation for STBM implementation at all levels must pay attention to cross-sectoral and cross-stakeholder coordination, including across drinking water and sanitation development programs so that integration in the preparation and implementation of STBM can be achieved.

Based on the results of interviews conducted by researchers to participants that the Implementation of the STBM Program (Community Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is that STBM implementation has been carried out to villages assisted by village heads, hamlet heads, local officials, and the surrounding community.

According to the Ministry of Health of the Republic of Indonesia, (2012) the government prepares tools to operationalize the STBM national policy and facilitate the provision of resources including funding that supports capacity building for the development of the STBM approach through various funding alternatives, increasing capacity and monitoring system tools, disseminating and facilitating product development. knowledge and learning and the creation of incentive systems.

The involvement of other stakeholders (donors, NGOs, the private sector, educational institutions, religious institutions) supports the efforts of the Government and Local Governments in the implementation of the STBM program in the form of financial support, advocacy, and technical assistance. The support provided by these non-government institutions can be carried out at various levels of government as well as at the implementation stage, by the presence and capacity of the stakeholders. This support must be coordinated with the Government/Regional Government as well as coordinating institutions in the local area so that it is in line with and synergizes with STBM national policies and strategies. The role of the community is as the main actor, motivator, and facilitator of STBM in the preparation of action plans, implementation, monitoring, and evaluation of the prepared action plans.

4.4. Family-Based PHBS (Clean Living Behavior) Program

Implementing PHBS in the household will certainly create a healthy family and be able to minimize health problems. The benefits of PHBS in the household include, each family member can improve welfare and is not susceptible to disease, a healthy household can increase the productivity of household members and the next benefit of household PHBS is that family

members are accustomed to implementing a healthy lifestyle and children can grow up healthy and adequate nutrition.

Health problems often arise in the community without realizing it and the cause is known. This happens because of the low level of public knowledge about health in the community. These health problems that often arise include high maternal and child mortality rates, poor nutrition, infectious and non-communicable diseases, unhealthy lifestyles, and others.

Based on the results of interviews conducted by researchers to participants that the family-based PHBS Program is the basic goal of implementing clean and healthy living behavior, from home we train children and members to get used to doing clean and healthy living behaviors with small examples of washing hands before and after eating, then the puskesmas will carry out monitoring to family homes to follow up on the implementation of PHBS although sometimes not all of them have a high level of awareness to implement PHBS, but for this activity, we always support and provide counseling.

According to the results of research conducted by Taufik M (2013) in Parangloe Sub-district, Makassar City, the results showed that 71% of households gave birth by health workers, provided 91% of exclusive breastfeeding, weighed infants and toddlers 94%, used 99% clean water, used 90% healthy latrines, eradicate mosquito larvae 93%, family consumption of vegetables and fruit 66%, a family does not smoke 28%.

According to the results of research by Noviati S and Maywati (2014) showed the average application of PHBS in household arrangements was as much as 82%, the most behavior was the use of clean water and 99% physical activity.

4.5 Equitable Supply of Nutritious Food for Children and Pregnant Women

Breastfeeding until the age of two years has been widely reported to have many short-term and long-term benefits for children and mothers (Horta & Victora, 2013). WHO, UNICEF, and the Indonesian Ministry of Health recommends that infants should be exclusively breastfed for the first six months from birth and thereafter the introduction of complementary foods in solid or semi-solid form along with continued breastfeeding until the age of 24 months. The 2015-2019 RPJMN target for exclusive breastfeeding is likely to be achieved. Despite these obvious achievements, the practice of infant and young child feeding (IPM) in Indonesia is still woefully inadequate. While 61% of mothers started breastfeeding within the first hour of their baby's birth, only half (54%) continued to breastfeed until the age of two (BPS & MoH, 2017). More than a third (37%) of mothers in 2012 bottle-fed their children between the ages of 0-23 months which increases the risk of infectious diseases such as diarrhea due to the difficulty of sterilizing the pacifier on the bottle properly (BPS & Ministry of Health, 2012). In addition, the types of complementary foods introduced are not adequate to meet the nutritional needs of children who are still growing. In 2012, only 58.2% of children aged 6 to 23 months received meals with four or more food groups. This means that almost half of all Indonesian children do not receive the nutrition they need during the first two years of life to grow and develop optimally.

Based on the results of interviews conducted by researchers to participants that Equitable Supply of Nutritious Food in the form of manufacturers (bread) to all pregnant women and toddlers has been running every month at the posyandu with the target of pregnant women with chronic energy deficiency (KEK) with upper arm circumference less than 23.5 cm and toddlers Malnutrition, Below the red line, 2 T (two consecutive weighing does not increase) and for the provision of local food ingredients sourced from local wisdom, it is given to all pregnant women and toddlers who come to the posyandu.

V. CONCLUSION

Based on the results of research that has been done through interviews and observations, it can be concluded that the phenomena that occur are:

a. Implementation of the STBM Program (Community-Based Sanitation) Cross-Sectoral and Involving Stakeholders Per Region is the implementation of STBM has been carried out to villages assisted by village heads, hamlet heads, local officials, and the surrounding community.

b. The Family-Based PHBS (Clean Living Behavior) Program is the basic goal of implementing clean and healthy living behavior, from home we train children and members to get used to doing clean and healthy living behaviors with small examples of washing hands before and after eating, then from the puskesmas will monitoring family homes to follow up on the implementation of PHBS although sometimes not all of them have a high level of awareness to implement PHBS, but for this activity, we always support and provide counseling.

c. The Posyandu Program with Its Focus, Among Other Things, Overcoming Stunting is a posyandu program that focuses on addressing stunting, that the posyandu continues to carry out health education, especially to pregnant women and newly married mothers with a pregnancy program to have the will and focus on the nutritional level of the mother and fetus. during pregnancy, we provide counseling about what nutrition is good during pregnancy to prevent stunting at birth, then we have a program for pregnant women with pregnancy exercises and health checks for pregnant women. Then when the child is born, we provide information for the child to be brought to the posyandu regularly so that the health center and posyandu can monitor the development and abnormalities experienced by the baby so that it can be anticipated, but the implementation has not been fully followed by pregnant women and mothers after giving birth on the grounds work and personal affairs.

d. Food Fortification Program that food fortification in the form of iodine is not carried out because there are no reports that the salt consumed does not contain Iodine increase the nutritional value of infants and children.

e. The Equitable Supply of Nutritious Food for Children and Pregnant Women that the Equitable Supply of Nutritious Food in the form of manufacturers (bread) throughout pregnant women and toddlers has been run.

REFERENCES

1. Adani, F. Y., & Nindya, T. S. (2017). Perbedaan Asupan Energi, Protein, Zink, dan Perkembangan pada Balita Stunting dan non Stunting. *Amerta Nutrition*, *1*(2), 46-51.

2. Agustina, A. 2015. *Faktor-faktor Risiko Kejadian Stunted pada Balita (24-59 bulan) di Wilayah Kerja Puskesmas Sosial Palembang Tahun 2014.Skripsi.* Fakultas Kesehatan Masyarakat Universitas Sriwijaya.

3. BAPPENAS. 2011. *Rencana Aksi Nasional Pangan dan Gizi 2011-2015*.

4. Badan Perencanaan Pembangunan Nasional (BAPPENAS). Jakarta: 10. Lembaga Penerbitan Balitbangkes Kementerian Kesehatan Republik Indonesia. (2015). Riskesdas 2015.

5. De Onis, M., & Branca, F. (2016). Childhood stunting: a global perspective. *Maternal & child nutrition*, *12*, 12-26.

6. Kemenkes RI. 2015. Buku Kesehatan Ibu dan Anak. Kementerian Kesehatan dan JICA. Jakarta.

7. Kesehatan K. Pusat Data Dan Informasi Situasi AnakPendek. Jakarta: Kementerian Kesehatan Replubik Indonesia; 2016

8. Lestari, W., Margawati, A., & Rahfiludin, Z. (2016). Faktor risiko stunting pada anak umur 6-24 bulan di kecamatan Penanggalan Kota Subulussalam Provinsi Aceh. *Jurnal Gizi Indonesia (The Indonesian Journal of Nutrition)*, *3*(1), 37-45.

9. Nadiyah, N., Briawan, D., & Martianto, D. (2016). Faktor Risiko Stunting Pada Anak Usia 0—23 Bulan Di Provinsi Bali, Jawa Barat, Dan Nusa Tenggara Timur. *Jurnal gizi dan pangan*, *9*(2).

10. Nasikhah, R., & Margawati, A. (2015). *Faktor risiko kejadian stunting pada balita usia 24–36 bulan di Kecamatan Semarang Timur* (Doctoral dissertation, Diponegoro University).

11. Oktarina, Z., & Sudiarti, T. (2015). Faktor risiko stunting pada balita (24—59 bulan) di sumatera. *Jurnal gizi dan pangan*, *8*(3), 177-180.

12. Proyek Kesehatan dan Gizi berbasis Masyarakat Untuk Mengurangi Stunting. In: Corporation M, editor. Jakarta: MCA-Indonesia; 2015

13. Puskesmas. Rekapitulasi Hasil Penimbangan Massal Puskesmas Perawatan Lubuk Gadang. Solok Selatan: Puskesmas Lubuk Gadang; 2016.

14. Putra O. Pengaruh BBLR Terhadap Kejadian Stunting Pada Usia 12-60 Bulan di Wilayah Kerja Puskesmas Pauh Pada Tahun 2015 [SKRIPSI]. Padang: Universitas Andalas; 2016.

15. RENSTRA. Rencana Strategis Kementrian Kesehatan 2015-2019. Jakarta: Depkes; 2015.

16. Setiawan, E., Machmud, R., & Masrul, M. (2018). Faktor-Faktor yang Berhubungan dengan Kejadian Stunting pada Anak Usia 24-59 Bulan di Wilayah Kerja Puskesmas Andalas Kecamatan Padang Timur Kota Padang Tahun 2018. *Jurnal Kesehatan Andalas*, *7*(2), 275-284.

17. Sulastri, D. (2015). Faktor determinan kejadian stunting pada anak usia sekolah di Kecamatan Lubuk Kilangan Kota Padang. *Majalah Kedokteran Andalas*, *36*(1), 39-50.

18. Ulfani, D. H., Martianto, D., & Baliwati, Y. F. (2015). Faktor-faktor sosial ekonomi dan kesehatan masyarakat kaitannya dengan masalah gizi underweight, stunted, dan wasted di Indonesia: Pendekatan ekologi gizi. *Jurnal gizi dan pangan*, *6*(1), 59-65.

19. Wellina, W. F., Kartasurya, M. I., & Rahfiludin, M. Z. (2016). Faktor risiko stunting pada anak umur 12-24 bulan. *Jurnal Gizi Indonesia (The Indonesian Journal of Nutrition)*, *5*(1), 55-61.

http://ijses.com/
All rights reserved