



Exclusive Breastfeeding as an Effort to Prevent Stunting in Toddlers

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Abstract

Stunting is a growth disorder in children; namely, the child's height is lower or shorter (dwarf) than the legal age. Stunting occurs when a newborn is malnourished, even in the womb. Stunting is a severe threat to the future human quality and the nation's competitiveness. One form of nutritional intervention efforts carried out for infants and toddlers to prevent stunting is exclusive breastfeeding for 6 months and continued until the age of 2 years. Exclusive breastfeeding is expected to help children obtain proper nutrition and reduce the risk of stunting. This study uses a qualitative approach with a descriptive method in describing the research analysis. The survey results show that stunting is one of the most common problems in developing countries, including Indonesia, which is generally caused by a lack of nutrients, infectious diseases, the number of children under five in the family, socio-economic status, and education, etc. Exclusive breastfeeding from an early age has been proven to prevent or reduce the risk of stunting in toddlers because breast milk contains sufficient micro and macronutrients such as colostrum to provide immunity to infants. At the same time, lactose, iron, and other minerals are helpful for infant brain development.

Keywords: Exclusive Breastfeeding, Stunting, Toddler, Nutrition.

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A. INTRODUCTION

The problem of malnutrition often gets attention in some developing countries, including underweight, stunting, wasting, and micronutrient deficiency (Neuman et al., 2002; Caulfield et al., 2006; Hadi, 2004). Nutritional status is a significant health indicator where the age of toddlers is a group that is very vulnerable to nutritional problems, especially stunting, which is a condition of failure to grow in children under five with chronic malnutrition so

that they are less tall in their age (Sahyoun et al., 2003; Anten, 2010; Sartika, 2010). Short-term risks due to malnutrition are increased morbidity and mortality, developmental disorders, and increased burden of care and treatment. Long-term risks can disrupt reproductive health, learning concentration, and decreased work productivity (Black et al., 2008; Khalil et al., 2018; Ariati, 2019).

When compared to other middle-income countries, Indonesia has a



comparatively high rate of stunting among children. According to Basic Health Research, the incidence of stunting in children under five was 10.2 percent in 2018, while the prevalence of stunting in children under five was 30.8 percent in the same year (MOH, 2018). Stunting is a disorder in which children have a shorter body size than the usual child their age and a delay in their ability to think. This also fails to develop in the physical and mental development of the child for an extended period of time due to malnutrition. When a fetus is in the womb till the beginning of his or her existence, he or she is suffering from malnutrition for an extended period of time (Neelsen & Stratmann, 2011; Roseboom et al., 2011; Budiastutik & Rahfiludin, 2019). This is due to a lack of availability to appropriate and nutritious food, a lack of vitamins and minerals required by pregnant women, inadequate sanitation in the surrounding environment, and a lack of consumption of food derived from animal sources, among other factors (Ladipo, 2000; Anand et al., 2014; Kusuma & Nuryanto, 2013).

The mother's limited knowledge will pose a risk to the health and growth of the child, both in the womb and in its development. This is reinforced by Rahma & Nadhiroh's (2016) research, concluding that young mothers whose toddlers experience stunting have shared nutrition knowledge. Increasing public awareness of maternal nutrition when the child is still in the womb until 2 years old is essential homework for the regional government and the central government.

Many factors cause stunting, namely low socio-economic problems, food insecurity, maternal nutritional status during pregnancy, low birth weight (LBW) babies, child care patterns, nutritional status, sanitation, and water availability (Fenske et al., 2013; Kumar et al., 2021; Permatasari & Suprayitno, 2007) The government has tried to prevent and overcome the problem of stunting in toddlers through various nutrition programs, both specific and sensitive, such as giving blood-added tablets to pregnant women, promoting exclusive

breastfeeding, providing macro and micro nutritional supplements to providing non-food aids cash. However, the results have not overcome the stunting problem (Paul et al., 2011; Gomez et al., 2013; Bima, 2019).

It is defined as exclusive breastfeeding when a baby is only given breast milk, without the addition of other fluids such as formula or milk as well as fruits and vegetables such as oranges, honey, tea water, and water. It is also defined as exclusive breastfeeding when a baby is only given breast milk, without the addition of other solid food ingredients such as bananas, papaya, milk porridge, biscuits, and rice porridge (Lawoyin et al., 2001; Kakute et al., 2005; Afifah, 2007). At this age, optimal nutrition for healthy children is regarded to be dependent on the fact that they are nursed exclusively for the first 6 months before being introduced to complementary foods. Nursing status and nutritional condition of infants aged 0-6 months are investigated. This will make it easier to determine where the infant is starting from a nutritional standpoint prior to introducing complementary food to the youngster (Beauchamp & Moran, 1982; Roesli, 2000; Kavle et al., 2017).

Stunting can be prevented by several things such as exclusive breastfeeding, providing nutritious food according to the body's needs, getting used to clean living behavior, doing physical activity, balancing energy expenditure and nutrient intake into the body, and monitoring children's growth and development regularly. According to the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), exclusive breastfeeding should follow the following guidelines: breastfeeding should begin within the first hour of delivery, should be exclusive for the first six months, and should be continued for two years with the addition of supplemental foods beginning in the sixth month (Unicef, 2013; WHO, 2016).

Because breast milk contains complete and balanced nutrition that is easily digested by the baby's stomach, only giving breast milk alone is sufficient to meet the nutritional needs



of infants under the age of six months. Another benefit of exclusive breastfeeding is that it protects babies from germ infections such as bacteria, viruses, and parasites. The reason is that breast milk contains particular proteins that can boost the child's immune system. The more routine mothers give exclusive breastfeeding, the more protected the child's body is from various diseases (Tamiru et al., 2012; Babakazo et al., 2015; Hapsari et al., 2019).

Although there is a lot of knowledge about the benefits of exclusive breastfeeding for a baby's health, the fact is that there are still many mothers who give complementary foods known as MP-ASI before the baby is six months old for various causes and reasons. When babies are exclusively breastfed too early, before the age of six months, this can increase the risk of stunting children. When the baby is introduced to food before six months, the baby will prefer the food to breast milk, so the baby will be packed first and not have time to drink breast milk. Exclusive breastfeeding until the age of 6 months and breastfeeding along with MP-ASI until the child is 2 years old will make the baby's growth and development much more optimal and less sick during its growth period (Kramer & Kakuma, 2004; Rahmat, 2017).

Many people believe that the condition of a child's short body is caused by a hereditary element (genetic) that is passed down from both of their parents. As a result, people simply accept it without doing anything to avoid it. At the same time, genetics is a health determinant that has the least impact when compared to other factors such as behavioral factors, the social environment, the economics, culture, and health-care resources. For better or worse, stunting is a condition that can be avoided and resolved.

B. METHOD

The method used is a descriptive qualitative method resulting from literature studies from various international and national journals; this method is used to summarize the current state of understanding and knowledge about a topic or problem (Sugiyono, 2011). The

literature study restates the material discussed previously, reports the latest facts and analyzes with a review of various works of literature, summarizes the most valid and relevant publications, and then compares the results presented in the article.

C. RESULT AND DISCUSSION

Stunting is a problem of child growth and development that is increasingly found in developing countries, including Indonesia. According to data from the World Health Organization (WHO), in 2013, 22.9% or 154.8 million children under five experienced stunting. Therefore, the state plays a critical role for the community in reducing stunting cases through government programs and excellent and balanced nutritional supplementation activities (WHO, 2016).

According to Sudiman (2008), stunting can also be considered a form of physiological adaptation to growth or a non-pathological condition, as the two primary causes are insufficient food intake and response to highly infectious diseases. The variables that can contribute to stunting are classified as direct and indirect causes. Direct factors include dietary intake, infectious infections, low birth weight, and heredity. Simultaneously, indirect determinants include dietary awareness, parental education, socioeconomic status, parenting, food distribution, and family size/members (Supariasa et al., 2002). Many factors, including the following cause stunting (Nabwera et al., 2022):

1. Nutrients are essential components in growth and development during pregnancy and child growth; if nutrients are not fulfilled or not fulfilled, they will inhibit growth and development in children.
2. Exclusive breastfeeding and complementary feeding (MP-ASI) Infants or toddlers in exclusive breastfeeding and complementary feeding that are less than optimal and limited food in terms of quality, quantity, and type will contribute to stunting.
3. Infectious Diseases Infectious diseases can also cause stunting. Still, it depends on the severity, duration, and recurrence of



infectious diseases suffered by infants and toddlers and if there is insufficient food for recovery (WHO, 2012). Contagious diseases that toddlers often sustain are ARI and diarrhea.

4. The number of children under five in the family. Many toddlers in the family cause the problem of stunting nutrition. The number of children under five in the family also affects the nutritional status of children under five. The number of toddlers in the family affects the mother's visit to the posyandu so that it affects the nutritional quality of the toddler. In families with a small number of children under five, the mother will focus more on paying attention to her child. In contrast, if there are a large number of children under five in the family, the mother's attention will be divided.
5. Socio-Economic status can affect the occurrence of stunting because socio-economic conditions or household conditions that are classified as low will affect low education levels, low quality of sanitation and drinking water, low purchasing power, and limited health services, all of which can contribute to disease and low intake of nutrients so that there is an opportunity for stunting.
6. Family Education Status. Low family education levels will make it challenging to receive direction in fulfilling nutrition. They often do not want or do not believe in the importance of fulfilling nutritional needs and the importance of other health services that support growth in children so that there is a chance of stunting. The higher the education, knowledge, and skills, there is a possibility that the better the level of family food security, the better the pattern of parenting for children, and the more families take advantage of existing services. Family food security is also related to food availability, food prices, family purchasing power, and knowledge about nutrition and health.
7. Occupation of Parents of Toddlers whose mothers work will be more likely to

experience stunting than mothers of toddlers who do not work because mothers and children meet very rarely; at the age of toddlers who still have to be given exclusive breastfeeding and complementary foods are sometimes inappropriate so that it has a significant effect on the child's growth.

8. Low Birth Weight. Low birth weight and preterm birth often coexist, and both factors are associated with increased neonatal morbidity and mortality. Babies underweight at birth are at significant risk for life during labor and after delivery. It is said to be low birth weight if the baby weighs less than 2500 grams. Premature babies have organs and body organs that have not functioned normally to survive outside the womb, so the younger the gestational age, the less available the organ functions and the poorer the prognosis. The Low Birth Weight Group often gets complications due to immaturity of organs due to premature birth.
9. Gender of toddlers. The problem of stunting is more experienced by boys. Some of the reasons for this are that boys' gross motor development is faster and more diverse, requiring more energy. The increased risk of stunting in boys under five is related to giving additional food too early, and the incidence of diarrhea is more frequent than in girls. In addition, it is suspected that there is gender discrimination where parents tend to pay more attention to girls.
10. Toddler Age. Toddlers who experience stunting are more common in toddlers aged 12 months than toddlers with nutritional deficiencies. These include decreased child appetite, low nutritional intake, reduced sleep hours, and susceptibility to infection when mothers/caregivers pay less attention to hygiene and sanitation.

Short toddlers (stunting) show erratic behavior; these behaviors include fussiness and increased crying frequency, lower activity levels, enthusiasm for playing and exploring smaller environments, communication less often, expressions of not so happy, apathetic,



and tend to be near the mother. Several studies have found a link between height growth and developmental changes in the first 3 years. In a survey conducted in the Philippines, children who were stunted at the age of 6 months had lower IQ scores at the age of 11 years than children who were short at 24 months.

Numerous cross-sectional studies have established a link between stunting and impaired motor and cognitive development in early childhood, as well as impaired cognitive and academic performance in later childhood. Short (stunted) children show more inadequate ability in various cognitive functions. They also have more inhibited behavior problems, are less attentive, and are more likely to exhibit conduct disorders (Pantaleon et al., 2016).

Breast milk (ASI) is the first liquid food produced naturally by the mother's breasts. Breast milk contains a variety of needed nutrients that are uniquely formulated in the mother's body to ensure the growth and development of the baby. Breast milk not only provides a child with sufficient nutrients, but also protects the newborn from infections and infant ailments. Breast milk is a solution of protein, lactose, and inorganic salts released by the mother's mammary glands that functions as a food source for her infant. Breast milk in appropriate quantity is the optimal diet for infants and can meet their nutritional requirements for the first six months. Breast milk is the primary natural food source for infants in order to ensure healthy growth and development (Kania, 2006).

Exclusive breastfeeding refers to the administration of breast milk alone, without the inclusion of other fluids or foods such as formula milk, water, honey, or tea water (Roesli, 2000). According to the World Health Organization / WHO (2016), exclusive breastfeeding means that babies receive only breast milk and no other food or drink until they reach the age of six months, save for medications and vitamins. The World Health Organization (WHO) and UNICEF (2013) both suggest initiating and achieving exclusive breastfeeding within the first hour after birth, a

practice known as Early Initiation of Breastfeeding (EIB). Breastfeed whenever the baby asks for it or according to its needs (on demand). Do not use milk bottles or pacifiers. When not with the child, expressing breast milk by pumping or expressing by hand and controlling emotions and thoughts to remain calm. Along with introducing complementary foods, infants should still be breastfed for up to 2 years.

According to MOH (2018), exclusive breastfeeding provides two benefits at once, namely for babies and mothers. The benefit of breast milk for babies is natural immunity to prevent the baby from getting sick. Breast milk also optimizes the baby's brain and physical development. The benefits of breastfeeding for mothers include preventing trauma, strengthening bonding, and being able to prevent breast cancer. The composition of breast milk cannot be replaced by other foods, especially in the first 6 months. This is due to the content of colostrum; the protein content in breast milk can protect babies from infection. Another research on the benefits of breast milk is the content of Human Alpha-Lactalbumin Made Lethal to Tumor Cells (HAMLET). The content of breast milk can prevent cancer. In children who are exclusively breastfed, the development of leukemia has decreased by up to 20%.

Because of the micro and macronutrients found in breast milk, nutrition specialists from Hohenheim University in Germany, Scherbaum and Srouf (2016) asserted that breast milk has the ability to lessen the likelihood of stunting in children because of its micro and macronutrients. As a result, it is recommended that women continue to breastfeed their children exclusively for the next six months. Whey protein and colostrum, both of which are included in mother's milk, are also thought to help strengthen the immune systems of babies who are particularly vulnerable. Breast milk contains lactose, AADHA, iron, zinc, selenium, and iodine, which are the primary raw materials for the formation of brain nerve cells. Breast milk will also



experience changes over time. At the time of new birth, breast milk contains colostrum which provides immunity and gastrointestinal protection for babies. Antibody levels in breast milk can reduce the risk of infection. 3 to 4 months of breast milk calories increase to meet the needs of children's motor development. When the phase is 6 months, the content of essential omega acids is abundant for the development of brain cells. In the last stage, which is 9 to 12 months, amino acids form the protein requirements for muscle growth and IQ optimization.

Insufficient breastfeeding for up to six months, weaning breast milk too quickly, and giving complementary foods too early can make babies lose the nutrients they need from breast milk. Quoted to the WHO website, in addition to poor nutrition, stunting also occurs due to infections that have occurred for years; that's when the benefits of breastfeeding are felt. Therefore, children will be healthier during development and growth, nutrients that enter the child's body can also be absorbed optimally, and will avoid the risk of stunting. Insufficient breastfeeding and giving MP-ASI or formula milk to babies too early can increase the risk of stunting. The frequency and quality of food (MP-ASI) given to infants are influenced by the knowledge and understanding of the mother and the state of the food at home. A mother's understanding of good nutrition given to children is very important in maintaining the quality of the food provided. Research shows that families with an understanding of good nutrition awareness can reduce the risk of stunting in children under five. (Riyadi et al., 2011).

D. CONCLUSION

Stunting is a condition that frequently affects people in underdeveloped nations. Direct factors such as food intake, infectious diseases, low birth weight, and the presence of genetic disorders cause stunting, while indirect factors such as knowledge about nutrition, parental education, socio-economic factors such as parenting patterns and food distribution and family size/number of family members

contribute to stunting. One of the simplest stunting prevention efforts is exclusive breastfeeding from an early age through Early Breastfeeding Initiation. Exclusive breastfeeding will give the baby two benefits, namely natural immunity to prevent the baby from getting sick and optimize the baby's brain and physical development. The content of whey protein and colostrum found in mother's milk is also considered to improve the immune system of relatively vulnerable babies. Breast milk contains lactose, AADHA, iron, zinc, selenium, and iodine, which are the primary raw materials for the formation of brain nerve cells.

REFERENCES

1. Afifah, D. N. (2007). Faktor yang berperan dalam kegagalan praktik pemberian ASI eksklusif. *Universitas Diponegoro, Program Pasca Sarjana. Semarang: Universitas Diponegoro.*
2. Al Rahmad, A. H. (2017). Pemberian ASI dan MP-ASI terhadap pertumbuhan bayi usia 6–24 bulan. *Jurnal Kedokteran Syiah Kuala, 17(1), 4-14.*
3. Anand, T., Rahi, M., Sharma, P., & Ingle, G. K. (2014). Issues in prevention of iron deficiency anemia in India. *Nutrition, 30(7-8), 764-770.*
4. Antén, J. I. (2010). The impact of remittances on nutritional status of children in Ecuador. *International migration review, 44(2), 269-299.*
5. Ariati, L. I. P. (2019). Faktor-Faktor Resiko Penyebab Terjadinya Stunting Pada Balita Usia 23-59 Bulan. *Oksitosin: Jurnal Ilmiah Kebidanan, 6(1), 28-37.*
6. Babakazo, P., Donnen, P., Akilimali, P., Ali, N. M. M., & Okitolonda, E. (2015). Predictors of discontinuing exclusive breastfeeding before six months among mothers in Kinshasa: a prospective study. *International Breastfeeding Journal, 10(1), 1-9.*
7. Beauchamp, G. K., & Moran, M. (1982). Dietary experience and sweet taste preference in human infants. *Appetite, 3(2), 139-152.*



8. Bima, A. (2019). Analisis bagaimana mengatasi permasalahan stunting di Indonesia? *Berita Kedokteran Masyarakat*, 35(4), 6-10.
9. Black, R. E., Allen, L. H., Bhutta, Z. A., Caulfield, L. E., De Onis, M., Ezzati, M., ... & Maternal and Child Undernutrition Study Group. (2008). Maternal and child undernutrition: global and regional exposures and health consequences. *The lancet*, 371(9608), 243-260.
10. Budiastutik, I., & Rahfiludin, M. Z. (2019). Faktor Risiko Stunting pada anak di Negara Berkembang. *Amerta Nutrition*, 3(3), 122-129.
11. Caulfield, L. E., Richard, S. A., Rivera, J. A., Musgrove, P., & Black, R. E. (2006). Stunting, wasting, and micronutrient deficiency disorders. *Disease Control Priorities in Developing Countries. 2nd edition*.
12. Efendi, S., Sriyanah, N., Cahyani, A. S., Hikma, S., & Kiswati, K. (2021). Pentingnya Pemberian ASI Eksklusif untuk Mencegah Stunting pada Anak. *Idea Pengabdian Masyarakat*, 1(02), 107-111.
13. Fenske, N., Burns, J., Hothorn, T., & Rehfuess, E. A. (2013). Understanding child stunting in India: a comprehensive analysis of socio-economic, nutritional and environmental determinants using additive quantile regression. *PloS one*, 8(11), e78692.
14. Gómez, M. I., Barrett, C. B., Raney, T., Pinstrup-Andersen, P., Meerman, J., Croppenstedt, A., ... & Thompson, B. (2013). Post-green revolution food systems and the triple burden of malnutrition. *Food Policy*, 42, 129-138.
15. Hadi, H. (2004). Gizi lebih sebagai tantangan baru dan implikasinya terhadap kebijakan pembangunan kesehatan nasional. *Jurnal Gizi Klinik Indonesia*, 1(2), 47-53.
16. Hapsari, D. I., Dewi, R. R. K., & Selviana, S. (2019). Deteminan kejadian stunting pada balita di wilayah 3t (tertinggal, terdepan, dan terluar)(studi kasus di wilayah kerja puskesmas darajuanti kabupaten sintang). *Jurnal Publikasi Kesehatan Masyarakat Indonesia*, 6(2).
17. Kakute, P. N., Ngum, J., Mitchell, P., Kroll, K. A., Forgwei, G. W., Ngwang, L. K., & Meyer, D. J. (2005). Cultural barriers to exclusive breastfeeding by mothers in a rural area of Cameroon, Africa. *Journal of midwifery & women's health*, 50(4), 324-328.
18. Kania, N. (2006). Stimulasi tumbuh kembang anak untuk mencapai tumbuh kembang yang optimal. *Bandung: Universitas Padjajaran*.
19. Kavle, J. A., LaCroix, E., Dau, H., & Engmann, C. (2017). Addressing barriers to exclusive breast-feeding in low-and middle-income countries: a systematic review and programmatic implications. *Public Health Nutrition*, 20(17), 3120-3134.
20. Khalil, I. A., Troeger, C., Rao, P. C., Blacker, B. F., Brown, A., Brewer, T. G., ... & Mokdad, A. H. (2018). Morbidity, mortality, and long-term consequences associated with diarrhoea from Cryptosporidium infection in children younger than 5 years: a meta-analyses study. *The Lancet Global Health*, 6(7), e758-e768.
21. Kramer, M. S., & Kakuma, R. (2004). The optimal duration of exclusive breastfeeding. *Protecting infants through human milk*, 63-77.
22. Kumar, P., Srivastava, S., Chauhan, S., Patel, R., Marbaniang, S. P., & Dhillon, P. (2021). Associated factors and socio-economic inequality in the prevalence of thinness and stunting among adolescent boys and girls in Uttar Pradesh and Bihar, India. *PloS one*, 16(2), e0247526.
23. Kusuma, K. E., & Nuryanto, N. (2013). Faktor risiko kejadian stunting pada anak usia 2-3 tahun (Studi di Kecamatan Semarang Timur). *Journal of Nutrition College*, 2(4), 523-530.
24. Ladipo, O. A. (2000). Nutrition in pregnancy: mineral and vitamin supplements. *The American journal of clinical nutrition*, 72(1), 280S-290S.
25. Lawoyin, T. O., Olawuyi, J. F., & Onadeko, M. O. (2001). Factors associated with



- exclusive breastfeeding in Ibadan, Nigeria. *Journal of Human Lactation*, 17(4), 321-325.
26. Ministry of Health. (2018). Infodatin Situasi Balita Pendek. Jakarta: Ministry of Health.
27. Nabwera, H. M., Mwangome, M. K., & Prentice, A. M. (2022). Stunting of Growth in Developing Countries. *Nutrition and Growth*, 125, 14-27.
28. Neelsen, S., & Stratmann, T. (2011). Effects of prenatal and early life malnutrition: Evidence from the Greek famine. *Journal of Health Economics*, 30(3), 479-488.
29. Neumann, C., Harris, D. M., & Rogers, L. M. (2002). Contribution of animal source foods in improving diet quality and function in children in the developing world. *Nutrition research*, 22(1-2), 193-220.
30. Pantaleon, M. G., Hadi, H., & Gamayanti, I. L. (2016). Stunting berhubungan dengan perkembangan motorik anak di Kecamatan Sedayu, Bantul, Yogyakarta. *Jurnal Gizi dan Dietetik Indonesia (Indonesian Journal of Nutrition and Dietetics)*, 3(1), 10-21.
31. Paul, V. K., Sachdev, H. S., Mavalankar, D., Ramachandran, P., Sankar, M. J., Bhandari, N., ... & Kirkwood, B. (2011). Reproductive health, and child health and nutrition in India: meeting the challenge. *The Lancet*, 377(9762), 332-349.
32. Permatasari, D., & Suprayitno, E. (2020). Implementasi Kegiatan Pendidik Sebaya dan Konselor Sebaya dalam Upaya Pencegahan Triad KRR di Pusat Informasi dan Konseling Remaja. *Jurnal Ners Dan Kebidanan (Journal of Ners and Midwifery)*, 7(1), 143-150.
33. Rahma, A. C., & Nadhiroh, S. R. (2016). Perbedaan sosial ekonomi dan pengetahuan gizi ibu Balita gizi kurang dan gizi normal. *Media Gizi Indonesia*, 11(1), 55-60.
34. Roesli, U. (2000). *Mengenal ASI eksklusif*. Niaga Swadaya.
35. Roseboom, T. J., Painter, R. C., van Abeelen, A. F., Veenendaal, M. V., & de Rooij, S. R. (2011). Hungry in the womb: what are the consequences? Lessons from the Dutch famine. *Maturitas*, 70(2), 141-145.
36. Sahyoun, N. R., Lin, C. L., & Krall, E. (2003). Nutritional status of the older adult is associated with dentition status. *Journal of the American Dietetic Association*, 103(1), 61-66.
37. Santi, M. Y. (2017). Upaya Peningkatan Cakupan ASI Eksklusif dan Inisiasi Menyusu Dini/IMD (The Improvement Efforts of Exclusive Breastfeeding and Early Initiation of Breastfeeding). *Jurnal Kesmas Indonesia*, 9(1), 69-80.
38. Sartika, R. A. D. (2010). Analisis pemanfaatan program pelayanan kesehatan status gizi balita. *Kesmas: Jurnal Kesehatan Masyarakat Nasional (National Public Health Journal)*, 5(2), 90-96.
39. Scherbaum, V., & Srouf, M. L. (2016). The role of breastfeeding in the prevention of childhood malnutrition. *Hidden Hunger*, 115, 82-97.
40. Sudiman, H. (2008). Stunting atau Pendek: Awal Perubahan Patologis atau Adaptasi Karena Perubahan Sosial Ekonomi yang Berkepanjangan?. *Media Penelitian dan Pengembangan Kesehatan*, 18(1).
41. Sugiyono, P. (2011). *Metodologi penelitian kuantitatif kualitatif dan R&D*. Bandung: Alfabeta.
42. Supariasa, I. D. N., Bakri, B., & Fajar, I. (2002). Penilaian Status Gizi [Nutritional Status Assessment]. *Jakarta: Penerbit Buku Kedokteran EGC*.
43. Tamiru, D., Belachew, T., Loha, E., & Mohammed, S. (2012). Sub-optimal breastfeeding of infants during the first six months and associated factors in rural communities of Jimma Arjo Woreda, Southwest Ethiopia. *BMC public health*, 12(1), 1-9.
44. Unicef Indonesia. (2013). *Ringkasan Kajian Gizi Ibu dan Anak*.
45. World Health Organization. (WHO). (2016). *Nutrition Landscape Information System (NLIS) Country Profile Indicators: Interpretation entirely (Serial Online)*.

