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Utilization of Local Culture "Mbolo Weki" For Stunting Prevention in Bima District.

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Abstract
Stunting is a condition of failure to thrive in children under two years old, due to chronic malnutrition so that the child becomes too short for his age. Children with stunting experience impaired physical growth and brain development, which has a negative impact on the child's health.
One of the efforts to prevent stunting is by utilizing local culture. *I'm sorry*(Bima language), is a deliberation event at night, which is held to prepare for important events such as weddings, circumcisions, thanksgiving and so on in a family of the Mbojo tribe.
This study aims to analyze the effectiveness of the interventions carried out. With the research design used is "Pre-Post" in different groups (control and intervention).
This study aims to analyze the effectiveness of the intervention carried out. With the research design used is "Pre-Post" in different groups (control and intervention). The data obtained were analyzed using the Wilcoxon statistical test with a significance limit of $p \leq 0.05$. The sampling technique was random proportional to size type. The results of this study indicate that there is a difference in knowledge and attitudes between the control group and the Intervention Group before and after the health education intervention was carried out by utilizing the local culture of mbolo weki for stunting prevention. The difference in knowledge and attitudes after receiving health education intervention by utilizing the local culture of mbolo weki for stunting prevention was greater in the intervention group compared to the control group. The government wants to establish the Mbolo Weki Stop Stunting Movement Program (Gembos stunting).

Keywords: Gembos Stunting, Local Culture.

Background

Stunting is a condition of failure to thrive in children under two years of age, due to chronic malnutrition so that the child becomes too short for his age. According to the Indonesian Nutritional Status Survey Data (SSGI), in 2021 the prevalence of stunting in West Nusa Tenggara (NTB) Province showed that the incidence of stunting reached 31.4%. Bima Regency is one of the red zones for stunting, namely 30.4%, (Bima Regency Health Office). Bima Regency was designated as one of 169 priority areas for handling Stunting by the Vice Presidential Secretariat.

Children with stunting experience impaired physical growth and brain development, so that stunted children do not have creativity, productivity and achievement in school, the child's future becomes bleak. Stunting threatens the quality of Indonesia's human resources. Many factors cause stunting, direct factors (LBW, infectious diseases) and indirect causes (parenting patterns, environmental sanitation, economy and family knowledge). In Bima Regency, Wawo District, the most dominant factors causing stunting are food security and parenting patterns.

One of the efforts of the provincial government and local government in handling stunting is to establish the GEN = NTB Golden Generation program, the ASHAR = First Thousand Days of Birth action program, and the GEBRAK BIMANTIKA program (a joint movement of Bima Regency in preventing stunting and anemia. Handling stunting is not an easy job, it requires hard work, cooperation and strong commitment from all parties.

Utilization of all resources, facilities and infrastructure, community empowerment needs to be done to prevent stunting in Bima Regency, and the most important thing is to increase the knowledge of the Bima community about stunting prevention. On the other hand, gathering the masses to conduct health education and promotion has its own obstacles, especially for the people in Bima, because the characteristics of the majority of the community's work are farmers who are almost full every day in the rice fields and fields, especially during the planting and harvest seasons. One effort that is very possible, easy and affordable that can be done is to utilize local culture to disseminate information as widely as possible about stunting prevention to the community.

As from Nurhaeni, et.al. (2021) found that a collaborative study between nurses, doctors, and health cadres who provided stunting cognitive strengthening services for 28 stunting cases during the 2019-2020 pandemic. The results of the study showed a significant increase in the weight of stunted children and maternal knowledge. The presence factor for mothers and children is always at home during the pandemic, intensive supervision by health cadres is a factor of easy access to provide integrated reinforcement. Likewise, the Dana Mbojo Community (Bima Regency, Bima City, Dompu Regency) has a local culture that is very much attached to their lives, namely Mbolo Weki. Mbolo weki (Bima Language) is a consensus event held to prepare important events such as preparations for wedding parties, circumcisions, thanksgiving and others in a family in the Dana Mbojo Tribe. Mbolo Weki is attended by the entire family and local community. Mbolo Weki can be used as a means for health promotion and dissemination of information very quickly because it involves many people (the whole village).

Local culture which has great potential for disseminating information should be used as much as possible and established as an official program by the Dana Mbojo government, in this case the Mbolo weki Stop Stunting Movement Program (Gembos Stunting).

METHOD

a. Research Design.

This type of research is analytical research, the research method used in this research is analyticalresearch.

This research is a quasi-experiment with a pre-test and post-test with control group design. This design attempts to reveal the effectiveness of a treatment by involving a control group in addition to the experimental group. The experimental group is given treatment while the control group is not and both groups are given a pre-test and post- test (10)

The design can be described as follows: 3 days 3 days

Intervention Group:	01 X 02
Control Group:	01 02

In this study, O1 is the first assessment before being given treatment, X is the group given treatment: Health promotion on stunting prevention provided by health workers and/or researchers. and distribution of booklets, while the control group was not given health promotion on stunting prevention, only given booklets to study independently and O2 is the second assessment. after being given treatment. The time required for the assessment is 3 days before treatment and 3 days after treatment.

b. **Population, sample and sampling**

The population is all people who attended the Mbolo Weki event in Done Rite a number of729 people) in Bima Regency.The sample size in this study will be calculated using the Slovin formula with the following calculation:

n = N / (1 + Nd2)

Information :

n = Sample size

N = Population size

d = Standard error (tolerance limit) 10% = 0.1 So the sample size in this study is:

n = N / (1 + Nd2)

$$n = \frac{729}{1 + (729 \; x \; 0.1 \; x \; 0.1)}$$

$$n = \frac{729}{1 + (729 \; x \; 0.01)}$$

$$n = \frac{729}{1 + 7,29}$$

$$n = \frac{729}{8,29}$$

n **=87 (87 people)**

Furthermore, the sample size for each RT will be taken proportionally using the following formula:

ni = Ni / N x 87 Information :

ni = Number of samples per RT

Ni = Total population in the Village N = Total population

NO	RT Name in Rite Village	Total Sample According to Slovin	Presentation Each RT	Number of Samples in each RT	Rounding
1	RT 1	87	19.09	160	20
2	RT 2	87	18.13	152	18
3	RT 3	87	24.70	207	25
4	RT 4	87	23.86	200	24
Total			86.14		87

The number of samples in this study was 87 people in both the intervention group and the control group.

Results And Discussion

A. Univariate Analysis

1. Respondent characteristics based on age, education level and occupation.

Table 1. Characteristics of respondents based on age, education level and occupation in the Ambalawi Health Center Working Area, Bima Regency in 2024 (n = 87)

	Variables Group			
	Intervention		**Control**	
	n	**%**	**n**	**%**
Age				
20-44	80	80	82	94.3
45-59	7	8	5	5.7
Total	87	100	87	100
Level of education				
PT	21	24.1	39	33.3
SENIOR HIGH SCHOOL	63	72.4	58	66.7
JUNIOR HIGH SCHOOL	3	3.4		
Total	87	100	87	100
Work				
Civil Servant/First Aid	3	3.4	4	4.6

Self-				
	17	19.5	21	24.1

employed

Farmer/Laborer	67	77.162	71.3
Total	87	10087	100

Based on table 1. above, the majority of respondents' ages are in the 20-44 year category, namely 80 people (92%) for the intervention group and 82 people (94.3%) for the control group.
In the education level data, the majority of respondents' education level was in the high school education category, namely 63 people (72.4%) for the intervention group and 58 people (66.7%) for the control group.
Respondents' employment data shows that the majority of respondents' jobs as farmers/laborers were 67 people (77.1%) for the intervention group and 62 people (71.3%) for the control group.

2. Respondents' knowledge before and after the intervention in the intervention group and control group

Table 2. Knowledge before and after intervention in the intervention and control groups in the community in Bima Regency in 2024 (n = 87)

Variables	Group	Good		Enough		Not enough		Total	
		n	%	n	%	n	%	n	%
Knowledge	**Intervention**								
	Pre	7	8.0	46	52.9	34	39.1	87	100
	Post	66	75.9	21	24.1	0	0		
	Control								
	Pre	5	5.7	45	51.7	37	42.5	87	100
	Post	5	5.7	49	56.3	33	7.9	87	100

Based on the data in Table 2, there is a significant difference between the intervention group and the control group in terms of changes in the level of knowledge of respondents after the intervention. In the intervention group, before the intervention, most respondents had a level of knowledge in the sufficient category, namely 46 people (52.9%). After the intervention, there was a significant increase, with the majority of respondents in the good knowledge category, namely 66 people (75.9%). This shows that the intervention given is effective in increasing respondents' knowledge.

On the other hand, in the control group, before the intervention, most respondents also had a level of knowledge in the sufficient category, as many as 45 people (51.7%). However, after the intervention, there was no significant increase, where most respondents were still in the sufficient category, as many as 49 people (56.3%). This shows that the intervention given to the control group did not provide a significant effect on increasing

The significant increase in the intervention group can be explained by the theory that providing structured interventions tailored to the needs of respondents can increase knowledge absorption. According to previous studies, effective interventions, such as health education or training based on learning theory, can improve respondents' knowledge and skills in understanding the material provided. One of them, in a study by Fletcher et al. (2021) showed that Structured Education Interventions increased Health Knowledge.

Another study by Zhang et al. (2022), also showed that on the contrary, in the control group that did not show significant improvement, it is likely that the intervention received was more general or not specifically designed to facilitate in-depth knowledge improvement. Several studies have also shown that interventions that are less structured or without ongoing evaluation tend to have minimal impact on knowledge change.

3. Respondents' attitudes before and after the intervention in the intervention group and control group

Table 3. Respondents' attitudes before and after the intervention in the intervention group and control group in the community in Bima Regency in 2024 (n = 87)

Variables	Group	Good	Enough	Not enough	Total
	N	%	n %	n %	n %
Attitude	**Intervention**				
	Pre 6	6.9	45 51.7	36 41.7	87 100
	Post 6	69.0	25 23.7	2 2.3	87 100
	Control				
	Pre 5	5.7	43 49.4	39 44.8	87 100
	Post 5	5.7	46 52.9	36 41.4	87 100

Based on the data in Table 3, there is a significant difference in the change in respondents' attitudes between the intervention group and the control group after the intervention was given. In the intervention group, before the intervention was given, most of the respondents' attitudes were in the sufficient category, which was 45 people (51.7%). However, after the intervention was given, there was a significant increase, where most of the respondents' attitudes were in the good category, which was 60 people (69.0%). This shows that the intervention given was effective in changing respondents' attitudes in a more positive direction.

On the other hand, in the control group, before the intervention, most of the respondents' attitudes were in the sufficient category, as many as 43 people (49.4%). After the intervention, there was only a slight change, with the majority of respondents remaining in the sufficient category, as many as 46 people (52.9%). This indicates that the intervention in the control group did not have a significant impact on changes.

The improvement in attitudes in the intervention group can be explained by the theory of behavioral change, where increased knowledge is often followed by changes in attitudes. Attitudes are cognitive, affective, and conative components that can be changed through educational and active learning-based interventions. According to Ajzen's Theory of Planned Behavior.

Research by (Sharma et al. (2022), shows that structured health education interventions have a significant impact on health behavior.

In contrast, a control group that did not show significant improvements in attitudes may be due to the intervention being general in nature or not designed to modify attitudes in depth.

This study is in line with the research of Patel et al. (2023) which proves that structured and active participation-based interventions are very effective in changing respondents' attitudes, while less targeted interventions do not provide results. Patel et al. (2023)

2. Bivariate Analysis

a. Normality Test

This data normality test determines the type of test to be used using Parametric and Non-Parametric tests. The number of samples is less than 50 using the Shapiro Wilk test and if the sample is more than 50 using the Kolmogorov-Smirnov test, with decision-making guidelines, if the significance value is greater than 0.05, then the data is normally distributed (using the paired sample T-test, if the significance value is less than 0.05 then the data is not normally distributed (using the Wilcoxon Signed Rank test).

Table 4. Normality test of research variables for the intervention and control groups in the community in the Ambalawi Health Center Work Area, Bima Regency in 2024 (n = 87)

	Kolmogorov-Smirnova			Shapiro Wilk		
	Statistics	df	Sig.	Statistics	df	Sig.
Pre-control group knowledge	.307	87	.000	.741	87	.000
Post control group knowledge	.331	87	.000	.738	87	.000

Pre-group Intervention Knowledge	.302	87	.000	.759	87	.000
Post Intervention group knowledge	.471	87	.000	.531	87	.000
pre-control group attitude	.295	87	.000	.740	87	.000
post control group attitude	.313	87	.000	.741	87	.000
pre-group intervention attitudes	.301	87	.000	.750	87	.000
Post Intervention Group Attitude	.429	87	.000	.621	87	.000

Based on the normality test table above, the significance value in the Kolmogorov- Smirnov table is less than 0.05, so it can be concluded that the data is not normally distributed, so the test used is the Wilcoxon test.

b. Analysis of the differences in average knowledge and attitudes before intervention in the Case and Control groups

Table 5. Differences in average knowledge and attitudes before intervention in the intervention and control groups in the community in the work area of the Ambalawi Health Center, Bima Regency in 2024 (n = 87)

Variables	**Group**	**Mean**	**SD**	***P value***
Pre-knowledge	Case	1.69	0.616	***0.482***
	Control	1.63	0.593	
Pre attitude	Case	1.66	0.607	***0.620***
	Control	1.61	0.598	

Based on the data in Table 5, it can be concluded that there is no significant difference between the intervention group and the control group in terms of knowledge and attitudes before the intervention. This can be seen from the results of the statistical test which shows a P-value > 0.05 for both variables.

In the knowledge variable, the test results showed a P-value of 0.482 (P-value > 0.05), which indicated that there was no significant difference between the knowledge scores of respondents in the intervention group and the control group before the intervention. This means that at the beginning of the study, both the intervention and control groups had comparable levels of knowledge regarding the topic being measured.

The same thing also happened to the attitude variable, where the test results showed a P-value of 0.620 (P-value > 0.05). This indicates that the public's attitude towards stunting before the intervention in both groups also did not have a significant difference. Thus, it can be concluded that before the intervention, respondents from both groups had almost similar attitudes regarding the issues discussed.

Similarities in the level of knowledge and attitudes between the intervention and control groups before the intervention are important because they ensure that the intervention results obtained later are not due to initial differences in respondent characteristics. This is one of the basic principles in experimental research to ensure the validity of the results, where differences observed after an intervention can be attributed to the treatment given, rather than to differences in initial conditions between the groups being compared.

According to research by Jones et al. (2023), it was proven that randomization in Health Intervention studies is effective in ensuring the equality of the control group and the experimental group.

The results in Table 5 show that in terms of knowledge and attitude, there was no significant initial difference between the intervention and control groups. This provides a good basis for spreading the impact of the intervention given. Another study by Gomes et al. (2022), proved that educational interventions can modify knowledge and attitudes towards health problems.

c. Analysis of differences in average knowledge and attitudes about stunting after intervention in the Case and Control groups

Table 6. Differences in average knowledge and attitudes after intervention in the intervention and control groups in the community in the work area of the Ambalawi Health Center, Bima Regency in 2024 (n = 87)

Variables	Group	Mean	SD	*P value*
Post knowledge	Intervention	2.76	0.430	***0,000***
	Control	1.68	0.581	
Post attitude	Intervention	2.67	0.521	***0,000***
	Control	1.66	0.587	

In table 6. Shows that the knowledge variable, the test results show a P-value of 0.000 (P-value <0.05), which indicates a significant difference in knowledge scores between the intervention group and the control group after the intervention was carried out. This means that the intervention given to the intervention group, namely in the form of health education in the use of local culture mbolo weki for stunting prevention information, succeeded in significantly increasing respondents' knowledge compared to the control group who did not receive the intervention or only received a booklet containing information about stunting prevention.

Similar things were also found in the attitude variable, where the P-value of 0.000 (P- value <0.05) indicated that the intervention succeeded in creating significant changes in attitudes between the two groups. After the intervention, the community's attitude towards stunting in the intervention group changed positively compared to the control group. This shows that the intervention given not only increased knowledge, but also succeeded in influencing respondents' perceptions and views regarding the problem of stunting prevention.

This finding is in line with various studies showing that education-based interventions and health education are effective in increasing knowledge and changing public attitudes towards health issues, based on research by Miller et al. (2023) and

Singh et al.'s research (202). This study proves that significant results on both variables (knowledge and attitude) indicate that the intervention carried out in the Ambalawi Health Center work area is effective in increasing understanding and modifying community attitudes regarding stunting. This is evidence that a well-designed intervention strategy has a positive impact that can be measured.

Overall, the results in Table 6 strengthen the argument that educational interventions that are planned and carried out intensively are able to provide meaningful changes in community knowledge and attitudes, especially in the context of preventing and handling stunting problems.

d. Analysis of the difference in average knowledge before and after intervention in case and control groups

Table 7. Differences in average knowledge before and after intervention in the intervention and control groups in the community in the work area of the Ambalawi Health Center, Bima Regency in 2024 (n = 87)

Variables	Group	Mean	SD	Z	P value
Pre-knowledge	**Interventio**	1.69	0.616	-0.200	***0,000***
Post knowledge	**n**	2.76	0.430		
Pre-knowledge	**Control**	1.63	0.593	-0.743	***0.046***
Post knowledge		1.68	0.581		

Based on the data in Table 7, it can be seen that there is a significant difference in knowledge scores before and after the intervention in the intervention group and the control group. However, the magnitude of the increase in knowledge in the two groups is different.

In the intervention group, the average knowledge score before the intervention was 1.69, and increased to 2.76 after the intervention. The results of the Wilcoxon Signed Rank statistical test showed a p value = 0.00 (p <0.05), which indicates that the difference was significant. This means that the intervention given to the intervention group, namely health promotion by utilizing the local culture of mbolo weki, succeeded in significantly increasing the knowledge of respondents. This significant increase shows that interventions carried out with programs that are designed in a structured manner and adjusted to needs can be effective in expanding respondents' understanding of the issues raised, in this case the utilization of the local culture "mbolo weki" to prevent stunting

This is in line with research showing that health education-based interventions, as found by Brown et al. (2023), that structured educational interventions influence increased health knowledge.

Meanwhile, in the control group, the average knowledge score before the intervention was 1.63, and increased slightly to 1.68 after the intervention. Although this increase looks small, the results of the statistical test showed a value of p = 0.046 (p <0.05), which means that this increase is also significant, although the impact is not as large as in the intervention group. This shows that although the control group also experienced an increase in knowledge, because respondents received information from the booklets distributed, it was less effective, so that the level of knowledge of respondents, although there was an increase, was not as large as the increase produced by the intervention group. When compared, the average increase in knowledge scores in the intervention group was much higher than in the control group. This indicates that the intervention given to the intervention group was more effective in significantly increasing respondents' knowledge. This emphasizes the importance of the quality and intensity of intervention in influencing changes in knowledge. The intervention group that received more targeted and intensive intervention experienced a greater increase, while the control group, although there was an increase, did not experience a significant change in knowledge.

This is in line with research by Smith et al. (2022), that active learning in health education interventions can increase respondents' knowledge.

Overall, these results suggest that carefully designed interventions based on effective educational methods can produce significant gains in knowledge. It is also important to note that while both groups experienced gains, the quality and type of intervention received had a direct impact on how much knowledge increased.

e. Analysis of the average difference in attitudes before and after intervention in the intervention and control groups.

Table 8. Differences in average attitudes before and after intervention in the intervention and control groups in the community in the work area of the Ambalawi Health Center, Bima Regency in 2024 (n = 87)

Variables	Group	Mean	SD	Z	P value
Pre attitude	**Case**	1.66	0.607	-0.200	***0,000***
Post attitude		2.67	0.521		
Pre attitude	**Control**	1.61	0.598	-0.743	***0.046***
Post attitude		1.66	0.587		

Based on the data in Table 8, there was a significant change in attitude scores in both the intervention and control groups after the intervention, although the level of change in both groups was different.

In the intervention group, before the intervention, the average attitude score was 1.66, and after the intervention, the score increased significantly to 2.67. The results of the statistical test showed a value of p = 0.000 (p <0.05), which indicated that there was a significant difference in attitudes before and after the intervention in the intervention group. This large increase indicates that the intervention provided, namely health education by utilizing the local culture of mbolo weki, succeeded in increasing changes in respondents' attitudes about preventing stunting in a positive direction.

The significant changes in the intervention group are in line with research by Thompson et al. (2023) which shows that structured education and counseling-based interventions can change individual attitudes towards public health issues.

Meanwhile, in the control group, the average attitude score before the intervention was 1.61, and only increased slightly to 1.66 after the intervention. Although the increase was small, the statistical test results showed a p value = 0.046 (p
< 0.05), which also indicated a significant difference, although the change was not as large as in the

intervention group. This small increase indicates that the provision of booklets on stunting prevention given to the control group had an effect on respondents, and still had a slight impact on respondents' attitudes, although not strong enough to create a change in attitude.

Research by Garcia et al. (2022) found that changes in attitudes in the intervention group were much greater than in the control group. This shows that the type and intensity of intervention have a significant influence on attitude change. More intensive and targeted interventions, such as those applied to the intervention group, are more capable of significantly changing respondents' perceptions and views, while minimal interventions in the control group only produce very limited changes.

CONCLUSION:

Based on the research results, it can be concluded:

1. There is a difference in knowledge between the control group and the intervention group before and after the health education intervention was carried out by utilizing the local culture of mbolo weki to prevent stunting.
2. There is a difference in attitude between the control group and the intervention group before and after the health education intervention was carried out by utilizing the local culture of mbolo weki to prevent stunting.
3. The difference in knowledge after receiving health education intervention using the local culture of mbolo weki to prevent stunting was greater in the intervention group compared to the control group.
4. The difference in attitudes after receiving health education intervention by utilizing the local culture of mbolo weki to prevent stunting was greater in the intervention group compared to the control group.

BIBLIOGRAPHY

1. Arikunto. (2013). Research Procedures of a Practical Approach. PT Rineka Cipta. 1-36 months. NERS Nursing Journal, 16(1).
2. Brown, L., Williams, A., & Harris, M. (2023). "The Effects of a Structured Educational Intervention on Health Knowledge: A Randomized Controlled Study." Journal of Health Education Research.
3. Dahlan, MS (2016). Sample size in medical and health research. Salemba Medika.
4. Bima District Health Office. (2022). Annual Report on Stunting Cases in Bima District.
5. Dowse, ILAO and R. (2018). An illustrated booklet for reinforcing community health worker knowledge of tuberculosis and facilitating patient counselling. African Journal of Primary Health Care and Family Medicine, 10(8).
6. Ernawati, N. (2019). Incidence of Toddler Stunting at the Posyandu Apel, Jambearjo Village, Tajinan District, Malang Regency. Mesencephalon Health Journal, 5(2). https://doi.org/10.36053/mesencephalon.v5i2.108
7. Fauziatin, N., Kartini, A., & Nugraheni, S. (2019). The Influence of Health Education with Flip-flop Media on Stunting Prevention in Prospective Brides. VISIKES: Journal of Public Health, 18(2), 224–233.http://publikasi.dinus.ac.id/index.php/visikes
8. Fletcher, A., Smith, R., & Taylor, J. (2021). "The Impact of Structured Educational Interventions on Health Knowledge: A Meta-Analysis." Journal of Health Education.
9. Garcia, P., Silva, M., & Alvarez, R. (2022). "Minimal vs. Structured Interventions in Public Health Awareness Campaigns: Effectiveness in Attitude Change." International Journal of Health Promotion , 32(1), 78-84.
10. Gomes, A., de Silva, R., & Mendez, F. (2022). "The Role of Educational Interventions in Modifying Knowledge and Attitudes toward Public Health Problems: A Review." Journal of Public Health Education.
11. Jones, M., Clark, A., & Peters, D. (2023). “The Effectiveness of Randomization in Health Intervention Studies: Ensuring Equivalence in Control and Experimental Groups.” Journal of Health Research Methods , 15(1)
12. Kemendikbud.go.id, (2020). Educational Psychology.
13. Ministry of Health of the Republic of Indonesia. (2018). Results of Basic Health Research 2018. Ministry of Health of the Republic of Indonesia, 53(9), 1689– 1699.

14. Listyarini, & Fatmawati. (2020). Nutrition education for pregnant women using booklet media on behavior to prevent stunting in toddlers in the Undaan Health Center Area, Kudus Regency. Journal of Nursing and Midwifery.
15. Machfoedz, I. (2009). Basics of public health science in midwifery. Fitramaya.
16. Mardiana, S., & Yunarfi, A. (2021). The Relationship between Education Level and Knowledge of Nutritional Status with the Incidence of Stunting in Secanggang Village, Langkat Regency. Maksitek Scientific Journal, 6(2), 24– 66.
17. Maulana. (2009). Health promotion. ECG.
18. Miller, J., Thompson, R., & Ahmed, K. (2023). "Impact of Health Education Interventions on Knowledge and Attitudes: A Meta-Analysis of Community- Based Programs." Journal of Global Public Health.
19. Notoatmodjo S. (2012). Health Promotion and Health Behavior. PT Rineka Cipta. Ramdhani, A., Handayani, H., & Setiawan, A. (2020). The Relationship Between Mother's Knowledge and the Incidence of Stunting. National Seminar of Lppm, ISBN: 978-, 28–35.
20. Patel, A., Kumar, R., & Singh, P. (2023). "The Role of Active Learning in Attitude Change: A Systematic Review of Health Education Programs." Health Education and Promotion“
21. Richa Yuswantina. (2019). Relationship between Age Factors and Education Level to Knowledge of Antibiotic Use in Sidorejo Kidul Village. Indonesian Journal ofPharmacy and Natural Product, 2(1).
22. Sharma, P., Gupta, R., & Verma, S. (2022). "Impact of Structured Health Education Intervention on Attitudes Towards Health Behaviors: A Quasi- Experimental Study." Journal of Public Health Research.
23. Singh, A., Patel, R., & Gupta, S. (2022). "Educational Intervention in Low- Income Communities: Impact on Public Health Awareness and Attitudes." Journal of Public Health.
24. Smith, P., Johnson, T., & Lee, S. (2022). “The Role of Passive and Active Learning in Health Education Interventions: A Comparative Analysis.” International Journal of Public Health Studies , 36(4).
25. Susasi, L. (2021). The Effect of Health Education with Booklets on Pregnant Women's Knowledge of the First 1000 Days of Life. Jurnal Delima Harapan, 8(1).
26. Thompson, R., Clark, M., & White, A. (2023). "The Impact of Educational Interventions on Attitudes Toward Public Health Problems: A Comparative Study." Journal of Public Health Education.
27. Zhang, L., et al. (2022). "Participatory Learning and Knowledge Enhancement in Health Education Programs: A Systematic Review." Health Promotion International